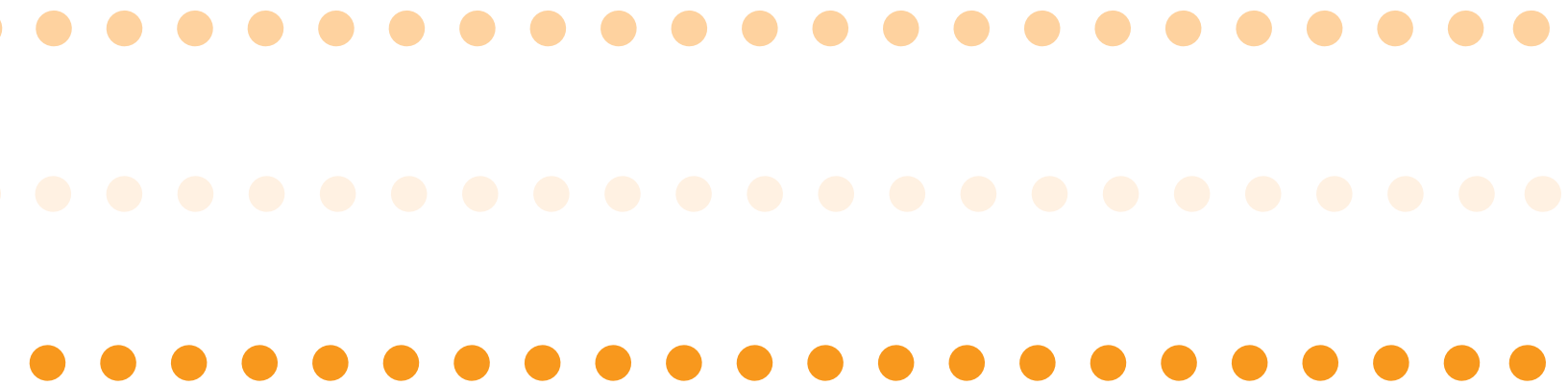
Young People Most at Risk of HIV

A Meeting Report and Discussion Paper from the Interagency Youth Working Group, U.S. Agency for International Development, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Inter-Agency Task Team on HIV and Young People, and FHI



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Contributors are listed below according to the chapters of the report:

Framing the Issue: Bruce Dick, World Health Organization (WHO); Ward Rinehart, consultant; and Diane Widdus, UNICEF.*

Young Men Who Have Sex with Men: Kent Klindera, amfAR; Rafael Mazin, Pan American Health Organization (PAHO); Brian Ackerman, Advocates for Youth; Donna Sherard and Brian Pederson, Population Services International (PSI); Philippe Girault and Bill Finger, FHI; Cheikh Traore, United Nations Development Programme, and Bruce Dick, WHO.

Young People Who Sell Sex: Jay Silverman, Harvard School of Public Health; Brad Kerner, Save the Children; Jenny Butler, UNFPA; Bruce Dick, WHO; Kwaku Yeboah* and Bill Finger, FHI.

Young People Who Inject Drugs: Diane Widdus, UNICEF;* Shimon Prohow, PSI;* Kyla Zanardi and Caitlin Padgett, Youth RISE;* Mary Dallao and Simon Baldwin, FHI; Ward Rinehart, consultant; and Bruce Dick, WHO.

Conclusions: Shanti Conly and Debbie Kaliel, USAID; Bruce Dick, WHO; Ward Rinehart, consultant.

Overall report: Bruce Dick and Jane Ferguson, WHO; Jenny Butler and Mary Otieno, UNFPA; Debbie Kaliel and Jenny Truong, USAID; Ward Rinehart, consultant; Joy Cunningham and Karah Fazekas, FHI.

Peer review: Jyothi Raja N.K. and Michael Bartos, UNAIDS Secretariat.

This report draws heavily on materials presented at a meeting of the same title held June 25, 2009, in Washington, DC, sponsored by the USAID Interagency Youth Working Group. Those who contributed to planning that meeting were Debbie Kaliel, Shanti Conly, and Jenny Truong, USAID; Linda Wright-Deaguero, U.S. Centers for Disease Control and Prevention; Karina Rapposelli, U.S. Office of Government AIDS Control; Diane Widdus, UNICEF; Mary Otieno, Jenny Butler, and Koye Adeboye, UNFPA; Bruce Dick, WHO; and Joy Cunningham, Karah Fazekas, Bill Finger, and Elena Lebetkin of FHI.

FHI coordinated the editorial process for this paper, led by Bill Finger with assistance from Suzanne Fischer, Jan Wheaton, Elizabeth Futrell, and Elena Lebetkin. Design by Hopkins Design Group Ltd.

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* These people were with the organization indicated at the time of the June 2009 meeting, but they have since moved to other organizations.

This publication does not necessarily represent the views, decisions, or policies of the U.N. agencies involved in the UNAIDS Inter-Agency Task Team on HIV and Young People, which supported the development of this document. This document is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID). The contents are the responsibility of FHI and do not necessarily reflect the views of USAID or the United States Government. Financial assistance was provided by USAID under the terms of Cooperative Agreement No. GPO-A-00-05-00022-00 and the Preventive Technologies Agreement No. GHO-A-00-09-00016-00.

ISBN: 1-933702-62-1

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Introduction

Young People Most at Risk of HIV

This paper is designed to call more attention to young people within the groups considered "most at risk" for HIV—those who sell sex, those who inject drugs, and young men who have sex with men. Despite the growing attention that has been given to programming for these groups, little explicit focus has emerged on the particular needs of young people in these populations. At the same time, efforts to prevent HIV among young people have tended to focus on the general population of young people, for whom more is known about effective programming, instead of focusing on young people in most-at-risk groups. As a result, young people who inject drugs or sell sex and young men who have sex with men are often not targeted in either type of programming.

Research has begun to show the importance of focusing on young people within most-at-risk populations, and there are increasing examples of programmatic approaches for meeting their needs. But many challenges remain, including the fact that there are significant differences among young people between the ages of 10 and 24. For example, the United Nations has stressed that the term *sex worker* can apply only to those at least 18 years of age because younger adolescents are considered to be victims of commercial sexual exploitation. In addition, much more work is needed to understand the intersection of programming between young people in general and young people most at risk of HIV and other sexual and reproductive health (RH) problems.

On June 25, 2009, the U.S. Agency for International Development (USAID) sponsored a daylong meeting in Washington, DC, entitled "Young People Most at Risk for HIV/AIDS," working through the Interagency Youth Working Group led by FHI. The UNAIDS

In this report the following definitions are used: *adolescents*, which refers to individuals between the ages of 10 and 19; *youth*, which refers to individuals between the ages of 15 and 24; and *young people*, which refers to those between the ages of 10 and 24. If the text does not specify a particular age group, it refers to all young people, i.e., individuals between the ages of 10 and 24.

Inter-agency Task Team on HIV and Young People (IATT/YP) participated in the planning of the meeting through its working group on most-at-risk young people. The meeting had three objectives:

1. To provide an overview of the specific needs of young people (between the ages of 10 and 24) who are vulnerable and most at risk of HIV
2. To provide examples of policies and programs that are designed specifically to address the needs of most-at-risk young people
3. To identify the next steps in addressing the needs of vulnerable and most-at-risk young people

The meeting was the first time that the UN and the key groups in the United States that are responsible for administering the President's Emergency Plan for AIDS Relief (PEPFAR) had come together to share information and explore future directions regarding policies and programs for young people most at risk of HIV. The IATT/YP working group on most-at-risk young people had previously held two meetings, one in Ukraine (Kiev) in 2006 and the other in Vietnam (Hanoi) in 2007. Both of these meetings focused on developing plans and sharing experiences in selected countries (Brazil, Iran, Pakistan, Ukraine, and Vietnam participated) to accelerate action for meeting the needs of young people most at risk of HIV.

Debbie Kaliel of USAID introduced the meeting by highlighting some of the challenges of conceptualizing and responding to the needs of young people who are vulnerable and most at risk of HIV infection. "The spectrum ranges from street youth who are engaged in sex work and injecting drugs, which may take place in both concentrated and generalized epidemics, to the significant risk of HIV faced by many adolescent girls in countries with generalized epidemics. Understanding risk within a context of vulnerability helps us to be clear about what we need to be doing, and for whom. Concentrating this meeting on the three traditional most-at-risk populations groups provides some focus and suggests some conceptual models that may provide us with guidance."

Even within this more narrow focus, Kaliel pointed out, there are tough questions to address. "Do we need to include a focus on young people into programming for most-at-risk populations, or should we give more attention to most-at-risk young people in on-going youth programs?" she asked. "Or should we create separate programs for most-at-risk young people?"

Based on the June 2009 meeting and additional material from literature reviews and field experiences, this paper is designed to promote greater awareness and attention to the needs of most-at-risk young people among donors, policymakers, program planners, and others. It does not attempt to provide a systematic review of all the available literature related to the topic, nor does it provide specific programmatic guidance. It does, however, include suggested actions based on the presentations and discussions at the June meeting and on the other materials synthesized in this report.

The paper has the same structure as the June meeting (see Appendix 1: Agenda, "Young People Most at Risk for HIV/AIDS"). The first chapter frames the issue and discusses the unique characteristics of young people most at risk of HIV, the concept of vulnerability, and the implications for programmatic approaches. It includes several boxes on related topics, such as the roles of different UN agencies and the importance of involving most-at-risk young people in developing and implementing programs that meet their needs. This first chapter introduces several themes that are common across the three subsequent chapters that focus respectively on young men who have sex with men, young people who sell sex, and young people who inject drugs. A concluding chapter summarizes key themes and suggested next steps. Appendix 2 provides a summary of overall resources on this topic, complementing those resource materials referenced in the footnotes of the preceding chapters.

Chapter 1.

Framing the Issue: Young People, Risk, Vulnerability, and the HIV Epidemic

Millions of young people around the world face a high risk of infection from HIV and other negative sexual and reproductive health (RH) outcomes as a result of behaviors that they adopt, or are forced to adopt. Three groups of young people who are considered to be most at risk of HIV are young men who have sex with men and young people who sell sex or inject drugs. In addition to these three groups, other young people are also at higher risk of infection, especially in generalized epidemics. Those who have sex with someone who is or is likely to be HIV-infected are at risk of acquiring HIV if they do not use a condom. This broad group includes the clients of sex workers, the wives of these clients, an HIV-negative partner in a discordant couple, and, in high prevalence settings, adolescent girls who have sex with older men. All of these groups include substantial numbers of young people.

HIV programs and policies have in general failed to respond to the specific needs of young people in most-at-risk populations. Such programming is challenging because related data are usually not disaggregated by age, and there are few good examples of effective programs to provide inspiration and guidance. Furthermore, these are often not discrete groups because the behaviors frequently overlap—for example, young people who inject drugs might sell sex to buy drugs, and sex workers might inject drugs to provide some escape from their situation.[1] Improving our response to HIV prevention and care among most-at-risk young people could play a pivotal role in strengthening national HIV programs.

Consistently using condoms and clean injecting equipment greatly reduces the risk of HIV infection among these groups. But the young people who most need such protection often have the most difficulty accessing appropriate services and adopting behaviors that protect them from HIV. The behaviors that put them at risk are usually heavily stigmatized and take place clandestinely, often illegally.[2] Existing policies and legislation, lack of political support, and other structural issues often prevent most-at-risk young people from receiving the services that they need. Such factors contribute to marginalizing these young people further, which then contributes to undermining their self-efficacy, their confidence in health and social services, and their willingness to make contact with service providers.

To help frame the discussion about young people who are most at risk of HIV and other sexual and RH issues, this chapter first summarizes key factors that mark the period of adolescence, i.e., the factors that make adolescents different from small children and adults. Second, it discusses the term *most at risk* in more detail, defines the behaviors that put some young people more at risk of acquiring HIV, and synthesizes the data that are available to help understand the importance of these populations in the HIV epidemic. Third, the chapter addresses the broader concept of vulnerability and outlines those factors that make some young people particularly vulnerable to becoming most at risk of HIV. Finally, it discusses programmatic approaches for most-at-risk young people and introduces issues that are discussed in more detail in the chapters that follow.

Understanding Young People

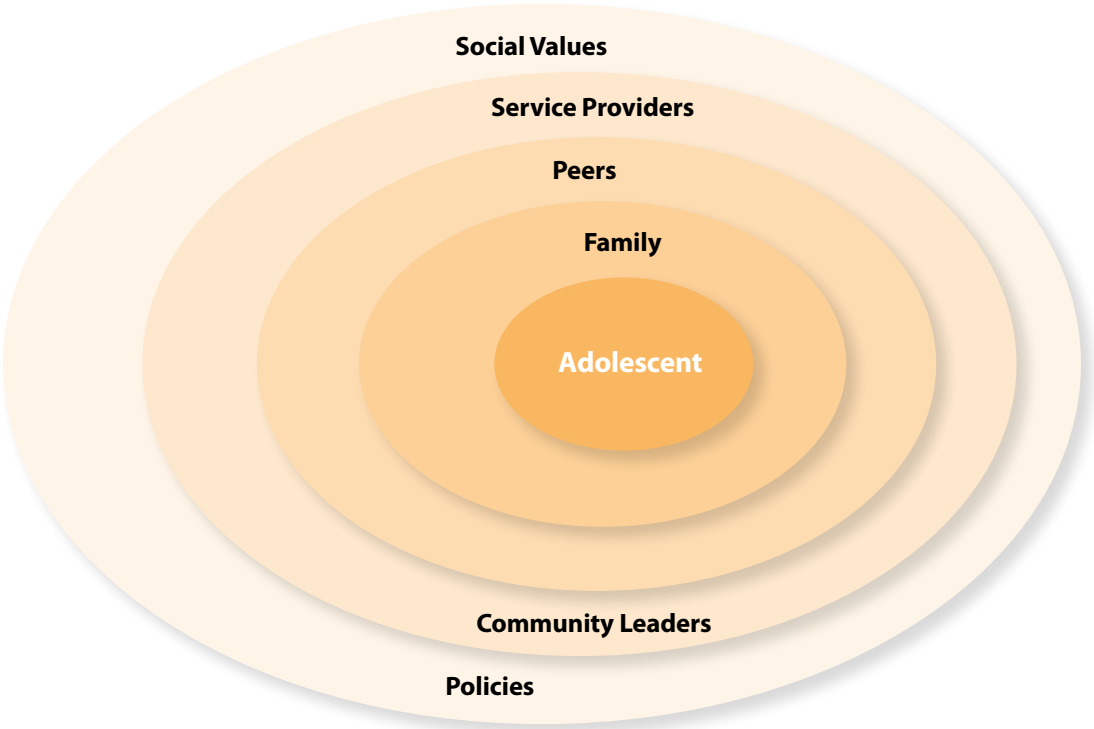
The period between childhood and adulthood includes a wide age range and significant variations between and within individuals in terms of the physical, psychological, and social development that takes place. Besides their age, factors such as marital status and economic independence have implications for how society views young people and how they view themselves. Adolescence is the time when puberty takes place, when the majority of people initiate sex, and when sexual preference and identity are formed. Many characteristics of young people need to be taken into consideration in both the content and delivery channels of services that are provided for them. These characteristics include their age and sex, whether or not they are in school, their family relationships and support, and where they live (i.e., in rural or urban areas). Programmers need to be aware of such factors and, at the same time, be able to capitalize on the vibrancy, innovation, and sense of hope that is inherent in many young people.

During the second decade of life, adolescents make important transitions, which often include not only sexual initiation but also leaving school, entering the labor force, forming partnerships, and having children.[3] This is a period of first-time experiences, risk-taking, and experimentation with many things, including alcohol and other psychoactive substances. Many things, including the fact that their capacity for complex thinking is still developing, affect how young people deal with the opportunities and challenges that surround them.[4]

The changes that take place during adolescence need to be understood by the people who are responsible for HIV programming because these changes affect:

- How adolescents understand information
- What information and which channels of information influence their behavior
- How they think about the future and make decisions in the present
- How they perceive risk in a period of experimentation and first-time experiences
- How they form relationships, respond to the social values and norms that surround them, and are influenced by the attitudes (or perceived attitudes) of their peers and others

Figure 1. An Ecological Model of Young People's Health and Development



The World Health Organization (WHO), the United Nations Population Fund (UNFPA), and United Nations Children's Fund (UNICEF)[5] have grouped young people's needs for health and development into four priority areas: comprehensive information and life skills; services, including counseling and commodities; safe and supportive environments; and opportunities for participation. These needs are for the most part also defined as rights in the Convention of the Rights of the Child. Many people need to be involved in meeting these needs, including parents or guardians, peers, teachers, service providers, community and religious leaders, and policymakers. The ecological model in Figure 1 provides a synthesis of the many different actors and determinants that have an impact on the health and development of young people.

At an individual level, many factors affect young people's health. In terms of HIV, young people are less likely to be able to prevent themselves from becoming infected. They often do not have sufficient correct knowledge about HIV, the skills to use the knowledge that they do have (to negotiate condom use, for example), or access to the services and commodities that they need. Broader factors include the role of parents and the community, as well as social values and norms. Studies from more than 50 countries have identified a number of common determinants that are associated with behaviors that could undermine adolescents' health, such as early sexual activity and substance use.[6] These determinants could either increase the risk of negative behaviors (risk factors) or protect against them (protective factors). They include the young person's relationship with his or her parents and other adults in the community, family dynamics, the school environment, the attitudes and behavior of friends, and spiritual beliefs. Protective factors in preventing early sexual debut are a positive relationship with parents, a positive school environment, and spiritual beliefs. Risk factors associated with early sexual debut include having friends who are negative role models and engaging in other risky behaviors, such as substance use.[7]

Most-at-Risk Young People

Two behaviors pose the greatest risks for the acquisition of HIV: penetrative sex (vaginal or anal) with multiple partners without using condoms, and sharing infected needles and syringes to inject drugs. Unprotected vaginal sex is a risk not only for HIV, but also, of course, for pregnancy (see Table 1).

Table 1. Risk Behaviors for HIV, STIs, and Pregnancy

Risk Behaviors	HIV	STIs	Pregnancy
Vaginal sex without a condom	yes	yes	yes
Anal sex without a condom	yes	yes	NA
Multiple partners	yes	yes	Frequency of sex is important, but not the number of partners
Injecting drugs with shared equipment	yes	Other diseases are associated with injecting drugs, such as hepatitis	NA

Some groups of young people are most at risk of HIV because they adopt, or are forced to adopt, behaviors, which, if practiced unsafely, might put them at risk of becoming infected with the virus: young men who have sex with men, young people who sell sex, and young people who inject drugs. Even for these groups, a number of factors affect the degree of risk, including the frequency of the risk behavior, the likelihood of HIV exposure associated with the behavior (e.g., the prevalence of HIV among sexual partners and those using the same injecting equipment), and the likelihood of infection if exposed (e.g., anal sex is a higher-risk behavior than vaginal sex).

In terms of the epidemiology of HIV, most-at-risk populations are particularly important in concentrated epidemics, although they also require consideration in generalized epidemics.[8] In regions where concentrated epidemics are common, the most-at-risk groups represent a large percentage of those living with HIV: 76 percent in Eastern Europe/Central Asia, 35 percent in South and Southeast Asia (India excluded), and 49 percent in Latin America.[9] If the clients of commercial sex workers are also included, then the percentage of overall infections attributable to most-at-risk groups jumps to 83 percent in Eastern Europe/Central Asia, 76 percent in South and Southeast Asia (India excluded), and 62 percent in Latin America. The clients of sex workers who also have sex with their wives and girlfriends might transmit HIV through unprotected sex, which links most-at-risk groups with the general population. A similar process can occur with the sexual partners of drug users[10] and the female sexual partners of men who have sex with men (MSM).

Consultation on Strategic Information and HIV Prevention among Most-at-Risk Adolescents

In collaboration with the Inter-Agency Task Team on HIV and Young People, UNICEF held a Consultation on Strategic Information and HIV Prevention among Most-at-Risk Adolescents (between the ages of 10 and 19) in 2009. The Consultation provided a forum for the exchange of information on country-level data collection and programming targeted at most-at-risk adolescents with the goal of identifying tactics for employing strategic data to improve HIV prevention among these adolescents and building support for programming among decision makers to help these young people.

The report from the consultation offers recommendations to address research and programming challenges specific to these adolescents. These challenges include the following:

- **The difficulty in reaching these adolescents**
- **Legal and ethical concerns**
- **Weak collaboration and coordination efforts**
- **Conflicting agendas among agencies**
- **Lack of political and social support**
- **Information gaps as barriers to effective programming**

The report identifies 10 key actions to broaden the evidence base, strengthen political commitment, and expand links across sectors. The report also offers detailed suggestions for national, regional, and global efforts to support each of these actions. The actions are shown below as they are grouped in the report.

Improving the collection and analysis of strategic information

- **Systematically disaggregate data on most-at-risk populations by age group: 15-19, 20-24, and 25 and over.**
- **Strengthen capacity and willingness to estimate population size of most-at-risk adolescents.**
- **Improve data collection coordination and approaches.**

Generating political support for policies and programs

- **Integrate most-at-risk adolescents into existing systems, publications, and reports.**
- **Support a cyclical approach: research to advocacy to programming to advocacy to implementation.**
- **Foster productive partnerships.**

Building links and strengthening partnerships across sectors and services

- **Use evidence to promote a multi-sectoral response.**
- **Work with existing systems and processes and encourage parallel, mutually supportive approaches.**
- **Strengthen knowledge management.**
- **Expand partnerships.**

Programs seeking to prevent the spread of HIV use the phrase "know your epidemic and response."[11] When considering most-at-risk groups, knowing the epidemic includes understanding the crucial role that young people play in the transmission of HIV. Not only do young people constitute a large percentage of most-at-risk groups, but they also frequently have higher HIV infection rates within these groups.[12] An estimated 70 percent of the world's injecting drug users are under the age of 25.[13] A study of injecting drug use (IDU) in cities around the world found that between 70 and 95 percent of users had started before the age of 25. In most of the cities, at least half had started injecting between the ages of 16 and 19, and some had started even younger.[14] In many places, a significant proportion of women in sex work start before they reach age 20, with the majority of sex workers being under the age of 25.[15]

Not only do young people constitute a large percentage of most-at-risk groups, but they also frequently have higher HIV infection rates within these groups.

Regarding rates of HIV infection among most-at-risk young people, in Myanmar, for example, the highest HIV rates among female sex workers and those injecting drugs occurred in the 20- to 24-year-old age group (41 percent and 49 percent, respectively), with rates in the 15- to 19-year-old age group also being very high (41 percent and 38 percent).[16] In some places, young sex workers are more likely to inject drugs[17] and less likely to use condoms than older sex workers.[18] In the United States, the number of infections among MSM increased from 2001 to 2006 only among those in the 13- to 24-year-old age group, while the numbers have either declined or stayed the same among other age groups.[19]

In summary, young people comprise a significant proportion of most-at-risk populations, and they often have higher HIV prevalence than older people in these groups. Therefore, the following factors need to be considered when developing programs:

- Young people's behavior is less fixed than adults' behavior. Drug use and particular sexual practices are sometimes experimental and might or might not continue.
- Young people are less likely than older adults to identify themselves as drug users or sex workers. This makes them harder to reach with programs and less responsive to communication addressed to groups with specific identities.
- Young people are more easily exploited and abused.
- Young people have less experience coping with marginalization and illegality.

- Young people might be less willing to seek out services, and service providers might be less willing to provide services to them because of concerns about the legality of behaviors in some settings and informed consent.
- Young people are often less oriented toward long-term planning and thus might not think through the consequences of the risks that are related to the choices they make.

Vulnerability and Young People

The behaviors of some young people, such as selling sex or injecting drugs, put them at high risk of HIV infection. But clearly not all young people adopt these behaviors, and even among those who do adopt them, some use condoms or clean needles and syringes, and some do not. As a report from the Joint United Nations Programme on HIV/AIDS (UNAIDS) explains, *most at risk* refers to behaviors, while *vulnerability* refers to the circumstances and conditions that make most-at-risk behaviors more likely.[20] Many of these conditions are beyond an individual young person's control, and they are often referred to as *structural factors* or the *risk environment*.[21]

Young people are more vulnerable to HIV infection because of the societal factors that reduce their ability to avoid risky behaviors.

- They might not have access to information and services.
- They might be living without parental guidance and support.
- They might have been trafficked or exposed to physical or sexual violence and abuse.
- They might live in societies where laws or social values force young people to behave in ways that place them at risk, for example, homophobia or norms that encourage adolescent girls to have sex with older men.

Young people become more vulnerable if their health and development needs are not met, i.e., if they do not have access to information and services, do not live and learn in environments that are safe and supportive, and do not have opportunities to participate in the decisions that affect their lives. Table 2 provides examples of some of the factors that can cause young people to become vulnerable and adopt most-at-risk behaviors.

Table 2. What Makes Some Young People Vulnerable to Becoming Most at Risk?

Young people's needs	Factors that make young people vulnerable and likely to adopt most-at-risk behaviors
Access to information and opportunities to develop life skills	■ Lack of access to age-appropriate information through schools, the media, and other sources ■ Not being in school ■ Lack of opportunities to develop self-efficacy
Access to services	■ Lack of services that meet their specific needs ■ Families and communities that oppose or fail to support young people using services ■ Laws and policies that restrict access to services by young people (e.g., requirements for parental consent)
Supportive and safe environments	■ Lack of family attachment, parental guidance, and family support, e.g., orphans and young people in institutions and poorly functioning families ■ Living in situations of marginalization, discrimination, exploitation, abuse, poverty, and easy access to drugs ■ Homelessness and lack of access to safe spaces
Participation in the making of decisions that affect their lives	■ Lack of community organizations working with and for young people ■ Lack of opportunities to participate in programs that affect their health ■ Few advocacy/activist organizations that involve and engage young people

The term *especially vulnerable young people* refers to those whose living conditions are particularly likely to lead them to adopt most-at-risk behaviors. These conditions include living on the street or as an orphan, in a correctional facility, in a family or community where drug use is common, in a family where there is physical or sexual abuse, in extreme poverty, in areas where human trafficking is common, in displacement or migration, in war or conflict situations, or with disabilities.

In the hyper-endemic countries of southern Africa, all girls and young women could be considered to be especially vulnerable.[22] In countries with HIV prevalence above 15 percent, women between the ages of 15 and 24 are two to four times more likely to be infected than men in the same age group, largely because of age-disparate sex. The greater the age difference between sexual partners, the greater the likelihood that the woman will become infected. Given the lack of livelihoods for young women and the imbalance of power, sex with older men is often transactional, coerced, or even forced.[23] Regardless of the degree of volition, however, these young women face a high risk of HIV infection.

In countries with HIV prevalence above 15 percent, women between the ages of 15 and 24 are two to four times more likely to be infected than men in the same age group.

Programs for Most-at-Risk Young People

All young people should receive information, life-skills development, and HIV prevention services and commodities, including services related to sexual and reproductive health. For especially vulnerable young people, programs should include all of the activities and services provided to the general population of adolescents plus actions that are designed to mitigate individual vulnerability. These actions should include counseling and protection from abusive or exploitative situations, and they should address structural determinants, such as alleviating poverty and changing harmful social values and norms, including gender norms.

Young people who have already engaged in behaviors that put them at risk of HIV infection (a subgroup within the especially vulnerable group) need all of the services provided for the general population of young people and those provided for vulnerable young people. In addition, they need programs to reduce the risk and the related harm of the behaviors that they have adopted, as well as support to stop these behaviors.

Young People's Participation: A Key Asset for Those Most at Risk

Programs and services for young people can benefit from including them in the design, implementation, and delivery of services. Over the last decade, more youth–adult partnerships and youth-led programming have been incorporated into general HIV and RH programming for young people. But youth participation in programs for most-at-risk young people creates extra and, at times, formidable hurdles, and requires greater advocacy from both young people and adults.

Support for harm-reduction programs for young people is not widespread, and high-level leadership is lacking. Meanwhile, many health programs and providers are fearful about serving adolescents. What can young people and their adult allies do about this situation?

Raising awareness is the first task, starting with people concerned about HIV and about young people. Health care providers, policymakers, educators, and advocates need to hear young people's first-hand experiences as providers and as clients of harm-reduction services. Participation in national, regional, and international meetings can help, but is difficult to arrange for those young people who are most at risk. Meaningful participation of most-at-risk young people requires that adult mentors and service providers supply a significant amount of financial and programmatic support. Meaningful engagement with these young people is a process that takes time and resources.

Input from the intended program beneficiaries can help programs avoid making unfounded assumptions. Involving young people can help those programs that lack experience working with young people who are engaged in illegal activities, such as drug use. For instance, local service providers in Vancouver, Canada, were convinced that they understood the needs of young people using drugs, and yet they had never asked them what kind of services they wanted or needed. A program that was developed by and for street-involved methamphetamine users, called Crystal Clear, sought to provide young people with the services they wanted to have access to in their community. The program asked their peers and friends about the what, when, where, and how of programming for young methamphetamine users. As the group developed the program, they surveyed their peers, used focus groups, and shared the findings with local service providers. As a result, the providers changed the ways they were reaching the young people.

Youth RISE (Resource, Information, Support, and Education) is the leading youth-led international organization dedicated to harm reduction among young people. Their work includes facilitating the involvement of young people in conferences and meetings at international and local levels to participate in policy change. Youth RISE also trains young people to carry out harm-reduction and youth-engagement activities and develops and distributes evidence-based information on young people, substance use, and harm reduction. Youth RISE and other groups seek to engage young people in decision-making processes, research, and training initiatives in order to develop programs that will work with young people who may use drugs. Peer-to-peer contact has proved to be an effective way to reach most-at-risk young people—sometimes it is the only way. When young people themselves are providing services, young clients feel more connected to the program, and they are more likely to stay engaged.

Youth RISE emphasizes that one program model does not fit all situations. A practice developed in one place might need to be tested and adapted before it can work elsewhere. With the help of young people themselves, programs can get to know their clients and develop programs that meet the needs that these young people are expressing.

Risk-reduction programs seek to support young people in avoiding behaviors that put them most at risk. These programs focus on preventing young people from selling sex or from using psychoactive substances, including injecting drugs. Program initiatives might include the following:

- Access to education
- Livelihood skills training and employment for vulnerable girls
- Prevention of trafficking and other means of sexually exploiting young girls
- Programs to decrease drug use in families and in places that young people frequent

Some refer to these efforts as *primary prevention*. Risk-reduction programs are not relevant or appropriate for preventing young men from having sex with other young men through choice because this is a matter of sexual orientation.

Harm-reduction programs address the needs of young people who have already adopted behaviors that put them most at risk of HIV. The first priority is to reduce the chances of HIV infection inherent in these behaviors. This can be done by ensuring that young people use condoms correctly and consistently when engaging in penetrative vaginal or anal sex, especially with multiple partners, or by ensuring that those who are injecting drugs use clean needles and syringes.

Beyond specific risk-reduction and harm-reduction programs, young people need expanded options and opportunities that will have the long-term effect of reducing harm, risk, and vulnerability. For any of the above approaches to succeed, a number of different types of programs will be needed, including biomedical, behavioral, and structural components. This is known as *combination prevention*. Table 3 provides some examples of combination prevention for most-at-risk young people.

HIV prevention programs for the general population of young people might consider most-at-risk young people, particularly those injecting drugs and selling sex, as outside their expertise and outside their sphere of responsibility.

For most-at-risk young people, these types of combination efforts are particularly important. Many programs focus on biomedical and behavioral components. Structural factors are equally important but often receive less attention for a number of reasons, including the fact that the evidence base for effectiveness is less strong and the programs are often more complex and long-term. For example, gender norms and

Table 3. Combination Prevention for Most-at-Risk Young People

Type of intervention	Strategy	Examples
Biomedical	Directed to individuals to decrease risk	Providing condoms, drug substitution, treatment for sexually transmitted infections (STIs)
Behavioral	Directed to individuals and their environments, to decrease risk and vulnerability	Providing information and life skills through schools, workplace, and community-based organizations; needle exchange programs (harm reduction); addressing social change programs that contribute to behavior through the media and other channels
Structural	Directed to individuals and their environments, to decrease risk and vulnerability	Increasing the number of schools, and increasing enrollment and retention in schools; increasing access to livelihood programs; decreasing discrimination and marginalization; changing policies and legislation that restrict access to services; engaging and mobilizing young people who are vulnerable and most at risk; addressing gender norms and harmful cultural practices (such as sexual violence) through policies and social norms

related laws can deny young women education and livelihoods and can contribute to conditions that allow young women's commercial sexual exploitation, abuse, and coercion.[24] Other structural factors include criminalization and discrimination against the behaviors that place some young people most at risk of HIV, and this can create serious obstacles to most-at-risk young people who are seeking the help that they need. Also, policies and laws could prevent minors from accessing services without parental consent, which is often not realistic for most-at-risk young people.

Program Challenges

Too often, most-at-risk young people fall into the gap between two different approaches to programming. HIV prevention programs for the general population of young people might consider most-at-risk young people, particularly those injecting drugs and selling sex, as outside their expertise and outside their sphere of responsibility. At the same time, programs for most-at-risk populations rarely adapt their service delivery to take into account the unique needs and circumstances of young people who are most at risk of HIV, especially adolescents.

Many programs focus on biomedical and behavioral components. Structural factors are equally important but often receive less attention for a number of reasons, including the fact that the evidence base for effectiveness is less strong and the programs are often more complex and long-term.

Widening this gap, resources for HIV prevention among young people frequently do not go where they can have the most impact in terms of preventing new infections. For example, in Asia, where concentrated epidemics predominate, at least nine out of every 10 newly infected young people come from most-at-risk groups, but the allocation of prevention resources is the reverse. According to the Asia Commission on AIDS, over 95 percent of all new HIV infections among young people occur among most-at-risk young people in Asia. Yet more than 90 percent of resources for young people as a target group are spent on low-risk youth, who account for less than five percent of infections. Countries must better track and analyze the information on high-risk populations and allocated resources accordingly.[25]

Most-at-risk young people are among society's most marginalized groups. They generally have few connections with social institutions, such as schools and organized religion, where many youth programs are provided. Furthermore, programs for most-at-risk young people often face explicit hostility, such as police harassment of young clients who come to needle and syringe exchange programs. In most societies, the prevailing reaction to most-at-risk behavior is to try to prevent and punish it, and these attitudes are even more entrenched when it comes to thinking about adolescents. Harm-reduction programs appear to some people as tolerating or even aiding illegal behavior. As a result of this hostile environment, programs for most-at-risk young people often spend much of their energy fending off opposition and lobbying for policy change. So programs face hard choices in balancing the energy needed to overcome these obstacles with that required to provide the services that their clients need for HIV prevention.

Most-at-risk young people are among society's most marginalized groups.

Young people below the age of 18 are considered to be children under the United Nations Convention on Rights of the Child. This establishes the obligation to remove these young people from exploitative situations, for example sexual exploitation, and to provide them with appropriate health, legal, and social services in accordance with their best interests and evolving capacities. Governments also have obligations to provide the information and services that are necessary to help reduce the harm from the risks that these young people face. Advocates need to ensure that laws and policies that are intended to protect the rights of most-at-risk adolescents do not end up preventing them from receiving the programs that they need.

A review of services for most-at-risk young people found that outreach by peers has often proven to be the best way of making contact with them.[26] Programs must work closely with young people, engaging them as partners in planning and learning from them about reaching young people with services (see box, Young People's Participation: A Key Asset for Those Most at Risk, page 16).

Some of the core elements for developing a more effective response to young people who are most at risk of HIV include the following:

- Collecting and disaggregating data by age, in addition to sex, which is important for advocacy, policies, and the development and monitoring of programs
- Developing and implementing policies that protect vulnerable young people, decriminalizing the behaviors that place them most at risk, and ensuring that most-at-risk adolescents can access the services that they need
- Training services providers, both those who work with most-at-risk populations and those who work with vulnerable groups of young people, so that they are better able to meet the specific needs of most-at-risk young people
- Making effective links between services and communities: with parents, schools, youth, civil society, religious and community leaders, and others
- Involving young people as advocates and as peers to make contact with, and provide outreach to, vulnerable and most-at-risk young people

Developing robust, effective programs that reach most-at-risk young people requires more attention from major donors. Both the United Nations (UN) and the U.S. government, through PEPFAR, have begun to address this challenge (see box on page 22, for a summary of the agencies involved). The UNAIDS Inter-agency Task Team (IATT) on HIV and Young People consists of all relevant UN agencies and involves a number of other organizations including civil society, donors, and youth organizations. The IATT has formed a working group on most-at-risk young people. This group is developing guidance on programming and case descriptions of good practice about most-at-risk young people.

PEPFAR currently does not have a specific strategy group or position paper that addresses the problem of most-at-risk young people. PEPFAR does, however, have an interagency technical working group that focuses on most-at-risk populations in general, and it has developed guidance for a minimum package of services. The package includes community-based outreach and education, access to sterile needles and syringes and safe disposal, condoms, STI screening and treatment, voluntary HIV counseling and testing, and addiction treatment. The guidance also includes HIV care and treatment, access to prevention of mother-to-child transmission (PMTCT), tuberculosis screening and treatment, and access to health and social services such as case management, family planning, and income generation.

This PEPFAR working group is beginning to discuss how this minimum package of services can more directly address the specific needs of young people. Some U.S. funding for programs with most-at-risk populations includes an explicit focus on young people, including improved access to youth-friendly clinics, peer outreach, and opportunities for job-skills training and education. The working group plans to focus more attention on young people, including age- and sex-disaggregated reporting of data. Such data can support operational research to determine what services are needed and how to deliver them, and to involve young people in all aspects of programming. All of these goals will require monitoring, including monitoring by youth advocacy groups, in order to ensure that such steps can be sustained in the face of the major HIV prevention challenges facing programs for most-at-risk young people, especially adolescents.

Young People and HIV: Which Agencies Do What?

Funding for HIV prevention within the U.S. government comes through PEPFAR. Coordination of this funding is the responsibility of the Office of the U.S. Global AIDS Coordinator (OGAC), which is part of the Department of State. The primary agencies implementing the PEPFAR program are USAID; the Centers for Disease Control and Prevention (CDC); the Peace Corps; and the Departments of State, Defense, Commerce, Labor, and Health and Human Services (see *http://www.pepfar.gov/agencies/index.htm*).

Within PEPFAR, an interagency Technical Working Group focuses on prevention for most-at-risk populations, with a subgroup focusing on substance abuse. The working group seeks to share scientific and programmatic information to improve service delivery for most-at-risk populations, to provide technical assistance to PEPFAR country programs, and to review prevention programs. A separate Technical Working Group addresses prevention for the general population and young people, including contextual factors that increase young people's vulnerability to HIV. Neither of these working groups focuses explicitly on young people most at risk of HIV.

The United Nations agencies have agreed on a UNAIDS technical division of labor concerning HIV prevention and young people. The agencies take both lead and partnership roles as shown in Table 4.

In 2001 the Joint United Nations Programme on HIV/AIDS (UNAIDS) formed the IATT on HIV and Young People to foster joint accelerated, harmonized, and expanded responses at the country level. UNFPA serves as the convener of this task team. In May 2008, membership expanded to include partners from civil society, academic institutions, youth networks and associations, the private sector, and other development organizations. Information can be found online at *http://www.unfpa.org/public/site/global/lang/en/iattyp*. Within the IATT on HIV and Young People, the Working Group on Most-at-Risk Young People, which is convened by UNICEF, strengthens collaboration and consensus among participating agencies and organizations to support action at the country level.

Table 4. Roles of UN Agencies in HIV Prevention among Young People*

Technical support areas of HIV prevention activities	ILO	UNAIDS Secr.	UNDP	UNESCO	UNFPA	UNHCR	UNICEF	UNODC	WFP	World Bank	WHO
IDU and prisoners	P	P	P	P	P		P	L			P
MSM		P	L	P	P			P			P
Sex workers	P	P		P	L	P	P	P			P
Vulnerable groups	P			P	L		P	P	P		P
Displaced populations			P	P	P	L	P		P		P
Workplace policy/progs.	L		P	P		P					
Health sector response	P		P		P	P	P	P		P	L
Young people in education institutions	P			L	P	P	P	P	P	P	P
Young people out of school	P	P		P	L		P	P			P

L = lead agency, P = main partner agency, IDU = injecting drug use, MSM = men who have sex with men

* ILO = International Labour Organization; UNAIDS = Joint United Nations Programme on HIV/AIDS; UNDP = UN Development Programme; UNESCO = UN Educational, Scientific, and Cultural Organization; UNFPA = UN Population Fund; UNHCR = UN Refugee Agency; UNICEF = UN Children's Fund; UNODC = UN Office on Drugs and Crime; WFP = UN World Food Program; WHO = World Health Organization.

Source: UNAIDS Inter-Agency Task Team on HIV and Young People. Global Guidance Briefs: HIV Interventions for Young People. New York: UNFPA, 2008.

Chapter 1. Notes

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Chapter 2.

Young Men Who Have Sex with Men

HIV infection has disproportionately affected men who have sex with men (MSM) since the beginning of the pandemic. In low-resource settings, MSM are on average 19 times more likely to be infected with HIV than the general population, and fewer than one in 20 MSM have access to lifesaving HIV care.[1] Stigma, discrimination, homophobia, violence, and criminalization prevent MSM from having access to and making use of the services that they need for HIV prevention, treatment, and care. The coverage of HIV prevention programs has generally increased in low-income countries, but this has rarely benefited MSM, particularly young men who have sex with men.

Definitions related to this population are critical. The Asia Pacific Coalition on Male Sexual Health (APCOM) captures the key issues in their definition of MSM: "An inclusive public health term used to define the sexual behaviors of males having sex with other males, regardless of gender identity, motivation for engaging in sex, or identification with any or no particular 'community.' The words 'man' and 'sex' are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts."[2] According to this definition, the term MSM can refer to:

- Men who identify themselves as gay, bisexual, or otherwise same-gender oriented in sexuality and sexual practice
- Men who do not identify themselves as same-gender oriented, but who have sex with other men because of economics (e.g., sex workers), environments (e.g., prisoners), societal constraints (e.g., gender separation, gender norms), experimentation (especially for young men), or simply for pleasure
- Male-to-female transgender individuals who are male biologically, but identify themselves as female and have sex with men

Studies on MSM report rapidly rising HIV infection rates in many areas. A recent review of global HIV infection rates among MSM found high and increasing HIV prevalence in Russia, China, and other parts of Asia. The review also summarized the large number of epidemiologic studies that have recently established the presence of populations of MSM throughout sub-Saharan Africa. The studies have reported infection rates among MSM ranging from 12 percent in Tanzania to 31 percent in a township of Cape Town, South Africa. High HIV prevalence rates among MSM were also seen throughout Latin America and the Caribbean.[3]

The impact of the epidemic on young MSM varies depending on the country. Studies in Bangkok indicate HIV incidence among young MSM (between the ages of 15 and 22) has nearly doubled in recent years, from 4.1 percent in 2003 to 7.7 percent in 2007, a faster increase than among older MSM.[4] A study in Russia reported young MSM (between the ages of 18 and 22) to have a significantly higher HIV prevalence (7.7 percent) than the general population of MSM (5.7 percent).[5] In contrast, a study from three African countries (Botswana, Malawi, and Namibia) with established, more generalized epidemics, found higher rates among older men: eight percent of MSM between the ages of 18 and 23 were infected compared to 25 percent of those 24 and older.[6] In the United States, where HIV programs

are widespread among older MSM, infection rates have recently increased "with incidence rates approximately 10 times higher [among those ages between the ages of 13 and 24] than that in the overall MSM community."[7] In particular, ethnic and racial minorities have markedly higher rates among young MSM.

Vulnerability and Risk

An important risk factor for HIV infection for all MSM is biological: transmission of HIV is five times more likely to occur through unprotected receptive anal than through unprotected receptive vaginal intercourse.[8] However, a number of other factors contribute to the risk for infection, especially for young men, including stigma, discrimination, and criminalization, which are reinforced in many cases by individual and cultural homophobia. Other factors that could affect the degree of vulnerability for young MSM include homelessness; abuse and victimization; substance abuse, including amphetamine-type stimulants; and poor access to health and other services.

In Africa, homosexuality is illegal in most countries, and political and social hostility is endemic.

In Asia, according to a major 2006 report, male-to-male sex is illegal in 11 of the 23 countries surveyed. In many of the other 12 Asian countries, MSM are subject to arbitrary persecution, often by police.[9] The report explained that male-to-male sex is widespread in Asia, but relatively few men adopt a Western-style gay identity in which sexuality defines identity.

In Africa, a recent overview of research reports that homosexuality is illegal in most countries, and political and social hostility is endemic.[10] In Senegal, a mostly Muslim nation where homosexuality is illegal, anti-gay demonstrators shouted slogans at a protest outside Dakar's main mosque after a gossip magazine published photos of a gay wedding. A leading newspaper in Uganda ran a feature story with photos and the headline "Top Homos in Uganda Named."

Many sexuality education materials ignore the idea of same-sex orientation, focusing instead on heterosexual issues. Not only do young MSM who are struggling with their sexuality not get help from sex education, but in some instances they are also harmed by the information they do receive. After exposure to HIV messages focusing on vaginal intercourse, some young MSM report that they consider anal intercourse to be safe. While clear information on HIV risk is important for all MSM populations, it can be particularly influential during the second decade of life when young people are establishing patterns of sexual behavior. A major

characteristic of sexual development during younger age is experimentation and eventual establishment of sexual orientation and identity.

Dependence on family for economic support and educational pursuits often keeps young MSM from disclosing their sexual identity and risky sexual behaviors. If exposed, these young men are often disowned and must survive on their own. Some might turn to sex work to survive. Young MSM are often left with many questions and concerns, but with no support from family, peers, or other significant adults in their lives, including teachers and service providers. In addition, the relationships that they have with older men in some settings might not provide them with the support that they need.

Young MSM are less likely to use protection during anal intercourse than older MSM, according to some research. Below are summaries of studies that highlight risk factors for HIV among young MSM, including the use of testing services to know their HIV status.

- In Senegal, a study among 250 MSM found that the first sexual encounter with a man occurred on average at age 15. This experience was often with an adult, someone they knew or had recently met. For about one-third of the sample, first sex was with an extended family member. In some cases, initial sexual encounters with a man were prompted by offers of money by an older man.[11] A separate study in Senegal found that 10 percent of MSM reported that their first sexual encounter with a man was forced.[12]
- A formative research project by Population Services International (PSI) and local partners in Togo, West Africa, trained 20 MSM as peer researchers, conducted in-depth interviews and focus groups discussions with them, and then broadened the research to 102 additional MSM. The average reported age of first sex with another man was 17.6 years; about half had intercourse with a woman first. About one-third reported having two or more concurrent partners, and about half reported that they had been tested for HIV. While nearly two-thirds reported using a condom at last intercourse with all men, only 21 percent reported regular condom use with their regular male partner. Some thought that HIV infection was transmitted through sex with women, but not with men. "We are virgins because we've never slept with women," said one, "so we cannot catch that sickness."[13]

- In China, a survey of 237 young men who had same-sex, transactional sex for economic survival (called "money boys") focused on migrants from rural villages to Shanghai. About one-fifth of the group self-identified as non-gay and the rest as gay. More than half left home before the age of 20, many before the age of 15. The gay-identified group was more likely to engage in anal sex and less likely to use condoms. Depression prevalence was high in the study, associated with stress, dissatisfaction with life, and prior or current exposure to sexual violence. There was low knowledge about HIV—more than 60 percent either thought incorrectly that HIV could be transmitted by a mosquito bite or weren't sure. Despite free HIV testing, only half of the young MSM had ever been tested for HIV.[14]
- In India, a survey among 600 men between the ages of 15 and 24 in villages in Uttar Pradesh found that 55 of the 300 who reported being sexually active had engaged in anal or oral intercourse, or both, with a man. Those having sex with men were significantly more likely to report inconsistent use of condoms, sex with multiple partners, and at least one symptom of sexually transmitted infections (STIs). Many reported they had sex with other men because it was an alternative to having sex with a woman in a socially restricted environment, even though they felt it was not right to have sex with a man.[15]
- A study in northern Thailand of more than 2,000 men enrolled in inpatient drug treatment identified 66 who reported having sex with men, mostly with partners known as katoey (transgendered male to female). About one-fifth of the 66 men were under the age of 21. The 66 MSM were more likely than other men to have ever injected or sold drugs, been in prison, injected in prison, and to be HIV-infected.[16]

- A study in Thailand also shows that MSM are vulnerable to the impact of using amphetamine-type stimulants. Use during last sex increased from less than one percent in 2003 to 5.5 percent in 2007, and overall the use of these stimulants among MSM increased from about four percent in 2003 to 21 percent in 2007.[17] While this study did not focus on young people, other studies have found that methamphetamines are widely used by young people in Thailand.[18]
- With regard to access to HIV testing, data from 2007 national surveillance systems in Thailand,[19] Cambodia,[20] and Indonesia[21] showed that about the same proportion of MSM 24 or younger reported voluntary HIV testing in the past year, compared to MSM 25 or older: 52 percent compared to 48 percent in Thailand, 35 percent compared to 34 percent in Indonesia, and 60 percent compared to 64 percent in Cambodia. These reports come from MSM gathering in "hotspots" rather than all MSM. The earlier a person is tested, the earlier he can learn his status and get treatment.

These studies provide insights into the types of issues that concern young MSM in particular. They indicate that many MSM begin same-sex sexual activity at a young age, and sometimes this occurs with older partners. Among young MSM, some groups are particularly marginalized, including ethnic minorities, migrants to cities, those living on the street, HIV-infected young people, and those injecting drugs. Greater isolation usually means that those who are HIV-infected are likely to learn about their HIV status later in the course of infection. These studies highlight the fact that young men have sex with other men for a variety of reasons, ranging from desire for economic survival in some settings to strict social norms and gender roles that limit sexually active young men from having sex with women. Recognizing both the similarities and the differences of such behaviors is crucial for developing effective prevention programs.

Programmatic Approaches

This wide range of risk factors emphasizes the need for programs to address both individual behaviors and the social determinants leading to vulnerability (i.e., structural changes). In countries where sex between men is illegal, local MSM organizations, where they exist, generally operate in difficult circumstances with relatively low levels of funding. They face official resistance, legal impediments, and high levels of stigma and discrimination. In addition, if such organizations work with young MSM, they could be seen incorrectly as interested in recruiting young men into the gay lifestyle, a misperception that might inhibit MSM organizations from working with young MSM. Concerns about the need for parental consent might also prevent such organizations from providing services to young MSM. Community-based groups provide essential access to young MSM, but they require strong links to the health infrastructure, expanded and sustained funding, and substantial capacity-building assistance.

Peer education within social networks is one approach that has shown some impact. A randomized study in Russia and Bulgaria recruited 276 MSM (with a mean age of 22.5) through 52 MSM social networks. The leaders in the 25 networks in the study's experimental arm received a nine-session training program on HIV risk-related knowledge and behaviors. They were then instructed to share that information through their networks. In these 25 networks, those reporting unprotected intercourse declined from 72 percent to 48 percent at the three-month follow-up, and those reporting multiple partners declined from 32 percent to 13 percent.[22]

Peer education within social networks has shown some impact among young MSM.

Another promising peer education project among young MSM took place in Togo, following the PSI formative research described above. The program recruited peer educators (generally between the ages of 18 and 20), distributed condoms and lubricants, promoted various information events, and supported mobile testing units. Peer educators used flip charts that dealt with issues such as multiple partners, stigma, cross-generational sex, and condom negotiation. The program has reached 3,000 men, many of whom are younger than 24, through peer education activities, and another 2,000 through mass educational activities. Involving peer educators who were motivated because the program focused on their needs enabled the project to reach young men who would not have gone to conventional services.

The project is now conducting an evaluation of the results so far and hopes to expand to a wider MSM audience, including young men who do not self-identify as gay, and to create a national network of reference centers for health and psychosocial services. The project is supporting local MSM organizations to pursue legal recognition and protections and to seek additional resources for more confidential spaces and STI/HIV-related services. The Togolese President and Minister of Health have recently made public statements recognizing the importance of including MSM in HIV prevention strategies.

In Thailand, another peer education approach proved successful. According to 2007 surveillance data,[23] MSM outreach projects using peer educators reached 52 percent of MSM between the ages of 15 and 24 during the past year. A significant proportion of the peer-outreach educators (mainly volunteers) are young MSM working with older MSM peer educators or outreach workers. This effort is one of approximately 60 programs with MSM and transgender persons that were supported by FHI in 2009, in 10 countries in the Asia Pacific Region and four countries in Africa, involving 79 implementing partners, and predominantly with USAID funding.

These projects operate within a framework based on a USAID comprehensive package for most-at-risk populations.[24] The framework includes individual- and group-level programs, peer outreach, linkages to services (HIV counseling and testing, STI care, and support and treatment), and targeted multi-media campaigns. The programs include policy and advocacy, strategic information, capacity building, community mobilization, and decreasing stigma and discrimination. They are usually carried out in collaboration with other agencies. Within this framework, strategic approaches to behavioral change can be used that help address the particular needs of younger MSM.

One of the multi-media campaigns used new technologies to alert MSM networks in Bangkok and Chiang Mai to the alarming increase in HIV prevalence among MSM: from 17 percent in 2003 to 28 percent in 2005. This "Sex Alert" campaign used multiple targeted channels, including the Internet and text messaging. A midterm review of this campaign at the fifth month of implementation, using a probability sampling methodology to reach 300 MSM, showed that the campaign reached 94 percent of MSM between the ages of 16 and 25 and 91 percent of those older than 25.[25] A final evaluation of the campaign reached similar findings.[26]

In an environment of marginalization and violence, programs designed to increase safe sex among individual MSM face many challenges. Efforts to address policies in Mexico and Brazil demonstrated the value of structural changes, including support from Ministries of Health that work with civil society groups supporting the lesbian-gay-bisexual-transgender (LGBT) community.

In Brazil, simultaneous efforts by multiple actors contributed to the current national response to prevent discrimination against LGBT people. The LGBT community has worked for more than a decade with Brazilian legislative leaders and the Ministry of Health to develop innovative approaches to combating HIV, including work with the president in a national campaign to combat violence and discrimination against LGBT people. In 2009, the Brazilian government, in consultation with civil society, issued the National Plan to Promote Citizenship and Human Rights of LGBT People with a focus on removing homophobia from family, schools, and religious institutions. Also, the Special Secretary on Human Rights convened a meeting on public policy for LGBT adolescents and youth, and a strategic plan within the Ministry of Education emphasizes sexual diversity as part of the country's pluralistic society—a program known as Schools without Homophobia.

In Mexico, the president of the National Center for the Prevention and Control of HIV/AIDS (CENSIDA) has initiated an anti-homophobia campaign focused on human rights, which includes proposals to address health disparities. In addition, CENSIDA linked with the Mexican National Campaign for the Sexual Rights of Young People to promote comprehensive sexuality education without stigma against sexual orientation and to strengthen interagency collaboration. The National Center is also emphasizing the importance of reducing homophobia within the family and is supporting laws to prevent and eliminate discrimination based on sexual orientation and to protect the rights of youth that include protection against discrimination based on sexual orientation. CENSIDA is sponsoring a rights-based marketing campaign with messages such as, "They have the right to be respected. Only one thing can stop them…Discrimination." The tag line at the bottom of this ad says: "These are your rights, from the National Campaign for the Sexual Rights of Young People."

The national campaigns in Mexico and Brazil emphasize the need for leading political groups to understand the marginalization of LGBT youth; to advocate for improved policies with local, civil society partners; to respond to institutional and social homophobia with substantial investments; and to integrate sexual and gender diversity into sexuality education, including curricula and teacher training.

Conclusions and Next Steps

A number of recent meetings have sought to focus more attention on the needs of MSM. In 2008, the Foundation for AIDS Research (amfAR) convened a global consultation on MSM and HIV/AIDS research in Washington, DC. Also in 2008, the WHO collaborated with UNAIDS and UNDP to hold a global consultation on MSM and the prevention and treatment of HIV and other sexually transmitted infections. And the same year, the Kenya National AIDS Control Council and the Population Council convened a technical consultation in Nairobi to address the prevention and treatment of HIV among MSM in national HIV programs. One debate in the Africa meeting was over how much to emphasize a public health or a human rights approach, with a general recognition that both are not only valid, but also necessary. As one participant put it, "When you walk over hot coals, you need both of your shoes."[27]

Although the meetings and reports did not focus on young men, many of the discussions and conclusions related to young men. These and other meetings emphasize common program elements that need to be expanded, including the following:

- Creating safe spaces for young MSM
- Developing close working relationships with ministries of health and AIDS programs
- Involving MSM in the development and implementation of programs for which they are the intended beneficiaries
- Training and sensitizing providers on MSM-friendly services

In addition to the efforts for all MSM, young men need more focused attention. Few school-based curricula in low-resource countries have included special attention to sexual orientation or transgender issues. A recent document from the United Nations Educational, Scientific and Cultural Organization (UNESCO), however, has begun to address such issues. The UNESCO guidelines state the following in the learning objectives that they recommend for ages 12 to 15: "People do not choose their sexual orientation or gender identity." The guidelines advocate "tolerance and respect for the different ways sexuality is expressed locally and across cultures."[28] A recent declaration on HIV prevention through education from the Ministers of Health and Education in Latin America and the Caribbean says comprehensive sexuality education will include "topics related to the diversity of sexual orientation and identities."[29]

As local and international programs begin to pay more attention to MSM and HIV in Africa and Asia, more focus is needed to meet the particular needs of young MSM. Below are some of the lessons learned from the few projects that have focused on these young men and some of the priority areas that require further attention:

- Building resilience among young MSM is needed and can be supported through MSM organizations. These groups can support a range of programs that contribute to young people's development through life skills, mentoring, and job skills. They can also provide role models, help build community support systems, and contribute to broader and more inclusive HIV advocacy efforts within countries.
- Gaining more understanding on the unique needs of young MSM through research in the following areas:
  - Culturally specific sexual and gender identities and expressions that include sexual experimentation
  - Unique prevention, treatment, care, and support needs within youth-focused programming
  - Approaches to developing social support from peers, family, and community, and support for the parents of young MSM so that they are in turn able to support their children
  - Prevention messages that take into account cognitive and physical development
  - Use of new technologies such as the Internet and cell phones to reach young MSM
  - Overcoming barriers to HIV testing for young MSM, because young MSM might avoid being tested as this can give rise to a double stigma (MSM and HIV infected)
- Using social networks and peer educators shows promise. The Russia-Bulgaria study found that engaging the leaders of social networks for at-risk, young MSM to communicate theory-based counseling and advice "can produce significant sexual risk behavior change," although it remains to be seen how much these behaviors are maintained over time.[30]
- Avoid a sharp dichotomy between homosexual and heterosexual, and address gender issues more broadly, especially in countries such as India. A recent *Consensus Meeting for Caribbean Countries on Access of Vulnerable Populations to HIV Health Services* offered guidance on this

issue. It suggested that services focus on men's health in general, including the health of young men, rather than MSM-targeted services.

- Consider more joint programs with drug prevention and harm reduction among injecting drug users and those using amphetamine-type stimulants, as well as overlapping programs with projects that support young men selling sex to other men. An epidemic of drug use among MSM appears to be emerging in Asia, and few programs are addressing this confluence of risks.[31]
- Particular efforts need to be made to address basic HIV prevention approaches for young men, including access to condoms and water-based lubricants. Also, the broader needs of young HIV-infected MSM need particular attention.
- Attention to the needs of young MSM should be integrated into HIV national strategic plans and current HIV response. Such practical public health efforts need to be complemented with human rights support to end criminalization of male-to-male sex and discrimination against MSM.
- Training of health care providers and educators needs to incorporate the particular needs of young MSM. The Pan America Health Organization is developing training materials for service providers who work with MSM. These materials include an explicit focus on ensuring that services can effectively meet the specific needs of young MSM.
- School-based sex education needs to include the perspective of gender orientation and sexual preference into materials and teacher training. In addition, supportive and safe spaces for young MSM need to be created in schools, as well as in health care services and communities.
- Programs need to engage the media to present sexual diversity in a non-stereotypical way.

Focusing more resources, attention, and energy on young MSM can help reduce the spread of the HIV pandemic among one of the population groups that is most at risk, at an age when sexual identity and behaviors are forming. Focusing more effort on the needs of young MSM can also help save many lives, protect future generations, and contribute to greater acceptance of all human beings.

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Chapter 3.

Young People Who Sell Sex

This chapter focuses on young women who sell sex for money regularly and on girl children who are commercially sexually exploited, although many of the issues also relate to young men, boys, and transgender persons. Definitions and language regarding sex work are sensitive for many reasons. The recently released *UNAIDS Guidance Note on HIV and Sex Work*, which is based on a series of consultations held between 2006 and 2008,[1] centers on the human rights of sex workers through what it calls three interdependent pillars

- Universal access to HIV prevention, treatment, care, and support
- Building supportive environments, strengthening partnerships, and expanding choices
- Reducing vulnerability and addressing structural issues

According to the U.N. Convention on the Rights of the Child (CRC), young people between the ages of 18 and 24 are legally adults, while those younger than 18 are defined as children. Regarding young people who sell sex, those younger than 18 are considered to be victims of commercial sexual exploitation. This extremely important differentiation means that in terms of the prevention, support, and treatment of HIV among those younger than 18, governments have a legal obligation as signatories to the CRC that goes beyond issues of public health.

For young people over 18, selling sex can be seen as something they may choose to do as consenting adults with the human right of agency over their own bodies. It needs to be noted that among young people who exchange sex for money, whether by choice or through exploitation, many do not like to be identified as, nor do they consider themselves to be, sex workers. This is an issue that affects many of the programming issues discussed below.

The status of those younger than 18 compared to those 18 and older should be kept in mind when reading this chapter. This distinction affects how people think about and respond to young people who sell sex.

The issue of young people selling sex involves many complex legal, economic, political, social, moral, and human rights issues. The involvement of children and young people in sex work can be related to many factors including poverty, commercial sexual exploitation and trafficking, childhood sexual abuse, homelessness, lack of job skills and employment opportunities, desire for a better life and increased income, migration and mobility, reduced options in situations of humanitarian concern, and dependent drug use.

Because of significant gaps in data and the quality of the data, no accurate estimates of the number of young people selling sex are available. In addition, some statistics on human trafficking fail to distinguish between commercial sexual exploitation of children and adult sex work.

For example, a study in 2007 estimated that 80 percent of the 600,000 to 800,000 individuals trafficked annually worldwide are girls and women, with an estimated 150,000 girls and women trafficked annually within and across countries in South Asia. The data do not, however, indicate the proportion of adolescents or children among the people trafficked.[2]

Behavioral surveillance systems have found that a significant proportion of people selling sex in Asia are young, and some studies that have linked age of entrance into

sex work with HIV risk indicate that the younger the person the higher his or her risk is of acquiring HIV. Sex work often starts at an early age. In Cambodia, Bangladesh, Laos, and areas of Indonesia and China, 58 to 74 percent of female sex workers are under the age of 25, with more than 20 percent of all sex workers under the age of 20 in four countries.[3] In Jamaica, one survey found that more than 50 percent of sex workers said that they became involved before the age of 18.[4] A 1998 UN report estimated that sex work generated some $20 billion yearly, with $5 billion attributed to those under the age of 18.[5]

Policy and programmatic attention is urgently needed to address the specific needs of different groups of young people who sell sex. Organizations and networks of sex workers are important partners and are in a good position to understand the dynamics of local, sex work settings. They understand the types of responses that are required to protect the human rights of young people who sell sex, and that, at a minimum, do no harm.

This paper does not consider young people who buy sex, which is also a potential area of programmatic effort that has been much neglected. There is some evidence that it is possible to rapidly change social norms concerning sex work, for example, Thailand's efforts in the early 1990s to change the expectation that young men's first sexual experience would be with a sex worker. These and similar efforts need to be considered but are not easy to address.

Young people who sell sex are more likely than adult sex workers to suffer from negative consequences.

Vulnerability and Risk

There are many reasons why young people who sell sex are more likely than adult sex workers to suffer from the negative physical and psychological effects of sex work, including HIV infection. They are more vulnerable for biological reasons, i.e., the development of their genital tract, and for social reasons. They are less likely to be able to negotiate condom use with clients, especially where clients are willing to pay more for sex with young girls and boys because they assume they are "pure."

The commercial exploitation of children through trafficking makes them particularly vulnerable, and a 2002 review in *The Lancet* outlined the adverse health effects that they face. The article reported that HIV infection rates among these children ranged from five percent in one study in Vietnam to 50 to 90 percent among children rescued from brothels in other parts of Southeast Asia. The review also discussed risks related to pregnancy. In one report, for example, 12 girls became pregnant.

Young girls in such situations also have to deal with mental stresses, including an increased risk of suicide and post-traumatic stress disorder, as reported in both a U.S. study and a separate five-country study (South Africa, Thailand, Turkey, the United States, and Zambia). Other increased risks include substance abuse, violence, malnutrition, and health problems among the infants born to these adolescents.[6]

The studies summarized below show a broad range of vulnerability and risk factors related to girls and young women who are exploited commercially and who sell sex:

- A 2005 study in West Bengal, India, conducted anonymous HIV testing on 2,076 sex workers. It found the infection rate to be more than twice as high among those 20 or younger as the overall rate (12.5 percent to 5.9 percent, respectively).[7]
- A study of 1,000 sex workers in Madagascar found a higher risk of chlamydial and gonococcal infection among those between the ages of 16 and 19 than among those over the age of 20.[8]
- A cross-sectional study among female sex workers in Thailand found that HIV infection was associated with initiating sex work before the age of 15.[9]
- A study among street-based sex workers in Ho Chi Minh City, Vietnam, found that injecting drugs and being younger than age 25 were both independently associated with HIV infection.[10]
- Studies in areas of Indonesia found that nine percent of sex workers under the age of 25 used condoms with all clients in the last month, compared to 15 percent of those 25 or older; and 59 percent of sex workers under age 25 had an STI, compared to 39 percent of those 25 or older.[11]
- Studies of 495 girls in Nepal and India who were involved in sex trafficking compared those under age 18 (51 percent of the total, with 15 percent being under age 15) to those over age 18.[12] The girls under the age of 18 were more likely than the older girls to have been drugged and abducted (25 percent vs. 10 percent), to have experienced family violence (38 percent vs. 15 percent), and to have been compelled into being trafficked by their families (11 percent vs. 0). Among the 109 girls younger than 18 in Nepal, 46 percent had acquired HIV, and among those younger than 15, 61 percent were living with HIV. Many of the youngest girls were moved from place to place so that they

would not be caught and could be marketed as "pure" without being recognized by repeat customers, and thus be worth a higher fee.

- A study in Nepal involved 202 sex-trafficked young women at six rehabilitation centers. It included in-depth interviews with 42 of them. One-third of the 202 women were trafficked at the age of 15 or younger; almost half were between the ages of 16 and 18; and more than 90 percent were 21 or younger. "When they brought me here, it was in a taxi," one girl in the study remembered. "Everywhere I looked I saw curtained doorways and rooms… I asked the other Nepali women if these were offices, it seemed the logical explanation. In two days I knew everything and I cried."[13]
- In Thailand, a cross-sectional survey conducted with a national stratified sample of 815 female sex workers found that 10.4 percent had entered sex work during adolescence. The survey found that sexual violence at initiation was more than twice as common for adolescents compared to adults and that violence or mistreatment in the preceding week was also substantially higher (51 percent vs. 35 percent). High-risk behaviors for HIV infection were also far more common, including anal intercourse, condom failure, nonuse of condoms, and unprotected sex. Moreover, sex workers brought in during the adolescent years more often had little knowledge of HIV (38 percent vs. 27 percent). A survey among 136 young women selling sex and commercially sexually exploited children in Indonesia showed dramatic findings regarding abuse of basic human rights, such as totally restricted movement (71 percent), denial of food and water (45 percent), deprivation of wages (61 percent), and physical or sexual abuse (91 percent).[14]
- A study in Liberia examined the sexual experiences and HIV vulnerability of girls who had previously participated in an armed force in any capacity. The study compared 50 former girl soldiers to a control group matched for age and education and found far higher rates of rape during the war (59 percent vs. 21 percent), post-war transactional sex (67 percent vs. 32 percent), and pregnancy (60 percent vs. 28 percent). The project recommended, among other things, a targeted program for girls involved in transactional sex as a high priority in the national response to HIV in Liberia.[15]

Trafficking

The United Nations Protocol on Trafficking in Persons has designated all types of human trafficking, including sex trafficking, as a modern form of slavery, but non-coerced movement is considered to be trafficking only when the individual is a minor. Although it is sometimes a challenge to distinguish between migration and trafficking, the United Nations has clearly defined these terms and discussed them in relation to commercial sex in several official documents (e.g., the Palermo Protocol).* It is also important that trafficking and sex work are not conflated.

Many NGOs in South Asia as well as the International Organization for Migration and other international groups undertake a broad range of programs including prevention, rescue, care and support, and awareness-raising. They address the underlying causes of trafficking through activities such as skill-building programs for adolescent girls and awareness-raising activities for community leaders and the general public. Rescue activities are difficult to implement for many reasons relating to the place of rescue, potential corruption among the officials involved, and stigma against those rescued.†

Experts have pointed to the National Child Protection Authority in Sri Lanka as a model coalition of NGOs, academics, governmental agencies, and political leaders working together in awareness-raising, capacity building, legal reforms, monitoring of enforcement, and protection and rehabilitation of the victims of trafficking. Networks in Bangladesh also hold promise in developing a coordinated set of activities linking small-scale NGO programs using contextualized and tailored solutions with large-scale programs focusing on advocacy and policies. Indicators and methods for monitoring and evaluation are important, including acceptable ethical and human rights standards of investigation.

* *Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime*. United Nations, 2000; see: *http://www.unodc.org/unodc/en/treaties/CTOC/index.html.*

† Huntingdon D. *Anti-Trafficking Programs in South Asia: Appropriate Activities, Indicators, and Evaluation Methodologies: Summary of a Technical Consultation Meeting. September 11-23, 2001, Kathmandu, Nepal.* New Delhi: Population Council/India, 2002.

Programmatic Approaches

Given the overwhelming health challenges and human rights violations that are faced by young people selling sex, programmatic approaches are complex. The elements of combination prevention (see page 17) are necessary in framing the different types of programs that are needed (biomedical, behavioral, and structural components) as are concepts of primary prevention, harm reduction, or some combination of these types of programs (terms discussed on page 17). While there is a primary responsibility of programs to reduce and work to eliminate the exploitation of children, there is also a need to address the immediate health concerns, including HIV risks, of those in situations of exploitation.

In the last decade, projects concerned with young people selling sex have focused on trafficking issues (see sidebar on page 46), with programs that focused on the following:

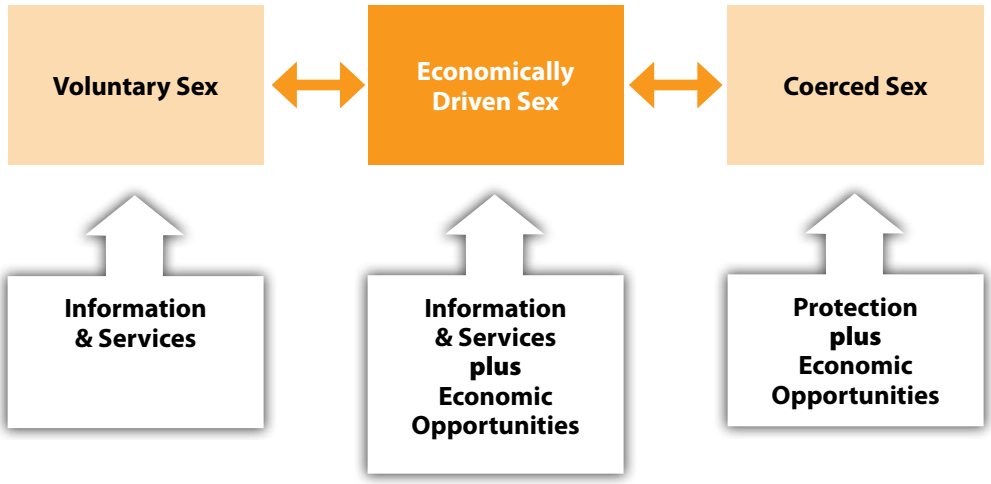
- Preventing girls from being trafficked
- Reducing the negative health consequences of behaviors that place young people selling sex at risk of HIV (for example ensuring access to condoms)
- Repatriation and the provision of shelters and alternative sources of income

Programs in a number of countries have also begun to demonstrate promising approaches that involve working directly with young sex workers that are not trafficked, which include efforts to reduce individual risk as well as create support systems, with an emphasis on reducing potential harm.

One example is a project based in Mumbai, India, involving a network of sex work organizations that seek to prevent trafficking and commercial sexual exploitation. The Durbar Mahila Samanwaya Committee (DMSC) has created self-regulatory boards composed of sex workers and local government officials to work together to prevent trafficking in their work sites. The groups seek to protect the health and human rights of all people selling sex and to provide appropriate referrals out of sex work to any trafficked person or child victim of commercial sexual exploitation.[16]

In Vietnam, the formative stage of an operations research/intervention development project suggested that interpersonal communication with effective referral to services would provide a useful model for expansion and scale up. The project builds on the continuum of volition model (Figure 2, page 48), which illustrates how programs

Figure 2. Continuum of Volition



The boxes in the second row indicate priority programs. If the transaction is coerced, the priority program is protection from physical harm and exploitation, although information and services are also required. If the transaction is economically driven for school fees, food, or even material comfort, then the program could include information and services, and access to economic opportunities. Finally, if the transactional sex is driven more by emotional security, love, pleasure, or social status, the programs would focus primarily on information and services to reduce the risk of HIV.

Adapted from Weissman A, Cocker J, Sherburne MB, et al. Cross Generational Relationships: Using a 'Continuum of Volition' in HIV Prevention Work among Young People. *Gender & Development* 2006; 14(1):81-94.

must recognize the girl's specific situation. For example, protection is the highest priority for girls being coerced to sell sex. In contrast, education, health services, and economic opportunities are the priorities for those motivated to sell sex primarily for economic reasons.

Supported by Save the Children, the project worked primarily with female street youth who are usually controlled by and in debt to the manager of the sex work, with some of the girls working out of cafes or bars. Many of these young women migrated to the city looking for jobs and started selling sex to support themselves. Most were 17 or older when they became involved, but some started as young as 13. "I don't want to earn my living this way, but what else can I do?" said one girl. Most of the girls are not willing to get tested for HIV because of the stigma associated with testing, as well as the associated fear and lack of options for care and support.

Family Planning and Reproductive Health

Young people who sell sex or are victims of commercial sexual exploitation need the full range of youth-friendly RH information, services, and care. They need counseling, testing, and treatment for other sexually transmitted infections. Promoting condom use not just for STI and HIV prevention, but as a core component of RH services in general could prove particularly appealing to young women who are worried about getting pregnant. Unfortunately, young sex workers and sexually exploited children often lack information and access to youth-friendly sources of supplies, services, and support, such as counseling on negotiating condom use.

The project trained and supported 15 paid peer educators, who had a high level of street credibility and were not using drugs, to work with 100 girls and young women selling sex. The peer educators led structured discussions for groups of girls and young women, using a well-tested curriculum that addresses gender roles, street life, condom negotiation, substance abuse, expressing emotions, and violence.[17] The peer educators were available via cell phones and street contact to follow up with the young women in their daily lives, including referrals to health services and condom distribution. The peer educators themselves received support from social workers and social work students. Social workers provided case management for service referrals, including issues relating to pregnancy, employment, and support to re-connect with family (if this was considered to be a positive thing to do). "I am very happy that my wish for a healthy baby came true," said one girl working on the street. "I promised my child that I will not start again so that he can have a mother like other mothers. I will leave my past behind."

Protection is the highest priority for girls being coerced to sell sex.

The program identified some valuable lessons. It found that peer educators could reach street girls selling sex and was effective in encouraging appropriate behaviors to reduce risk. Calling the program "youth programming" was more effective than calling it a "sex worker project." Having caring adults working with the peer educators and the girls was also important. While the girls were not always ready to make life changes, services and support needed to be available for when they were ready. Having more data would have increased the ability of the program to advocate for more services. The policy environment needed changing so that the girls were not

labeled as criminals or social evils. Such changes might also have helped to increase their willingness to access HIV testing and counseling.[18]

A project in Cambodia called SMARTgirl, coordinated by FHI,[19] has tried to reinvigorate HIV prevention among sex workers by changing how they see themselves, celebrating them as *smart* for their HIV prevention efforts rather than as *bad* because they are sex workers. In addition, the changes taking place in the country, i.e., girls moving out of brothels into other entertainment establishments, made it possible for them to see themselves as *entertainment workers* rather than sex workers. The project emphasizes the integration of family planning information and services with the HIV programs because between 17 and 26 percent of entertainment workers in the country had abortions in the preceding 12 months, according to the 2007 Behavioral Survey Surveillance in the country. The program also emphasizes condom use with regular partners as part of HIV risk reduction.

The SMARTgirl project celebrates women and the contribution that entertainment workers have made to HIV prevention efforts, putting HIV into a broader sexual health context and using a positive, fun, modern, and trustworthy tone in the messages. It works through six local NGOs in nine provinces, with support from the government of Cambodia and large private sector partners, including Coca Cola. It uses quarterly themes (a recent theme was alcohol/drug use), works with peer educators, uses group discussions, and supports referrals to HIV testing and counseling, reproductive health/family planning, and STI treatment centers, with referral cards used to track service utilization. The project has reached more than 8,600 women, nearly one third of the estimated number of entertainment workers in these provinces, and tracks referrals and condom distribution. Some of the girls are selling sex in part to support dependent drug use (known as cross-over between drug use and selling sex, an issue that is common in other Southeast Asian countries). Many of the girls are younger than 24. SMARTgirl therefore operates drug support groups and plans to offer needle and syringe programs. The Cambodian government has recently announced that it was introducing a new national sexual health model and standard procedures, based in part on the SMARTgirl approach.

In Ukraine, a local NGO is working in one region of the country with students who are involved in sex work, as part of a comprehensive HIV/STI prevention project for female sex workers. The project has reached more than 5,000 female sex workers; about one fourth of them are students who provide sexual services for cash, cash equivalents, goods, or services. They work systematically or occasionally "by call"

in dormitories, the streets, hotels, bars, saunas, and salons. Some also inject drugs. The project offers HIV counseling and rapid testing and training on behaviors that decrease their risk of HIV. The program also provides referrals and assistance in accessing free STI treatment, condoms and lubricants, syringes to those who inject drugs, information materials, professional counseling (psychologist, lawyer, gynecologist, STI specialist), and referrals to other projects if needed.

High unemployment, economic decline, IDU, and increased migration from rural areas have led to increased sex work among college students. Most come from poor villages and cannot pay for housing and other expenses. They often have little knowledge about the risks of HIV and are hard to reach in the student setting. Services are therefore adapted to reach the students, including using students already enrolled in the project to introduce others to project social workers. The staff also conducts information and training sessions on campus to make their services known. Individuals with leadership potential are encouraged to become volunteers for the project. After they have been trained, these volunteers work with their peers and receive follow-up support from project staff. The International HIV/AIDS Alliance coordinates the project.

A number of harm-reduction strategies for young people who sell sex have shown promise.

A separate project supported by the International HIV/AIDS Alliance is working with nearly 50,000 female sex workers in southern India, about 9,000 of whom are between the ages of 18 and 24. A behavioral survey in five of the 14 districts covered by the project found that the young sex workers consistently use condoms only seven percent of the time with nonpaying partners, and only nine to 16 percent of the time with paying customers. Their condom use is significantly less frequent than among older sex workers: 46 to 52 percent among those between the ages of 31 and 35 use condoms, and slightly less frequent among those between the ages of 25 and 30. The project concluded that the younger sex workers were more vulnerable to STIs/HIV and structured the programs accordingly. With the younger women, it initiated network mapping in order to understand the formal and informal associations and their risk. It also focused on one-to-one contact, condom demonstrations, condom distribution where the young women were selling sex, and on special awareness drives to overcome the extra challenges of bringing young sex workers into STI/HIV services.

Many of the strategies described above for those between the ages of 18 and 24 are similar to efforts that have been directed to HIV prevention among older adult sex workers. A 2005 article in *The Lancet* described work among adult sex workers as harm reduction. "The use of harm-reduction principles can help to safeguard sex workers' lives in the same way that drug users have benefited from drug-use harm reduction," the article said. It identified as promising a number of harm-reduction strategies for sex workers, including education, empowerment, HIV prevention, decriminalization of sex workers, and human rights-based approaches. The review identified evidence of successful harm-reduction programs, including peer education, training in condom-negotiating skills, safety tips, self-help organizations, and community-based child protection networks,[20] all of which are likely to be relevant to young sex workers and children who are commercially sexually exploited.

Conclusions and Next Steps

Many factors undermine the health and development of young women who are sexually exploited and sell sex, including drug use, disease, violence, discrimination, debt, and criminalization. Transactional sex with adolescents under the age of 18 is considered to be part of child exploitation, a criminal activity. All of these young women and girls require a range of services to protect their health, including the prevention of HIV.

Research and program intervention models for young people selling sex are developing, particularly in South and Southeast Asia, where sex trafficking is concentrated. While more work is needed, the following lessons have emerged:

- Preventing children from becoming victims of commercial sexual exploitation requires urgent attention (primary prevention). Programs need to be evidence-informed and human rights based when identifying and assisting victims of trafficking. Collaborations are needed with sex worker organizations/networks and credible anti-trafficking groups.
- Young people selling sex need individual attention, including training on condom use and support for using HIV prevention and related services.
- Peer educators, with professional support systems, are particularly helpful in reaching and working with young people selling sex.
- Young people who sell sex and are under the age of 18 must be recognized as children in terms of the Convention on the Rights of the Child, and should therefore be considered as being commercially sexually exploited.

- Vocabulary is important: young people selling sex might not wish to be labeled as sex workers. More generic terms attached to a program or intervention approach—such as *smart girl* and *youth programming*—might work better and be less stigmatizing.
- There are significant overlaps between the HIV risks and vulnerabilities of sex work and those of IDU, and these overlaps need to be addressed in programs.
- There are important links to be made between programs for HIV prevention among young people who sell sex and other programs to improve their health and development, including programs for sexual and reproductive health.
- While most programs have focused on girls involved in sex work, some young men and transgendered young people also sell sex. Programming related to these young people needs more attention. Although there are many similarities with programs directed to females selling sex, many issues are different and need specific attention.
- Greater advocacy is needed to ensure the basic human rights of young people who sell sex.
- More effort needs to be given to monitoring and evaluating existing programs focusing on young people who sell sex, and to disaggregating these data by age.
- Programs for young sex workers and sexually exploited children need to be guided by the evidence for effectiveness and good practice (where this exists), with more attention given to ensuring that effective programs are taken to scale.

As policymakers, donors, and program planners consider HIV prevention and related issues for those who sell sex, they need to give adequate attention to the particular needs of young people. They constitute a significant proportion of all those selling sex, including those being commercially exploited for sex (i.e., under the age of 18). These young people are particularly vulnerable and the most at risk. Addressing their specific needs will make an important contribution to the overall goals of preventing HIV and many other health problems, including unwanted pregnancy, among a particularly vulnerable group of young people.

Transactional and Nonconsensual Sex

Occasional transactional or nonconsensual sex involving girls and young women could be particularly important causes of HIV transmission in countries with generalized epidemics.

Transactional sex can include occasional exchange of sex for money, goods, or services. The term nonconsensual sex can refer to unwanted touch and molestation from strangers, peers, intimate partners, family members, and authority figures such as teachers.

Significant age disparities are common in transactional sex that is performed in exchange for material gifts. Among other factors, concern about HIV has prompted older men to seek younger sexual partners under the assumption that they are less likely to be infected. Young women are often willing to participate in these partnerships for emotional reasons; perceived educational, work, or marriage opportunities; monetary and material gifts; or basic survival. These young women may fail to realize their vulnerability to abuse, exploitation, and RH risks.

The power imbalances that exist between age-disparate partners and the transactional nature of these relationships often result in inadequate communication about risk, which might in turn give rise to decreased condom use. Low condom use and the higher likelihood that an older male partner is HIV positive increase the risk of HIV infection among these young women. In some sub-Saharan countries, young women between the ages of 15 and 24 are more than three times more likely to be infected with HIV than young men of the same age. Additional risks include anxiety, depression, social isolation, academic trouble, sexually transmitted infections, unintended pregnancy, abortion, and an increased propensity for high-risk behaviors in the future.

Young age, financial need, drug and alcohol consumption, previous abuse, and involvement with multiple partners are all individual risk factors for sexual coercion of young people. Environmental and structural risk factors include poverty, patriarchy, gender inequity, early marriage, weak educational and health systems, and ineffective policies and laws. More research is needed on how to effectively address nonconsensual sex among young people. Experts stress the importance of policy support and other programs for changing social norms of gender inequity and power imbalances and recommend community-based, youth-specific programs that use education, livelihood programs, and social marketing campaigns to empower young women. The continuum of volition conceptual model (Figure 2, page 48) addresses a range of issues involved in transactional and nonconsensual sex. For more information on these issues, see the resources listed on the next page.

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Chapter 4.

Young People Who Inject Drugs

A 2006 WHO analysis of HIV prevention programs among young people found few programs focusing on young people who inject drugs.[1] Similarly, a review of current HIV intervention projects working with people who inject drugs found few that targeted young people, either to prevent the initiation of injecting drugs or to reduce the risks of HIV associated with injecting drugs (harm reduction).[2] Despite this lack of explicit attention to young people, statistics indicate the importance of reaching young people before they start injecting drugs or using drugs that might lead to injecting practices. If they have already started injecting drugs, then harm-reduction strategies should be adapted to meet their specific needs and circumstances.

Most users of injecting drugs report that they started injecting in their teens or early 20s. A WHO study in 12 cities on five continents found that between 72 percent and 96 percent of people who injected drugs said that they started injecting before the age of 25.[3] Young people make up about seven of every 10 people who inject drugs in Russia, Central Asia, and Central and Eastern Europe, and they also account for a high percentage in such countries as Bangladesh and Indonesia.[4] Studies of people using injecting drugs in Nigeria also indicated initiation at young ages, with youth 18 or younger included in six of eight cities covered by the review.[5]

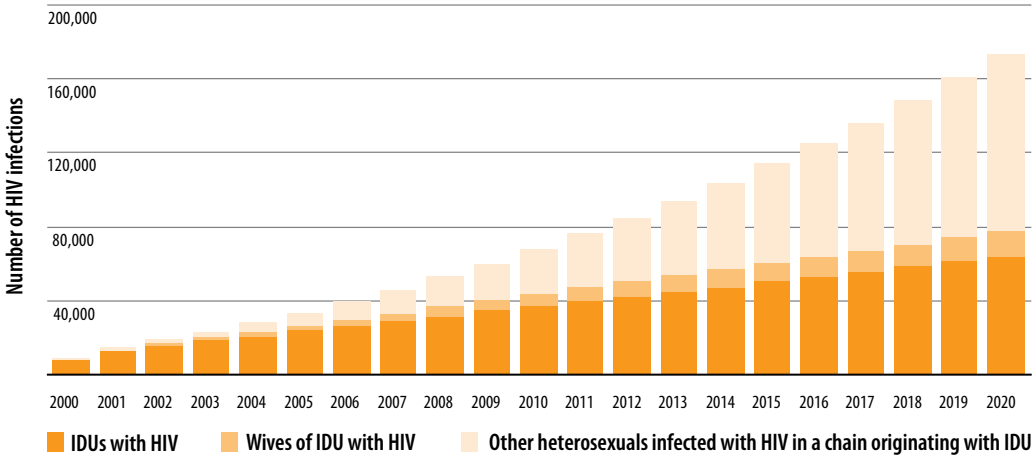
Injecting drugs can transmit HIV if people share injecting equipment or drug preparations that contain HIV-infected blood. Injecting drug use (IDU) also poses other serious health risks, including hepatitis and overdose.

Outside sub-Saharan Africa, IDU accounts for one in every three new cases of HIV. In much of Eastern Europe and Central Asia, some 80 percent of all new HIV infections come from injecting drugs, with high rates also reported in some countries of the Middle East, North Africa, Asia, and Latin America.[6] Of the estimated 13 million people injecting drugs worldwide, nearly three million are living with HIV. In 2008, the United Nations found rates of HIV infection among users of injecting drugs ranging from 31 percent to 61 percent in Vietnam, Ukraine, Thailand, Nepal, Belarus, Brazil, and Indonesia.[7] Data from sub-Saharan Africa are sparse, but they suggest that HIV prevalence among people who inject drugs is relatively high and rising.[8,9] In some countries, HIV infection can move rapidly from those who inject drugs to others. A study of data from Jakarta, Indonesia, found that the HIV epidemic began among people who injected drugs in 2000, but it is expected to have higher prevalence among other groups by the year 2020 (see Figure 3).[10]

Vulnerability and Risk

Risk factors for starting drug use include homelessness, dropping out of school, and unemployment. Patterns differ from place to place and change with time, but most people who begin injecting drugs have already used other drugs. For example, some begin sniffing or smoking opioids, then start injecting. In some places where IDU is common among young people, illicit drugs are easily available and relatively cheap. In Central Asia, for example, young people are in close proximity to about 90 percent of the world's opiate supply. Opioids are readily available and inexpensive in Tajikistan.

Figure 3. Projected Total Number of HIV Infections in Various Population Groups, 2000–2020, in Jakarta, Indonesia



Source: Asian Epidemic Model projects using Jakarta data.

Source: UNAIDS. Report on the Global AIDS Epidemic 2008. Geneva: UNAIDS, 2008.

Curiosity, availability, and imitating older youth contribute to first injections.[11] Young people seek out peers or siblings who already inject and ask them for help. First injections rarely occur alone. They usually take place in a social situation, with a young person first being injected by a friend, relative, or sexual partner. Young people take part because they want to be members of the group.[12] On these occasions, they might share or use non-sterile injecting equipment. Rituals can develop around injecting, and sharing injecting equipment can be a ritual of social cohesion.[13]

Young users of injecting drugs might be more likely to share needles and syringes than older people who use drugs, and at the same time they are generally less likely to have contact with an HIV prevention program.[14] They are also more likely to be injected by someone else and, as a result, are less in control of decisions that affect sharing injection equipment.[15] In a group, the younger people are often the last to inject, and thus the equipment is more likely to carry blood-borne infections by the time it reaches them. Furthermore, younger people often are not well established in

a network of drug users and might therefore have contacts with a number of networks, which increases their chances of exposure. Weighed against these riskier behaviors, however, is the fact that use is experimental and occasional for many young people who inject drugs, and so they could potentially have fewer exposures than older, confirmed users.

Young people who inject drugs also seem to take more risks with unprotected sex than older users. They tend to change sexual partners more often and might have several concurrent sexual relationships. In addition, young users of injecting drugs sometimes sell sex in order to pay for their drugs, which means multiple sexual partners and, often, unprotected sex.[16] Recent research by FHI in Bangladesh and Indonesia found that among 52 people injecting drugs, most of them were young, and many of them commonly engaged in unprotected commercial sex. While almost 90 percent said they were in a serious relationship, 75 percent of those with a regular partner said they were also having concurrent sexual relations with others, sometimes for payment.[17]

Young people might also be less likely to use drug-related health services than older people. Young people who inject drugs are often unaware of the associated health problems they could encounter. In addition, because drug use is illegal and often highly stigmatized, young users of drugs tend to be wary of mainstream institutions. At the same time, they often are excluded from school and other contacts that might channel them to health services. For their part, drug treatment services often overlook young people, especially those in the early stages of injecting and those who do not consider themselves to be dependent on drugs.[18] Furthermore, in many countries, service providers might not want to provide services to younger adolescents because of legal considerations relating to informed consent.

The broader environment in which illicit drug use takes place largely determines the types and degree of harm that results. For example, having one's own needle and syringe might be the safest way to inject in terms of avoiding HIV, but if possession of needles and syringes is illegal, carrying injection equipment poses a risk. Social factors that contribute to risky injecting practices are the levels of stigma, ostracism, and punishment faced by people who use drugs.[19]

Drug-related policies and programs generally fall into three broad categories: supply reduction, demand reduction, and harm reduction. Law enforcement agencies generally have the leading responsibility for supply reduction. Health and social services are largely responsible for demand reduction and harm reduction. Law enforcement agencies and social services could, however, find themselves in conflict. For example, police might harass clients at needle exchange points, or young people could be sent to jail for using drugs or placed in prison-like treatment camps where they might be more at risk than if they were on the street.

Programmatic Approaches: Demand Reduction

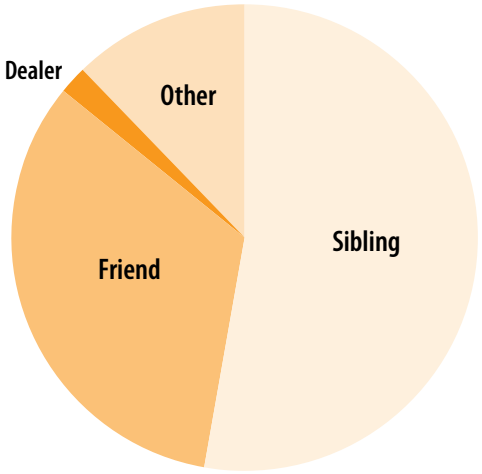
Demand-reduction initiatives help young people to avoid starting to inject (primary prevention) and help those already injecting to reduce or stop injecting drugs (secondary prevention). Primary prevention programs must explicitly address young people because drug use generally starts at a young age. Furthermore, because most IDU starts with casual or occasional injecting, services can help stop injecting before drug use becomes habitual. Many programs, particularly in schools, address young people in general to dissuade them from starting drug use.[20] However, the research and programmatic experience summarized here, while limited, suggests that the greatest impact on HIV infection occurs when programs focus on those young people who are especially vulnerable. These include young people who are taking drugs by means other than injection or who associate regularly with other young people who already inject drugs.

Research and programmatic experience, while limited, suggests that the greatest impact on HIV infection occurs when programs focus on those young people who are especially vulnerable.

Few projects seem to have focused specifically on demand reduction among vulnerable youth, on preventing them from starting to inject or helping them to stop injecting. There is a dearth of projects that have published any evidence of the impact of such projects. Several models do offer guidance, however, for working with young people who are currently using drugs and discouraging them from helping others to start injecting, improving communication between parents and vulnerable young people, and using peer education approaches that emphasize HIV prevention.

A project in Kyrgyzstan and Uzbekistan appears to have helped reduce the number of young people starting to inject. Surveys showed that 86 percent of young people who injected drugs had received help with their first injection, mostly from older siblings and friends (see Figure 4).[21] Such helpers had each assisted two or three people to start injecting in the preceding six months. The project therefore decided

Figure 4. First-Injection Helpers Kyrgyzstan and Uzbekistan (n=200)



to focus on encouraging and enabling the helpers to stop helping others to start injecting.[22] Population Services International (PSI) coordinated the project, building on a model called "break the cycle."[23]

In the capital cities of Tashkent and Bishkek, the project worked through existing needle exchange programs and building the skills of outreach workers. They encouraged those using drugs to discuss how they had begun injecting and situations in which non-injectors had asked for their help to learn how to inject. Interviewers discovered that many helpers really did not want to help others to start injecting drugs, but were pressured or pestered by a friend or sibling, usually younger, who was curious about drugs. If a helper expressed regret or reticence to the interviewer about that role, the interviewer would offer techniques that might assist the helper to refuse or deflect such requests. The motivational interviewing sessions encouraged the reluctant helpers (1) not to help others learn how to inject, (2) not to inject in the presence of those who do not inject (in order to reduce the modeling that makes non-injectors more comfortable with the idea of injecting), and (3) not to talk about using injecting drugs in positive terms. Preliminary results from a follow-up survey in 2008 indicated that fewer than 10 percent of people who used injecting drugs had helped someone else learn how to inject drugs in the preceding six months, down from 23 percent in 2006.[24]

A project in Russia provides another model. The program trained more than 180 health and education professionals as case managers to offer counseling and training to low-income youth and their parents so that they could communicate better with each other. Each young participant in the program works directly with

his or her own case manager, who counsels and refers the participant to specific services as needed. This approach is new to drug-use prevention programs in Russia. The program includes such activities as sports, computer classes, theater, and other arts to relieve the boredom and lack of purpose in young people's lives that can contribute to drug use. The program also offers correct information on substance use and HIV prevention. Through the end of 2008, the program had trained and provided consultations for more than 4,500 youth and 920 parents. About 50 families had participated in family therapy. Increased parental involvement appears to have led to more use of medical and psychological services. PSI supported this program with funding from USAID.[25]

A peer education and outreach project in Tanzania demonstrates a third approach to reaching vulnerable youth. The Zanzibar Association of Information against Drug Abuse and Alcohol (ZAIDA), with assistance from FHI/Tanzania, focuses on preventing substance use among vulnerable youth through peer education and community outreach. Youth peer educators, some of whom are former substance users themselves, provide life-skills education that emphasizes HIV prevention and the negative consequences of drug use. Community dialogues as part of theater performances also help raise awareness. The project has adapted peer education materials for youth audiences to substance-abuse situations. While no evaluation data are available from this project, other high-quality and targeted youth peer education projects have shown a positive impact on some behaviors related to HIV prevention.[26]

Programmatic Approaches: Harm Reduction

Harm-reduction activities focus on reducing HIV transmission and other harm among people who inject drugs. Needle and syringe programs and opioid-substitution therapy form the backbone of harm-reduction services, but ideally these programs should be part of a broader range of services.[27]

Needle and syringe programs provide people who inject drugs with sterile injecting equipment so that they can avoid sharing equipment. There are a variety of models, such as exchanges of used equipment for sterile equipment, free distribution of injecting equipment through health services, and pharmacy sales. Participants in needle and syringe programs are less likely, often much less likely, to share needles than those who are injecting drugs and not in such programs, according to an evidence review by WHO, which concluded: "There is compelling evidence that increasing the availability and utilization of sterile injecting equipment by IDUs reduces HIV infection substantially."[28]

A major evidence review commissioned by UNAIDS and the Bill and Melinda Gates Foundation was conducted by the U.S. Institute of Medicine in 2007. It concluded that there was good evidence of the benefits of needle and syringe programs and opioid substitution therapy in reducing HIV infection.[29]

Substitution treatment replaces opium-derived drugs, such as heroin, with methadone or buprenorphine. These drugs can be taken orally, eliminating the need for injection. Evaluations show that substitution therapy substantially decreases risky injection practices and, thus, HIV transmission,[29] as well as reducing crime, illegal drug use, and deaths from overdose.[30] The U.S. National Institute on Drug Abuse concluded: "Drug injectors who do not enter treatment are up to six times more likely to become infected with HIV than injectors who enter and remain in treatment."[31] Unfortunately, there are as yet no substitution treatments for injected cocaine or amphetamines, and few studies have explicitly explored substitution treatment among young people who inject drugs.

Needle and syringe programs and substitution treatment programs operate in at least 80 countries.[32] However, global guidance and protocols on substitution treatment and needle exchange programs rarely deal with the specific issues of young people. Some countries set a minimum age requirement for accessing services, thus posing a major barrier to substitution treatment for young people. Others in effect limit access by requiring parental consent for all medical treatment of legal minors.[33] For these and other reasons, young people who inject drugs use harm-reduction services less than older users. For example, in Moldova, 11 percent of adolescents who inject drugs said that they obtained sterile needles from harm-reduction services, compared with 33 percent of older users.[34]

Many countries where IDU is a main driver of the epidemic are failing to take full advantage of potentially available funds, and the coverage of harm-reduction programs is often inadequate, particularly for young people.[35] The Global Fund to

Fight AIDS, Malaria, and Tuberculosis has increased funding for harm-reduction activities (although as of late 2009 the U.S. federal government does not fund needle and syringe programs either domestically or abroad).

Some harm-reduction projects have found ways to reach young people, and below are some programmatic approaches that hold promise. The emphasis is generally on using innovative service delivery approaches and including needle exchange within a larger package of activities that appeal to young people.

A project in Uzbekistan has used a peer education approach to help young people who inject drugs. These young people are hard to reach because many live at home, go to school, or work. They keep their drug use well hidden and do not go to settings where they might be identified as drug users. The project trained a few peer educators initially, who then told their contacts about the health services available through a generic youth drop-in center. Health care providers become involved only when a young person initiates contact. The project, coordinated by UNICEF and PSI, includes a drop-in center that offers English and Russian language classes, computer lessons, and job training. The services are available to all youth and are provided by community volunteers. A young person visiting the center is not identified as an IDU, but staff can refer those who use drugs to health services, including needle exchange, and accompany them if they wish. Two-thirds of the people who came for services were 18 or younger.[36] The project also works with sex workers and MSM.

In Phnom Penh, Cambodia, the grass-roots organization Korsang (meaning "to rebuild") serves thousands of people, including those who use drugs. It offers needle exchange as well as a drop-in center, outreach to 20 locations, meals, medical care, HIV prevention education, HIV testing, and case management.[37] One innovative Korsang project, called Kormix, gives young men from the streets, including those who inject drugs, a way to express themselves and to build a new, positive sense of identity through hip-hop music, dance, and the visual arts. With the help of entertainment professionals, they learn performance skills in classes available five days a week. The young performers then give free outdoor dance and music performances. Artists also offer to paint murals in the community. The music and art often carry HIV prevention messages. Many of the Kormix participants reduce or stop their substance use as a result of this work, saying that they want to be better performers, to have stronger bodies, and have

Many countries where IDU is a main driver of the epidemic are failing to take full advantage of potentially available funds.

more options than before.[38] As of June 2009, some 150 young people had participated in Kormix activities.

The international, youth-led, harm-reduction organization Youth RISE is working with young people to support harm-reduction activities.[39] In Imphal, India, and Bucharest, Romania, the group is creating a training and best practices guide that examines the links between injecting drug use, harm reduction, and sexual health among young people. Young people who inject drugs, service providers, and HIV experts participated in developing the guide. The young people said that they wanted more information about STIs, overdose prevention, hepatitis, available community services, and safer drug use. In the training, young harm-reduction workers can help young people make informed decisions, free from stigma or discrimination, about their own drug use and sexual activity. As of June 2009, Youth RISE had conducted four pilot trainings to try out the new program. The MTV Staying Alive Foundation funds the project.

Conclusions and Next Steps

To prevent young people from starting to inject drugs, some risk-reduction programs are beginning to focus explicitly on especially vulnerable young people. Most seek to change people's immediate environments rather than the broader social conditions that drive IDU. There are also increasing calls for harm-reduction services to better address the specific needs of young people and for law enforcement agencies to harmonize their approach with those of social and health services. To date, however, most harm-reduction programs have been reluctant to focus on young people. Programs working with young people who inject drugs point to several lessons learned:

- Young people who inject drugs often do not think of themselves as drug users and would rather be identified as young people. They would rather obtain information and services in a setting for young people than in a setting for drug users.
- The illegality of drug use makes young drug users particularly wary of contact with organized activities. Programs might have to negotiate the cooperation of law enforcement agencies so that they can serve their clients, especially young clients.

- Legal minors' access to medical treatment—for example, substitution therapy—might be restricted by law or involve requirements, such as registration, that frighten away young people. Advocacy for supportive policies is crucial, while at the same time, existing laws may allow treatment in some settings, but these provisions might not be widely known or understood.
- Research with local young people helps programs understand the local drug scene and keep up with the changes that take place. Most research into patterns of injecting behavior has looked at older people who have used drugs for years. Relatively little is known about the injecting behavior of young people or those new to injecting.
- Young people can inform programs and help manage and provide services. Engaging young people who formerly used drugs and other vulnerable young people in organized activities is not easy, but it has often been the best way to reach and serve young people who inject drugs.

As policymakers, donors, and program planners consider HIV prevention and related issues for those injecting drugs, they need to give adequate attention to the particular needs of young people. Most injecting drug users begin when they are young and face particular risks, both in starting the practice and after they are injecting. Addressing the specific needs of young people who are at risk of injecting drugs will make an important contribution to the overall goals of HIV prevention, as well as prevent many other health problems among a particularly vulnerable group of young people.

Beyond HIV Prevention

The UNAIDS task team working with HIV and young people has outlined the broader package of services that can help young people who inject drugs. Addressing young people more holistically can meet a wide range of health, social, and developmental needs, including food, security, hygiene, job and skills training (such as computer skills and language lessons), psychological and legal services, and recreation and leisure activities. To attract young people who inject drugs, outreach is needed, often by peers. Drop-in centers and health services need to offer a safe, welcoming, and comfortable environment. Services must be confidential, private, nonjudgmental, and friendly to young people. A minimum package of health services should focus on an individual's injection and drug use practices, addressing HIV and hepatitis transmission, bacterial infections and vein care, and substitution and maintenance therapy.* Each of these involves a number of complex issues. For example, as those infected with HIV live longer using antiretroviral therapies, infection with hepatitis C can become more severe, requiring a careful mixing of medications.† Other priority areas for health services beyond HIV prevention include the following:

- **Preventing overdose.** Drug overdose is a serious a risk for young injecting drug users. The drug naloxone prevents death from drug overdose. HIV prevention programs for injecting drug users often overlook the life-saving potential of providing this treatment in advance and training in overdose response.§ Costing about U.S. $1 per treatment, naloxone could be sold in pharmacies, as it is in Italy, as well as provided free to those who cannot afford to buy it.

- **Family planning and reproductive health.** Young people who inject drugs are usually sexually active and need the full range of age-appropriate RH information, services, and care. They need counseling, testing, and treatment for other sexually transmitted infections. Discussing condom use not just for STI prevention but also as part of a larger package of RH services is important and could prove more appealing, particularly to young women who want to avoid or postpone pregnancy. Unfortunately, they often lack information and access to youth-friendly sources of supplies, services, and support, such as counseling on negotiating condom use.

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Chapter 5.
Conclusions

In this paper and in the June 2009 meeting on most-at-risk young people, several overarching issues emerged, including conclusions and recommended further actions regarding young men who have sex with men, young people who exchange sex for money or goods, and young people who inject drugs. Many of the findings overlap, which is not surprising because of significant overlaps in these behaviors.

The following important questions emerged:

- Should these three most-at-risk groups of young people receive specific attention in HIV-prevention programs and in programs working with young people more generally? And if they should, what are the most effective approaches to meeting their needs?
- Should programs for most-at-risk populations give young people particular focus?
- Should programs for vulnerable young people also be responding to the needs of young people most at risk of HIV, or should programs that are directed to the general population of young people also incorporate most-at-risk young people?
- Should separate programs address young people's needs or should young people be integrated into programs that are responding to the needs of all age groups?

"Most-at-risk young people are a highly neglected population," said Shanti Conly of USAID in her closing remarks at the June conference. Throughout the meeting, she observed, "We heard the phrase 'know your epidemic.' These three core groups are important across all epidemics. However, young people who belong to these core groups are especially important to address in concentrated epidemics, where they likely represent a substantial proportion of people living with or at very high risk of HIV. The relative importance of each of these most-at-risk youth populations will, however, vary depending on the local epidemic."

Many young people are at risk of HIV (and other negative health outcomes) because of the environments in which they live and not because of their individual characteristics. "We need to think in terms of concentric circles," said Conly, referring to the ecological model discussed in the meeting (Figure 1, page 8). "Programs should deal with context, with structural and environmental factors, and not focus just on the individual. They need to recognize that the ability to access HIV services for these most-at-risk young people is closely linked to issues of sexual and human rights. We need to link the expansion of targeted services to reduction of stigma and discrimination."

Unprotected vaginal or anal sex with multiple partners and sharing injecting equipment are the behaviors that place people most at risk of acquiring HIV. Those young people who frequently have unprotected vaginal sex face the dual risks of HIV and unintended pregnancy. "While integrating HIV and pregnancy prevention services makes sense in some instances, it does not always reflect the best use of resources," said Conly. "Even so, there is great commonality in the programs, especially regarding the need for education, stigma reduction, and access to services. Thoughtful approaches to integration based on convergence are the way to go."

The UN system has a working group on most-at-risk young people within its Inter-Agency Task Team on HIV and Young People. In a few countries, PEPFAR programs incorporate some focus on most-at-risk youth (see Chapter 1), but a more systematic approach to addressing these populations is needed. "Clearly, we need to advocate more consistently on behalf of most-at-risk young people, especially where they are an epidemiological priority," said Conly.

Incorporating the experiences and perspectives of young people themselves is important when addressing these issues. Contributing to the meeting and this paper were representatives of YouthRISE, which works primarily on issues related to young people and injecting drugs.

"Program initiatives cannot succeed if based on simplistic explanations of most-at-risk behavior—for example, that IDU is just a product of youthful curiosity and the availability of drugs," explained Kyla Zanardi, representing YouthRISE. "Successful programming requires deeper understanding of the complex and diverse situations in which young people live. While preventing initial injection among most-at-risk young people is important, also critical is programming that addresses young people who are already using drugs. They need access to nonjudgmental providers, including youth-friendly, harm-reduction services. The difficult life situations that make some people vulnerable also make it difficult for them to make decisions, stick to them, and develop trust in others. Working with most-at-risk young people takes effort, time, and people. Barriers to programs add to the difficulty."

The authors of this discussion paper seek to contribute to the increasing focus on ways to address the needs of most-at-risk young people. The following six suggested actions, which apply to all three most-at-risk groups of young people, emerged from the paper and the meeting.

1. Inform Advocacy with Better Data

More advocacy efforts are needed at both the policy and program levels on behalf of most-at-risk young people. Better statistics at the country level would help highlight how many young people are most at risk of HIV and provide an assessment of how many of these young people are living with HIV. Although the indicators developed for monitoring by the UN General Assembly Special Session on HIV/AIDS (UNGASS) stress the importance of reporting separately on those most-at-risk people under the age of 25 and those over the age of 25, to date few countries are reporting this way. Further disaggregating the data for those under the age of 25 by age and sex would make an important contribution to the development of effective programs. Better data can lead to better policies and programming, while the lack of data perpetuates neglect of these groups, contributing to what one speaker at the 2009 meeting called "a cycle of marginalization."

While better data are needed, the data presented in this report and at the 2009 meeting do show the need for more action:

- Adolescents and, more broadly, those under the age of 25 constitute a high percentage of those most at risk of HIV. In concentrated epidemics, young people can account for more than half of all new infections.
- Early age of initiation is typical in all three behaviors that place young people most at risk of HIV.
- Rates of HIV are high among the most-at-risk groups of young people, and in some places the rates appear to be increasing most rapidly among these younger groups.
- Most-at-risk young people have less information, are less likely to be reached by HIV programs, and are less likely to adopt protective behaviors than older populations.

2. Understand Risk Behaviors, Evaluate Interventions, and Consolidate Lessons Learned

More formative and operations research and more evidence on programs and strategies are needed. The following questions need to be answered:

- What are the best ways to reach most-at-risk young people with services?
- What changes in policies and legislation are crucial for protecting most-at-risk young people and their service providers?
- What structural changes are feasible and effective in helping to reduce vulnerability?
- To what extent are programs for most-at-risk populations and programs for the general population of young people reaching most-at-risk young people? And, how effective are they?

Some of the studies discussed at the meeting and in this report highlight these issues.

- Reports on young sex workers from Nepal and India show the importance of thinking more about primary prevention, i.e., preventing young people from getting involved in sex work in the first place, reducing vulnerability.
- The Togo study described in the MSM chapter (see page 30) points out the importance of young people understanding their risks, for example, the belief among some men that anal intercourse does not transmit HIV. Such knowledge is critical in designing messages for prevention efforts.

3. Promote Better Policies and Target Funding Appropriately

Policies need to be developed and implemented that protect vulnerable young people, decriminalize the behaviors that place them most at risk, and ensure that they have access to the services they need. Criminalization and imprisonment can endanger young people engaged in any of these most-at-risk risk behaviors. Policies need to be directed at changing structural determinants that contribute to primary prevention, preventing harm, and providing a broad range of services for most-at-risk young people. Achieving such policies requires political will and support for policymakers. Both Mexico and Brazil provide examples for how supportive policies can be developed over time.

Age restrictions on treating young people without parental consent could deter some harm-reduction and drug prevention programs from working with young people. While some programs adopt a "don't ask, don't tell" policy about their clients' ages, others might not want to develop special approaches for younger clients for fear of drawing attention to their age. Programs need clear ethical and profesional standards to ensure that they protect young people and do not increase the harms to which they might be exposed. Similarly, restrictions on research with legal minors and the lack of age-specific program records contribute to the lack of data and perpetuate a vicious cycle: bad policy means little information can be collected to support advocacy for better policy.

Part of policymaking is the appropriation of funds, both from governments and donors. The bulk of HIV resources for young people do not always go where the need is greatest and where the most infections can be prevented. Projects working with most-at-risk young people need more funding, and groups working with general most-at-risk populations need incentives to focus resources on meeting the specific needs of young people. Funds from the Global Fund, PEPFAR, and other donors are needed for direct program support, targeted research, capacity building, and advocacy at national and global levels for most-at-risk young people.

4. Engage Most-at-Risk and Vulnerable Young People.

A tenet of public health programming is that engaging clients in program design makes for greater success. Engaging young people in planning and implementing programs is important for many reasons. Peers have greater access to most-at-risk young people and are often better at communicating with them because they understand the reality of their lives and even the language that they use (more on programming and peer education in item 6). But young people can also have an important impact in helping to shape the design and implementation of programs at a broader level, including advocacy for better policies and other structural approaches. Such meaningful engagement of young people is challenging. Many programs are either hesitant to engage young people as serious partners or unsure how to do this, given differences in age and experience. Programs need to be willing to listen to and work with young people within their own program structures as well as through partnerships with youth groups.

5. Forge Partnerships and Linkages with Other Sectors and within Communities

Potential partners include health organizations, youth organizations, youth services agencies, community groups, advocacy groups from most-at-risk populations, local officials, schools, religious leaders, networks protecting children, and law enforcement agencies. At the service delivery level, linkages and collaborations will help meet a range of health and social needs among most-at-risk young people, whose needs are often considerably greater than those of others their age. One obvious opportunity for linkages that is often overlooked because of funding silos or other constraints is the link between HIV prevention programs and programs to prevent unintended pregnancy and improve sexual and reproductive health. These programs have many elements in common, including aspects of sex education, condom promotion, care and support, HIV and other STI testing and treatment.

6. Promote Comprehensive Services and Creative Programming

While many HIV prevention services are the same for all age groups (e.g., information on condoms and HIV risks), these services need to be delivered differently to most-at-risk young people:

- Peer education is particularly important. Young people who have injected drugs, exchanged sex for money, or have sex with other men have credibility with their peers. Also, they know how to find their peers through networks outside of the usual programmatic outreach channels, and they can both serve as a link to service delivery systems and provide a support system.
- Social networks are important. Peers can help programs identify and use social networks among most-at-risk groups.
- Most-at-risk young people need psychosocial services, caring adults, and specialized services. Service providers need training to help them understand how to provide services to these young people.
- Programs need to address complex and controversial issues, such as informed consent from minors, sexual exploitation, and the provision of clean needles and syringes.

Examples of creative programming that were discussed at the meeting are described in this report. While some have been more thoroughly evaluated than others, the potential value of these approaches needs to be shared, as do further evaluation results as they become known. These innovations suggest important approaches:

- Shift focus from stigmatized behaviors to primary prevention. For example, the "break the cycle" programs in the IDU area engage older users who may influence those who are initiating use.
- Avoid labeling young people as *sex workers* or *drug users* and instead try to reinforce the positive potential of the young people. A project in Cambodia, for example, is known as SMARTgirls, a term that emphasizes good choices rather than labeling them as sex workers. Similarly, programs find that young drug users prefer to obtain information and services in settings for *young people*, not for *drug users*.

- Highlight ways in which young people can help prevent more HIV infections, such as involving them in performing and visual arts as a way to help change their own behaviors while passing on HIV prevention messages to others.
- Build more capacity for all of these approaches, particularly where civil society is weak.
- Consider more projects that involve overlapping risks with drug use (including amphetamine-type stimulants), young MSM, and sex workers. An epidemic of drug use among MSM generally seems to be emerging in Asia, and few programs are reaching this segment.

Additional programming issues emerged that are specific to each of the three population groups.

Young men having sex with men:

- Programs need to be aware of culturally specific sexual and gender identities and expressions that reflect experimentation among young men having sex with men. Programs should avoid making categorical distinctions between homosexual and heterosexual and instead focus on reducing HIV risk that occurs through male-to-male sex.
- Programs should address barriers to HIV testing for young MSM, which result from a fear of a double stigma (MSM and HIV infected).
- Programs should help these young men gain resilience and hope for the future and assist MSM organizations that can offer support, role models, and advocacy for policy changes.

Young people exchanging sex for money or goods

- Programs should address structural factors that promote primary prevention, i.e., preventing the entry of young people into commercial sex work, including trafficking across and within countries.
- Programs need to be able to identify and assist victims of trafficking but also be aware that rescue efforts can sometimes stigmatize those who are rescued unless careful rehabilitation activities are part of the intervention.
- Programs with sex workers need to take into consideration the fact that young people need more personal attention than older sex workers, including training on using condoms and accessing HIV prevention and other supportive services.
- Programs need to give more attention to issues relating to boys and young men selling sex. Although most programs have focused on girls, boys also sell sex.

Young people injecting drugs

- Programs may need to negotiate with, and gain the cooperation of, law-enforcement agencies in order to serve young people. Issues of illegality make young drug users wary of contact with organized activities, particularly those connected with government.
- Legal minors' access to harm-reduction programs could be restricted by law or could involve requirements, such as registration, that frighten away young injecting drug users.

Appendices

Appendix 1:
Meeting Agenda

Young People Most at Risk for HIV/AIDS
Sponsored by the Interagency Youth Working Group (IYWG), June 25, 2009

Location: Academy for Educational Development, Academy Hall, Washington, DC
Time: 8:30 am–5:00 pm, continental breakfast and lunch provided

Meeting Objectives:

1. To provide an overview of young people (between the ages of 10 and 24) who are vulnerable and most at risk of HIV
2. To provide examples of policies and programs that address the needs of most-at-risk young people
3. To identify next steps toward meeting the needs of vulnerable and most-at-risk young people

8:30–9:00 — **Registration and Continental Breakfast**

9:00–9:10 — **Welcome and Overview**
Debbie Kaliel, USAID Office of HIV/AIDS

9:10–10:45 — **Framing the Issue: Adolescents, Risk, and the Epidemic**
Moderator: *Linda Wright-Deaguero, CDC*

Vulnerability and Most at Risk: Towards a Common Framework
Bruce Dick, WHO

Questions and Discussion

Panel on Perspectives of Partners: Opportunities and Challenges
Karina Rapposelli, OGAC
Diane Widdus, UNICEF
Kyla Zanardi, Youth RISE

Questions and Discussion

10:45–11:00 — **Break**

11:00–12:15 **Young Men Who Have Sex with Men (MSM): Research, Program Experiences, and Applications**

Moderator: *Clancy Broxton, USAID Office of HIV/AIDS*

Overview: HIV/AIDS and Young MSM
Kent Klindera, amfAR

Public Policy and Government Programming for Young MSM: Case Studies from Brazil and Mexico
Brian Ackerman, Advocates for Youth

Reaching Young Men Like Us: HIV Prevention among MSM in Togo
Donna Sherard, PSI

Questions and Discussion

12:15–1:15 **Lunch and Information Marketplace**

1:15–2:30 **Young Female Sex Workers (FSWs): Research, Program Experiences, and Applications**

Moderator: *Koye Adeboye, UNFPA*

Overview: HIV/AIDS and Young FSWs
Jay Silverman, Harvard School of Public Health

Program Experiences: The SMARTgirl Program in Cambodia
Kwaku Yeboah, FHI

Save the Children's Experiences from Vietnam: Reaching out to Young FSWs
Brad Kerner, Save the Children

Questions and Discussion

2:30–2:45 **Break**

2:45–4:00 **Young Injection Drug Users (IDUs): Research, Program Experiences, and Applications**

Moderator: *Diane Widdus, UNICEF*

Overview: HIV/AIDS and Young IDUs
Diane Widdus, UNICEF

Injecting Drug Use and Youth: PSI's Programs
Shimon Prohow, PSI

A Youth-Led Perspective: Best Practices for Youth Harm Reduction Programming
Kyla Zanardi, Youth RISE

Questions and Discussion

4:00 – 4:45 **Next Steps in Advocating for Most-at-Risk Young People**

Moderator: *Jenny Truong, USAID Office of Population and Reproductive Health*

Synthesis of the Day
Shanti Conly, USAID Office of HIV/AIDS

Panel on Perspectives of Partners: Looking Forward
Diane Widdus, UNICEF
Karina Rapposelli, OGAC
Brian Ackerman, Advocates for Youth

Questions and Discussion

4:45 – 5:00 **Wrap-up and Evaluation**

Jenny Truong, USAID Office of Population and Reproductive Health

Appendix 2:
References

Young People Most at Risk for HIV

Selected References—Framing the Issue

Definitions and concepts

- Dick, B. "Vulnerability and Most at Risk: Towards a Common Framework." Presented at Interagency Youth Working Group meeting, Washington, DC, June 25, 2009. *http://www.infoforhealth.org/youthwg/iywg/25June09.shtml*
- UNAIDS. Expanding the global response to HIV/AIDS through focused action. Reducing risk and vulnerability: definitions, rationale and pathways. Geneva, UNAIDS, 1998. 17 pp. This document provides the first full definitions and explores the concepts of most-at-risk and vulnerability. *http://data.unaids.org/Publications/IRC-pub01/jc171-expglobresp_en.pdf*

Overview

Inter-Agency Task Team on HIV and Young People. HIV interventions for most-at-risk young people. New York, UNFPA, 2008. 8 p. This brief provides an up-to-date overview of issues concerning most-at-risk young people. It covers definitions, key issues, key programs, action recommendations for UN country teams, and more. *http://www.unfpa.org/public/iattyp/*

Why focus on most-at-risk young people?

- de Lind van Wijngaarden, JW. Responding to the HIV prevention needs of adolescents and young people in Asia: Towards (cost-) effective policies and programmes. UNICEF, 2007. This 36-page document advocates prioritizing HIV prevention for young people in Asia—top priority for the most-at-risk, second priority for the vulnerable, and lowest for the low-risk/low-vulnerability majority. *http://www.unicef.org/rosa/Rosa_Aids_Commission_in_Asia_06September_07.pdf*

Strategic approaches

- Aggleton, P, Chase, E, and Rivers, K. HIV/AIDS prevention and care among especially vulnerable young people. A framework for action. WHO and UK Department for International Development, April 2004. 36 pp. Building on the concepts of risk and vulnerability, the authors conceptualize three key areas for action: risk reduction, vulnerability reduction, and impact mitigation. *http://www.safepassages.soton.ac.uk/pdfs/evypframework.pdf*
- International Harm Reduction Association. What is harm reduction? This Web site provides a brief introduction to this concept in the context of the use of psychoactive substances. *http://www.ihra.net/whatisharmreduction*.
- Rao Gupta, G, Parkhurst, JO, Ogden, JA, et al. HIV prevention 4: Structural approaches to HIV prevention. Lancet 372:764–75. 2008. *http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)60887-9/fulltext#article_upsell* (free with registration)
- UNAIDS Inter-Agency Task Team on Young People. Accelerating HIV prevention programming with and for most-at-risk adolescents: Lessons learned from the first global Technical Support Group, Kiev, Ukraine 24–26 July, 2006. UNAIDS, 2007. Meeting participants identified five, high-priority goals for HIV activities: (1) improve research and evidence; (2) improve legislation, policy, and implementation; (3) improve access to and the quality of comprehensive services; (4) reduce stigma and discrimination; and (5) improve the coordination of services. Citing examples, the report suggests how to take action. *http://www.unicef.org/aids/index_documents.html*
- Weir, SS, Tate, J, Hileman, SB, et al. Priorities for local AIDS control efforts (PLACE): A manual for implementing the PLACE method. Chapel Hill, University of North Carolina. MEASURE Evaluation, 2005. This is a guide to a methodology for identifying locations where contacts lead to most-at-risk behavior and for involving local people in programming. (It is not specific to young people.) *http://www.cpc.unc.edu/measure/tools/hiv-aids/place*

Program evidence

- Hoffman, O, Boler, T, and Dick, B. 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: Ross, DA, Dick, B, and Ferguson, J, eds. Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries. Geneva, World Health Organization, 2006. p. 287–315. A systematic review, conducted in 2005, found little research evidence on the effectiveness of interventions directed toward MARA in developing countries. Still, this and other evidence show that providing information and services through static facilities with outreach can be effective. *http://libdoc.who.int/trs/WHO_TRS_938_eng.pdf#page=296*

Adolescent development

- Juarez, F, LeGrand, T, Lloyd, CB, et al. Introduction to the special issue on adolescent sexual and reproductive health in sub-Saharan Africa. Studies in Family Planning 39(4):239–244, 2008. Highlights of recent research presented in this issue of SFP cover three areas: sexual and reproductive transitions, HIV risks, and schooling and adolescent sexual and reproductive transitions. *http://www3.interscience.wiley.com/journal/121536446/abstract* (Full text requires payment.) For a book-length look at contemporary adolescence in the developing world, see Lloyd, CB, ed. Growing up global. The changing transitions to adulthood in developing countries. Washington, DC, National Academies Press, 2005. 720 p. Read free online or buy download here: *http://www.nap.edu/catalog.php?record_id=11174#toc*)
- Morgan, E and Huebner, A. Adolescent growth and development. Virginia Cooperative Extension, Publication 350–850, revised 2008. This document summarizes facets of adolescent development and their behavioral manifestations, and common-sense advice for caregivers. Has a U.S. focus but provides a useful framework and quick overview. *http://www.pubs.ext.vt.edu/350/350-850/350-850.html*
- Steinberg, L. Cognitive and affective development in adolescence. Trends in Cognitive Science 9(2): 69–74, 2006. Adolescence is often a period of especially heightened vulnerability as a consequence of potential disjunctions between developing brain, behavioral, and cognitive systems that mature along different timetables and under the control of both common and independent biological processes. *http://www.temple.edu/psychology/lds/documents/CognitiveandAffective-DevelopmentTICS.pdf*

Useful Web sites

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

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

UNAIDS Inter-Agency Task Team on HIV and Young People:
http://www.unfpa.org/hiv/iatt

Interagency Youth Working Group: *http://www.youthwg.org*

International Harm Reduction Association: *http://www.ihra.net*

UNAIDS (publications):
http://www.unaids.org/en/KnowledgeCentre/Resources/Publications/default.asp

World Health Organization, Department of Child and Adolescent Health and Development:
http://www.who.int/child_adolescent_health/en/

Youth InfoNet:
http://www.infoforhealth.org/youthwg/pubs/IYWGpubs.shtml#InfoNet

Youth R.I.S.E.: *http://www.youthrise.org*

FHI
P.O. Box 13950
Research Triangle Park,
NC 27709 USA

Telephone: 919.544.7040
Fax: 919.544.7261
Web Site: www.fhi.org

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