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Thematic segment: HIV, adolescents and youth

Background Note

KEY MESSAGES

Adolescents and youth are increasingly recognized as a priority on the global agenda as well as in national HIV polices; now action and resources must follow. While there are excellent examples of programmes that address the needs of young people, they are still not taken to the scale required to reach the targets set in the *2011 Political Declaration on HIV and AIDS*. In order to increase the impact of the HIV response for adolescents and youth, the following strategies are needed:

I. **Know your local epidemic and scale-up evidence informed, youth-friendly programmes accordingly** for adolescents and youth, especially young key populations and young people living with and affected by HIV; ensure programmes are tailored to the specific needs of girls, young women, boys and young men, included in national strategic plans, and appropriately costed and earmarked in national budgets.

II. **Expand efforts to integrate HIV programmes** for young people, young key populations and young people living with HIV into a broader framework of sexual and reproductive health, ensure services are youth-friendly and explore opportunities for stronger linkages between the education, gender equality, social and child protection sectors and HIV prevention, treatment, care and support.

III. **Create enabling social and legal environments** for adolescent and youth HIV programmes, including programmes for young key populations and programmes to prevent gender-based violence while addressing harmful gender norms, and consider revising, where appropriate, age- and sex-related restrictions that prevent adolescents and young women and men from accessing effective HIV prevention, treatment and care, as well as sexual and reproductive health services.

IV. **Young people should be partners and leaders in the AIDS response** and included in HIV-related national, regional and global decision-making and policy processes. Their meaningful participation should be supported throughout the HIV programming cycle, including design, implementation, and monitoring and evaluation.

V. **Collect, compile and disseminate age- and sex-disaggregated data** on all relevant Global AIDS Response Progress Reporting (GARPR) indicators, including HIV treatment, and track resources on AIDS spending categories that are relevant to young people for evidence-informed advocacy, policy-making and programming.

DEFINITION

Defining adolescents, youth and young people

"Adolescents" are defined as persons between the ages of 10-19 and "youth" are defined as persons between the ages of 15-24. For the purposes of this thematic segment, the term "young people" will refer to both groupings unless otherwise specified in the text.

GUIDING PRINCIPLES

Youth Participation in the HIV Epidemic – an underlying principle of a successful HIV response

Young people's leadership and partnership are critical to ending the AIDS epidemic. The right to participate has been recognized as a cornerstone of good development practice, as outlined in the UN Declaration on the Right to Development, as well as a basic right for children in the International Convention of the Rights of the Child (*16-17*).[1]

Youth-led organizations, like other community based organizations, have in-depth knowledge of the challenges within their own contexts and are often able to access the hardest to reach populations within their networks (*19*). Actively involving young people within the leadership, development and evaluation of HIV programmes results in more tailored approaches that address the real needs and gaps identified by the young people themselves.

While many countries have acknowledged the importance of working with young people in the HIV response, young people still lack systematic ways to participate in national AIDS policy-making, programme development and decision-making spaces.

The UNAIDS Secretariat has adopted 'youth as asset' approach to strengthen youth participation in the HIV response, which views young people as:

- **Beneficiaries**—young people are identified and prioritized as recipients of, and are well-informed about, programmes or policies;
- **Partners**—programmes or policies are developed collaboratively, consulting young people at every step and implying a sense of cooperation and responsibility; and
- **Leaders**—programmes or policies are youth initiated or directed, and space is open within existing structures, systems and processes for youth-led decision-making (*22*).

[1] The Convention on the Rights of the Child notes that children have the right to participate in decisions that impact their lives. The Convention only applies to persons under the age of 18.

BACKGROUND

1. Recognizing the urgent need to scale-up effective HIV responses tailored to the needs of adolescents and youth, as well as the need and value of working effectively with and for young people, the UNAIDS Programme Coordinating Board (PCB) agreed that the subject for the 33rd PCB thematic segment would be *HIV, adolescents and youth* (*3*).[2]

2. The thematic segment on *HIV, adolescents and youth* is framed by the *Political Declaration on HIV and AIDS* (2011) (*2011 Political* Declaration) and the *UNAIDS Strategy 2011-2015, Getting to Zero* (*4*).Two imperatives underpin the thematic discussion on *HIV, adolescents and youth*: (a) the need to prevent new HIV infections among young people and (b) the need to secure access to high quality HIV treatment, care and support for adolescents and youth living with HIV.

INTRODUCTION

3. The world currently holds the largest generation of young people in history, with 1.8 billion adolescents and youth making up one quarter of the world's population. Fulfilling young people's right to health, education and decent work can create a powerful force for economic development and positive change across societies. A wide-lens perspective on health and development is needed to address the social determinants that put young people at risk of HIV and other sexually transmitted infections.

4. Young people are increasingly acknowledged as assets and key partners in development. In 2012, the United Nations Secretary-General recognized young people as one of five generational imperatives and opportunities in his Five Year Action Agenda, increasing the focus and depth of how the UN system works with and for young people. Similarly, in the process to arrive at a new global development framework for the Post 2015 world, young people have been noted as a priority in key documents and recommendations. Young people have also effectively advocated for an agenda that addresses inequalities, focuses on the most marginalized and secures the sexual and reproductive health and rights of all young people (*1*).

5. Despite the prominence of youth on the global agenda, young people are often left behind in national HIV responses. Access to high quality HIV prevention, treatment and care for young people is often lower than for their older adult counterparts. For example, modeling suggests that, between 2005 and 2012, the number of AIDS-related deaths among adolescents increased by 50%, while the overall number of AIDS-related deaths fell by 30% (*2*). While there has been progress in the HIV response for young people, with HIV prevalence in sub-Saharan Africa among young women and men aged 15-24 falling by 42% from 2001 to 2012, young people aged 15-24 still accounted for 39% of the 2 000 000 new adult infections in 2012 (*2, 6*).

6. Acknowledging the importance of young people within the HIV response, the PCB called for a thematic segment on adolescents and youth. In preparation for the thematic day, the UNAIDS Secretariat (Secretariat), with the support of the Joint Programme Cosponsors and the thematic segment Working Group, sent out a Call for Submissions of good practices, programmes and initiatives of working with and for adolescents and youth in the HIV

[2]The original name of the thematic segment, agreed to at the 31st PCB meeting in December 2012 was HIV and young people, which was subsequently amended by the PCB bureau to HIV, adolescents and youth in March 2013.

response. The Call was sent to PCB Member States, observers and civil society organizations, including youth organizations. The Secretariat received 213 full submissions.[3]

7. Based on the received submissions, as well as key reports sourced from the Joint Programme Cosponsors, this background note provides a summary of the HIV epidemic among young people, as well as the response, framed against the relevant targets of the *2011 Political Declaration*. It then highlights important elements of an effective HIV response for adolescents and youth. Specifically, the thematic segment will focus on the following aspects:

   a. Increasing political accountability for effective, youth-friendly HIV policies and initiatives;
   b. Addressing gaps and expanding successful approaches to working with and for adolescents and youth, as well as supporting their leadership; and
   c. Creating enabling legal and social environments for adolescents and youth in the HIV response.

HIV, ADOLESCENTS AND YOUTH: THE NUMBERS

8. This section outlines the latest UNAIDS estimates relating young people and HIV. It includes the number of new HIV infections, the number of young people living with HIV as well as the number of AIDS-related deaths.[4] Please note that these figures are based on modelled estimates only.

New HIV infections among young people (15-24)[5]

9. In 2012, an estimated 780,000 youth aged 15-24 were newly infected with HIV, with 97% of the new infections occurring in low and middle income countries (*5*). Globally, there has been a 32% reduction in the estimated number of new HIV infections among young people (15-24) from 2001 to 2012 (*2*). Across sub-Saharan Africa and the Caribbean, countries have achieved notable decline in incidence. In contrast, in the Middle East and North Africa, there was an estimated 50% increase in the number of new HIV infections among young people (*2*). Moreover, there is also a gender divide as young women ages 15 to 24 are 50% more likely to acquire HIV than their male peers (*7*).

Region	Number of new HIV infections (2001)	Number of new HIV infections (2012)	Decline/Increase in new HIV infections (%)
Caribbean	8 300	3 700	55% decline
East Asia	21 000	2 6000	24% increase
Easter Europe Central Asia	33 000	20 000	38% decline
Latin America	36 000	31 000	15% decline
Middle East and North Africa	7 700	12 000	50% increase
Oceania	1 200	<1000	53% decline
South- and South East Asia	150 000	110 000	28% decline
Sub-Saharan Africa	800 000	560 000	36% decline

[3] As of November 12, 2013, the UNAIDS Secretariat received 213 full submissions with the following regional breakdown, as per PCB guidelines: Africa (including North Africa) – 110; Asia (including Middle East) – 34; Latin America and the Caribbean – 16; Eastern Europe – 20; Western Europe and Other States – 21; Multiple regions/global – 12. Please note that the submissions have not been independently verified.
[4] Data may not add up in columns as totals are calculated from unrounded numbers.
[5] Please note that estimates are not available for children aged 10-14.

Number of adolescents and youth living with HIV

10. In 2012, an estimated 5.4 million young people aged 10-24 were living with HIV (*2*). There are some 900 000 adolescents (10-14) living with HIV, the vast majority of whom acquired HIV through vertical transmission. Unfortunately, many young people aged 10-14 remain unaware of their HIV status.

Age	Number of adolescents and youth living with HIV (2001)	Number of adolescents and youth living with HIV (2012)
10-14	250 000	900 000
15-19	1 300 000	1 200 000
20-24	4 400 000	3 300 000
Total (10-24)	**6 000 000**	**5 400 0000**

AIDS-related deaths among young people living with HIV

11. UNAIDS estimates indicate that AIDS-related deaths among young people are increasing (*2, 6*). While this is due in part to the fact that the total number of young people living with HIV is increasing, it is also likely a result of poorly prioritization of adolescents in national plans for scale-up of HIV testing and treatment services (*6*). Globally, AIDS-related deaths among youth (15-24) made up about 6% of total adult AIDS related mortality in 2012 (*2*).

Age	Number of AIDS-related deaths (2001)	Number of AIDS-related deaths (2012)
10-14	21 000	61 000
15-19	17 000	46 000
20-24	73 000	48 000
Total (10-24)	**110 000**	**154 000**

EVIDENCE-INFORMED HIV RESPONSES FOR ADOLESCENTS AND YOUTH – A REVIEW OF YOUTH-SPECIFIC PROGRESS AGAINST THE 2011 POLITICAL DECLARATION TARGETS

12. The following section presents an overview of the HIV response for adolescents and youth according to the relevant targets of the *2011 Political Declaration* (*37*).

13. Effective HIV responses for adolescents and youth are comprised of a variety of high quality programmes, ranging from those that have a proven direct impact on reducing new HIV infections and providing treatment and care, to interventions that create enabling environments for the HIV response. Synergies and linkages with other sectors, such as the education sector, must be leveraged for maximum impact. Developing and implementing effective and meaningful HIV programmes for young people requires the recognition that adolescence and youth is a time of great psychological, physical and social change at the individual level, where behaviours and perceptions of risk, illness and health are shaped in relation to parents, peers and the wider community.

Reduce sexual transmission by 50%

14. While the annual number of new infections among young people aged 15-24 and other adults decreased by 50% in 26 countries between 2001 and 2012, many countries are not on track to halve sexual HIV transmission by 2015 (*6*). Behaviours such as age-disparate and intergenerational sex, multiple and concurrent sexual partnerships, gender-based and sexual violence, low condom use, sexual exploitation in the sex industry (under 18 year olds) and selling sex (over 18 year olds) and unprotected anal sex sharply increase a young person's risk of HIV.

15. Condom programming, social and behaviour change programmes and voluntary medical male circumcision (VMMC) are interventions that have a proven direct impact on reduction new HIV infections; they are also interventions that are relevant to adolescents and youth. Condoms remain one of the most efficient technologies available to prevent sexual transmission of HIV (*6*), other sexually transmitted infections as well as unplanned pregnancies. Unfortunately, condom use among young people remains low (*11*), with only a modest increase reported from 2002 to 2012 in sub-Saharan Africa: 9% increase among young males and 5% increase among young females aged 15-24 (*2, 6)*. Condom programming should be an integral component of behavioural approaches and integrated within the broader adolescent sexual and reproductive health (SRH) services.

16. In combination with condom use and other high impact HIV interventions, social and behaviour change programmes can reduce the risk of HIV transmission and "promote the development of social, physical, and legal environments that are conducive to risk reduction" (*25*). The decline of HIV incidence among young people in several high-prevalence countries is attributed to changes in behaviour, including delayed sexual debut, increased levels of condom use and reductions in multiple partners (*6*). Finally, VMMC is recommended in countries with high rates of HIV infection and low rates of male circumcision as it reduces the likelihood that men will acquire HIV from a female partner. With regard to young people, there is evidence that VMMC programmes have had greater success in reaching males younger than 25 years (*27*).

17. Globally, transgender persons, sex workers and men who have sex with men and other key populations have a higher HIV prevalence than the general population (*28-29*).[6] For an evidence-informed response, each country should define the specific populations that are key to their epidemic and response based on their epidemiological and social context. While the exact proportion of young key populations within the HIV epidemic remains unknown, there is evidence that people start engaging in higher risk behaviours at young ages (*11*). Moreover, while limited, available disaggregated data show significantly higher HIV prevalence among young men who have sex with men under the age of 25 than among young males in the general population (*2, 6, 30*). Several programmes have been effective in preventing new HIV infections and AIDS-related deaths among transgender persons, sex workers and men who have sex with men – these include community empowerment interventions, addressing violence, community-based services, STI screenings, hepatitis B vaccinations and basic HIV programmes such as correct and consistent condom and lubricant use and voluntary HIV testing, counselling and treatment (*31-32*). Despite representing a significant portion of the epidemic in many regions, these populations still face challenges in accessing HIV services, both due to lack of funding as well as social and

[6] Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

legal obstacles, including stigma and discrimination (*6, 51*). Access for young people from key populations is even more difficult because of various factors such as age-related restrictions to HIV and SRH services and the limited availability of youth-friendly services. Size estimations, and operational and participatory research is urgently needed among adolescent and young key populations in order to develop a more effective and efficient HIV response tailored to their realities. Guidance on ethical considerations of enrolling under-18 year olds in such research is also required.

18. Ensuring that the HIV response links with child and social protection laws, policies and programmes is critically important as HIV "weakens traditional protective mechanisms" and intensifies vulnerabilities for children and adolescents (*33*). HIV-sensitive social protection programmes include (a) increased access to quality HIV and SRH services, (b) increased access to education and basic necessities (i.e. food, housing) for adolescents and youth in need, including child-headed households, and (c) financial protection/economic support for HIV-affected adolescents and youth, among other interventions (*34*). This is particularly relevant in light of the emerging evidence around the impact cash transfers on HIV incidence in high prevalence settings (*35*).

19. Parents have a critical role of play in the context of HIV and SRH as they influence the attitudes, values and behaviours of their children through the process of socialization. Under the Convention on the Rights of the Child, parents, or alternatively legal guardians, have "primary responsibilities for the upbringing and the development of the child…[and] [t]he best interests of the child will be their basic concern" (*17*). Within this framework, it is important to ensure that parents are sensitized and aware of the HIV, SRH and general health needs of adolescents. This principle is recognized in the Convention on the Rights of the Child, when it calls for governments to provide health care-related guidance for parents (*17*). Open communication between parents and adolescents on issues related to sexual health and social norms also contributes to adolescents and youth adopting strategies to protect themselves from HIV.

20. Education is another key sector with strong synergies to the HIV response and gender equality. As noted in the UNAIDS Programme Coordinating Board endorsed paper on *Intensifying HIV Prevention*, providing comprehensive and appropriate sexual education that is gender responsive, evidence-informed and culturally sensitive is a critical component of HIV prevention (*91)*, as well as protection of SRH more generally. Education can help adolescent boys and girls to make more informed choices and reduce their risks and vulnerabilities (*36*). Comprehensive and appropriate sexual education aims to ensure that young people have the "knowledge, skills and values to make responsible choices about their sexual and social relationships in a world affected by HIV" (*36*).

21. Like the education sector, youth employment programmes and services provide an effective platform for facilitating access to HIV services. In 2013, 73 million young people worldwide were unemployed (*38*). Youth unemployment is a particularly important issue for young people, as stable employment can reduce some factors related to HIV vulnerability (i.e. economic inequality), as well as increase access to HIV-related treatment and care for young people living with HIV through work-place programming. Moreover, as youth living with HIV or affected by the epidemic might have more difficulties in finding decent jobs because of HIV-related stigma and discrimination, workplaces in the formal and informal economies can play a critical role in ensuring that young people living with HIV are not denied access to employment (*39*).

Reduce transmission of HIV among people who inject drugs by 50%

22. The world is not on track to reduce HIV transmission among people who inject drugs by 50%, as recent evidence suggests little change in the HIV burden in this population (*6*). Preventing HIV transmission among people who inject drugs, like for other key populations at higher risk of HIV, should be a major priority in regions where the primary mode of transmission is through the use of non-sterile injecting equipment. This is particularly relevant for adolescents and youth (*11*) as in some parts of the world, HIV transmission via injecting drug use accounts for the largest proportion of all new HIV infections among adolescents and youth. While there is currently a recommended package of HIV-related interventions for people who inject drugs, which includes needle and syringe programmes and opioid substitution therapy (*40*),[7] coverage of these services is low (*6*). This may be due to the limited scale and availability of such services, as well as the legal, political and social environment in which the interventions are implemented. Services may not be youth-friendly and age-related restrictions may specifically hinder adolescents who inject drugs from accessing harm reduction services. Moreover, HIV prevention materials for this population are often aimed at adults, leaving adolescents and youth uninformed and therefore at higher risk of HIV infection. More information is needed on the size of the population of young people who inject drugs, the coverage of harm reduction services for young people, as well as guidance on youth-friendly approaches to the comprehensive package of harm reductions services.

23. Detention and incarceration make young people more vulnerable to HIV (*41*). With regard to incarceration, approximately 10-20% of the population in prisons are young people, many of whom are imprisoned on drug related offenses (*42*). Not only are young detainees and prisoners more prone to be victims of violence and abuse in closed settings, which can heighten their risk of HIV, but they also have little to no access to evidence-informed HIV prevention, treatment and care or sexual and reproductive health services.

Eliminate new HIV infections among children and substantially reduce AIDS-related maternal deaths

24. As a result of sustained progress, the world has the potential to reach at least 90% of pregnant women living with HIV with antiretroviral interventions by 2015 (*6*). Although there has been a significant increase in the provision of services for the elimination of new HIV infections among children and for keeping their mothers alive, many pregnant women still do not have access to these services. This is particularly relevant for young women, as adolescents make up a significant portion of pregnant women (*43*).[8] Adolescents have less access to programmes to eliminate new HIV infections among children than do adult women (*43*). Even when pregnant adolescents access such services, many health care workers are not properly trained to care for the needs of adolescents. They may have judgmental attitudes towards sexually active young women in general and young women living with HIV in particular, and in the latter case, may subject young women living with HIV to violations of their sexual and reproductive rights, including forced sterilization. More training for service providers is needed to make services which aim at eliminating vertical transmission more youth-friendly; it is also important to scale-up services and to have stronger integration into SRH services. The integration of HIV into SRH services is important for saving lives, as emergency obstetric care, skilled birth attendants and family planning account for more than 90% of preventing maternal deaths (*44*).

[7] For the reduction of new HIV infections in people who inject drugs, WHO recommends a comprehensive package of 9 harm reduction interventions: needle and syringe exchange; opioid substitution therapy; HIV testing and counselling; ART; prevention and treatment of STIs; condom programming; targeted information, education and communication; prevention and treatment of viral hepatitis; and prevention and treatment of tuberculosis.
[8] Approx 16 million.

Reach 15 million people living with HIV with lifesaving antiretroviral treatment (ART)

25. The world is within reach of providing antiretroviral therapy to 15 million people by 2015 (*6*). However, in this effort, adolescents and youth remain underserved. It is critical for adolescents and youth to know their HIV status and to be linked to appropriate care and treatment if diagnosed with HIV. Today, a majority of adolescents and youth living with HIV are unaware of their status. In a study of nine of the highest prevalence countries[9], "less than 20% of adolescent boys and 30% of girls have been tested and know their HIV status" (*8*). This may be due, in large part, to inadequate access and utilization of overall health services. In some settings, it is also a result of national guidelines limiting the ability of adolescents to independently access HIV testing and counselling (*8*). Moreover, linkages to care for adolescents who test positive are weak (*43*). Even when linked to care services, retention in care of adolescents living with HIV is poor (*8*).

26. With regard to adolescents living with HIV, late diagnosis of HIV infection is increasingly being recognized as a significant problem (*43, 45*) leading to delayed initiation of ART and poor linkages to and retention in care (*43*), which can lead to compromised treatment outcomes, premature deaths and risk of onward transmission. Adolescents also have a low adherence rate when on ART (*46*).[10] Given the lack of second line ART availability, maintaining adherence to ART is one of the most significant problems for optimizing health outcomes in young people living with HIV. Pilot programs have indicated that creation of youth-friendly centers increases retention of adolescents in care and treatment. More treatment and care services that specifically address the particular needs of adolescents and youth, including those who were born with HIV, are needed, as well as support for transitions from child to adolescent to adult care. Moreover, as adolescents living with HIV become sexually active, just like all other young people, they will need support for managing their sexual and reproductive health. Integrated approaches to treatment and care for young people living with HIV can also be beneficial to ensure that these adolescents and youth are empowered to protect themselves and others.

27. Special consideration should be taken in relation to young people within humanitarian emergencies caused by conflict or natural disasters (15). Such contexts greatly affect not only young people's vulnerability to HIV, but also the ability of young people living with HIV to continue HIV-related treatment and care.

28. With regard to treatment coverage, currently, there is no information on the number of adolescents and youth living with HIV in need of and accessing treatment; this is a major gap in global and national reporting and tracking. Unfortunately, the current global treatment indicator does not specifically capture adolescents or young people, as it disaggregates data in two categories: children (those under the age of 15, which can also be disaggregated according to the following ages: 0-1 and 1-4) and adults (15-49 years old). What is known is that the global number of people living with HIV who have access to lifesaving treatment has tripled over the last five years, and that the coverage of children is less than half of the coverage for adults (*6*). Countries should report age- and sex-disaggregated data to better understand treatment coverage for young people.

[9] Kenya, Lesotho, Mozambique, Namibia, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe
[10] An observational cohort study conducted by Nachega and colleagues in Southern Africa found that HIV positive young people (10 to 19 years) at two-year post initiation were approximately 50 per cent less likely to maintain adherence and 70-75 per cent less likely to achieve virological.

Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

29. In many countries, women and girls are more vulnerable to HIV due to political, socio-cultural, economic and biological factors (*47*). Around half (52%) of the people living with HIV globally in low and middle income countries are women (*6*). In sub-Saharan Africa, the area in the world that is most heavily affected by HIV, young women accounted for 68% of all young people living with HIV between the ages of 15-24 in 2012 (*2*). Widespread harmful gender norms and violence contribute to this heightened vulnerability. For example, the motivations to engage in transactional sexual relationships, which increase women's risk of HIV acquisition, can stem from harmful notions of masculinity, poverty *and* young women's aspirations for a better life (*13*). With regard to violence, a South African study presented evidence of a causal relationship between intimate partner violence and HIV transmission among young women, finding that 12% of new infections were attributable to intimate partner violence (*48*). In addition, young women have lower comprehensive knowledge about HIV than young men. For instance, in sub-Saharan Africa, only 28% of young women demonstrated comprehensive knowledge about HIV compared to 36% for young men (*6*).

30. Gender inequalities, poverty, limited access to education and gender-based discrimination have been shown to also significantly exacerbate women's and girls' risk of HIV infection. At the same time, girls and women living with HIV are more vulnerable to physical and psychological violence. More work is needed to advance gender equality and women's rights through the HIV response, in particular catalyzing transformation of harmful gender norms and practices. Equally important is the need to address the structural determinants, including the socio-cultural and economic environment, that hinder women and girls from accessing comprehensive and integrated HIV and SRH services, as well as to meet their specific needs and fulfil their rights.

Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms

31. Even if young people know where to access HIV prevention, treatment and care, as well as SRH services, they still face strong challenges in accessing and utilizing these interventions. In many countries, young people under the age of majority may face age- and sex-related restrictions in accessing HIV and SRH services (*49*). They may also face issues related to confidentiality and privacy of personal health information (*11*). In addition, adolescents and youth make-up a significant proportion of key populations (*11*); young key populations may face punitive laws or policies that deter them from seeking HIV services and treatment (*11*). In 2012, non-governmental informants in 70% of countries and national governments in 60% reported the existence of laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups (*6*).

32. Young people may be deterred from HIV testing or services due to worries that they will face rejection from family, friends, service providers and community members based on HIV status (*43*). Adolescents and youth living with HIV face HIV-related stigma and discrimination in various sectors including education, health care and employment (*51*). In addition, young key populations are stigmatized because the legal and policy environments can foster discrimination against key populations (*8*). While all countries have recognized the importance of reducing HIV-related stigma and discrimination and 61% of countries reported the existence of anti-discrimination laws that protect people living with HIV (*6*), programming to reduce stigma and discrimination, especially for young people living with HIV and other key populations, has been under-funded and not taken to scale (*50-51*).

Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts

33. Although a clear trend towards integration of HIV with diverse systems and sectors is apparent, greater efforts are needed to eliminate parallel structures and systems and to ensure integration of HIV in broad health and development efforts. In particular, the integration of HIV prevention, treatment, care and support into SRH services can maximize the impact of basic HIV programming. There are several reasons why integrated services are more effective. First, the majority of HIV infections globally are sexually transmitted or associated with pregnancy and child birth. The presence of STIs also increases the probability of HIV transmission (*52*). Many of the vulnerabilities that put young people at risk of HIV, including unprotected sexual intercourse, social marginalization and gender inequality, also results in wider ill- sexual and reproductive health (*53*). Importantly, integrating services makes it easier for young people to obtain a range of necessary services related to their sexual and reproductive health in one place and, to some extent, addresses concern about stigma in accessing stand-alone HIV services. Integration also promotes smarter investments and avoids duplication of effort. Evidence suggests that integrated HIV and SRH interventions can increase young people's use of such services (*52*).

34. After HIV, tuberculosis (TB) is the second leading cause of death from a single infectious agent for young people and adults (*54*). TB is one of the largest contributors of mortality among people living with HIV (*55*). As such, integrating HIV and TB services is critical. In 2012, 53% of all countries reporting "have taken active steps towards either fully integrating HIV/TB services or strengthening joint service provision" (*6*). Moreover, over 90% of countries reported an increase in the number of services offering HIV testing and counselling services integrated with TB services (*6*).

BUILDING ON WHAT WORKS IN THE HIV RESPONSE FOR ADOLESCENTS AND YOUTH – EXAMPLES OF GOOD PROGRAMMES, INITIATIVES AND PRACTICES

35. To advance the response for adolescents and youth, the thematic segment Working Group decided to focus on providing examples of the following three elements of an effective HIV response for adolescents and youth:

    a. Increasing political accountability for youth-friendly HIV policies and initiatives;
    b. Addressing gaps and expanding successful approaches to working with and for adolescents and youth, as well as supporting their leadership; and
    c. Creating enabling legal and social environments for adolescents and youth in the HIV response.

36. While there are many examples of programmes and activities for adolescents and youth in the HIV response, these often lack built-in programme monitoring and evaluation. In addition, the programmes that are evaluated often report on output indicators, such as number of people reached and number of people trained, rather than the outcomes of programmes such as changes in behaviours and increase in uptake of services. Even fewer can attribute impact on HIV incidence and treatment outcomes. This is a theme across the submission received, and consequently a strong call is made for increased investments in better programme monitoring and evaluation for and with young people, as well as more flexible and iterative programme design with strong process evaluation components to ensure feedback from clients and beneficiaries is regularly used to improve programme efficiency and effectiveness.

Element 1: Increasing political accountability for effective, youth-friendly HIV policies and initiatives

37. Mutual accountability lies at the crux of successful HIV responses. Members States reaffirmed this principle in the *2011 Political Declaration*, when they committed to having "mutual accountability mechanisms between all stakeholders to support multisectoral national strategic plans for HIV and AIDS to fulfil the commitments in the present Declaration, with the active involvement of people living with and affected by HIV, and other relevant civil society and private sector stakeholders" (*37*).

Accountability of Governments

38. Accountability is a cornerstone of good governance. It means that governments uphold their obligations to, and are responsive to the needs of, their citizens (*56*). In the *2011 Political* Declaration, Member States declared their "commitment to end the [HIV] epidemic with renewed political will and strong, accountable leadership and to work in meaningful partnership with all stakeholders at all level" (37). In alignment with this commitment, several governments have taken assertive action on working with and for adolescents and youth in the HIV response.

39. With over half of its population under the age of 25, the government of India has several strong HIV-related programmes for young people. It has two main programmes: the Adolescent Education Programme (AEP), which provides school-based life skill education for adolescents between the ages of 14-17, and the Red Ribbon Clubs, which encourage a responsible, non-discriminatory approach to addressing the HIV epidemic for youth between the ages of 18-24. These programmes clarify sexual and reproductive health issues, develop health-seeking behaviours, and promote active leadership among youth. Leveraging the use of online technology among adolescents, the AEP works through the State AIDS Control Societies to maintain an e-mail system that allows doctors to provide answers confidentially and anonymously to sexuality related queries from students and teachers. India also organizes special campaigns focusing on youth and HIV through music and sporting events. Special efforts are made to reach out-of-school youth through youth clubs as well as faith-based organizations (*57*).

40. Recognizing the right for young people to participate in decisions that affect their lives, the National AIDS Council of Zimbabwe, with the support of UNFPA, has established the Young People's Network on SRH, HIV and AIDS. Network members hail from all of the country's 10 provinces, with various stakeholders and young people represented, including youth in- and out-of school, young people living with HIV, arts institutions, faith-based organizations and media outlets. The goals of the network are to establish a mechanism for open dialogue and exchange between youth-led and youth-serving groups and to advise the national coordination forum on the strategic opportunities and actions to address HIV related issues for young people. Thus far, the network has provided opportunities for young people to participate in reviews of youth-relevant HIV and SRH policies, as well as in programme planning and management at the national level (*58*).

41. Highlighting the importance of youth leadership at the global level, the Point 7 constituency of the Global Fund Board[11] have committed to include a youth representative in its group.[12] In alignment with this principle, the Netherlands included a youth representative during their Board term 2009 – 2011. Norway then took over this responsibility and initiated a collaborative project between the Norwegian Ministry of Foreign Affairs, NORAD and the

[11] Sweden, Denmark, Luxemburg, Ireland, Netherlands, Norway
[12] This was after the Global Fund Board adopted a Decision Point (GF/B20/DP32), which emphasized the urgency of providing more room for youth leadership.

Norwegian Children and Youth Council, to fund a Point 7 youth representative to the Global Fund and to support a youth network on HIV. The Point 7 youth representative has worked closely with other global youth representatives and has participated at relevant international meetings. The representative has also contributed to building networks of youth in the Point 7 countries and around the world, including in Norway with the Norwegian Youth Network on HIV. Through the Global Fund youth representative and the Norwegian Youth Network, Norway has been able to address youth perspectives in international decision-making processes by directly involving youth organizations (*59*).

42. In the context of HIV and SRH, governments have shown leadership on complex issues like comprehensive sexuality education (CSE) in Latin America and the Caribbean. In 2008, Ministries of Health and Education[13] from various countries in Latin America and the Caribbean, at the invitation of Mexico and the Joint Programme, developed a Ministerial Declaration on *Preventing through Education*. Acknowledging the importance integrating the health and education sectors responses to HIV and SRH, countries pledged, by 2015, to reduce "by 75% the number schools that do not provide comprehensive sexuality education" and reduce "by 50% the number of adolescents and young people who are not covered by health services that appropriately attend to their sexual and reproductive health needs" (*60*). Widely held as a success in galvanizing political leadership, regional progress on implementation is currently at 58% (*61*). The Brazilian Ministry of Health, on its part, has also been emphasizing HIV prevention in educational settings by providing condoms in schools since 2007. A study by UNESCO in the country showed that two-thirds of the surveyed parents supported the idea of the government providing free condoms and sexuality education for their children (*62*).

43. Progress on CSE is also underway in East and Southern Africa where government leaders, alongside UNESCO, UNFPA, UNICEF, WHO, UNAIDS and other partners, are considering a CSE ministerial commitment. The initiative is led by a High-Level Group, consisting of H.E Festus Mogae, former President of Botswana and H.E Salma Kikwete, the First Lady of the United Republic of Tanzania, among others. It aims to increase the availability of good quality HIV and sexuality education and youth-friendly HIV and SRH services. Consultations on CSE and SRH services are currently running in a number of countries in the region. The recommendations of the High-Level Group, as well as the results of the consultations, will be presented in December 2013 at the International Conference on AIDS and STIs in Africa (ICASA) (*63*).

Accountability of Youth Organizations

44. The *2011 Political Declaration* notes that accountability of all stakeholders is critical to the success of the HIV response (*37*). Youth organizations, on their part, have also shown leadership, accountability and action on advancing the HIV response. They have made demands to be heard and have demonstrated commitment and leadership in discussing important and complex issues.

45. All around the world, networks of young people living with HIV are uniting to take action. In 2010, the Global Network of People living with HIV (GNP+), started the Y+ Programme for young people living with HIV. The Y+ Programme is a global structure that consults with and advocates for the needs of young people living with HIV. For example, for the 2011 High

[13] Ministries of Health: Antigua and Barbuda, Argentina, Barbados, Belize, Brazil, Bolivia, Chile, Colombia, Costa Rica, Cuba, Mexico, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, St. Vincent and the Grenadines, St. Kitts and Nevis, Suriname, Saint Lucia, Uruguay, Venezuela; Ministries of Education: Argentina, Bahamas, Barbados, Belize, Brazil, Bolivia, Chile, Colombia, Costa Rica, Cuba, Mexico, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Nicaragua, Panama, Paraguay, Dominican Republic, Suriname, Saint Lucia, Uruguay, Venezuela.

Level Meeting on HIV and AIDS, Y+ led a consultation with young people living with HIV, both online and offline, to develop a set of advocacy priorities. After reaching a set of priorities from the consultation[14], an advocacy brief was developed and shared with Member States and partners. Based on the consultation priorities, young people living with HIV were supported to lobby their national UN delegations and to meet with UN ambassadors in New York. Several of their priorities were included in the *2011 Political Declaration* (*64*).[15]

46. Young people living with HIV in Latin America and the Caribbean (LAC) are increasingly getting organized to assert their needs in the HIV response. In 2012, the LAC Positive Youth Network (Y+LAC) became the first regional network of young people living with HIV in the world.[16] Through a common strategy, Y+LAC aims to raise awareness on the unmet needs of HIV positive youth and to develop effective political advocacy for social change in the HIV response. Y+LAC recently launched a Regional Survey designed by young people living with HIV for young people living with HIV in order to generate information on several issues affecting their lives, including access to HIV-related services, stigma and discrimination and social participation. The results of the survey were used to identify the strategic direction of the network until 2015 and to develop a situational analysis that will be used for advocacy (*65*).

Youth Participation in the Post 2015 Development Agenda

47. Young people have been actively involved in shaping the Post 2015 agenda and have been calling specifically for increased access to health care and SRH services, including HIV services. For example, the youth constituency has been involved in national consultations as well as engaged in direct dialogue with the High Level Panel on the Post 2015 development agenda. As part of the consultations for the agenda, youth-specific consultations were held in 12 different countries[17] with the support of Restless Development. Health was one of the main themes of these consultations, as there was a call for “universal access to affordable, quality healthcare and youth friendly services that are particularly sensitive to young people’s sexual and reproductive health and rights, especially those living with HIV and young women and girls” (*1*).

48. Moreover, in March 2013, young people convened from all over the world for a Youth Forum in Indonesia as part of the review of the International Conference on Population and Development.[18] The Bali Declaration emerged from the meeting; it outlines many priorities for youth rights, including youth-friendly services, and SRH and HIV services that are high quality, integrated, affordable, accessible, confidential and free of stigma and discrimination (*66*).

[14] Meaningful involvement; empowerment and leadership; continuum of care; diversity; disclosure
[15] Support leadership development and active engagement in policy (paragraph 56); Develop and implement strategies to improve infant HIV diagnosis, treatment and care for children and adolescents living with HIV through providing financial and social support for adolescents, their families, caregivers among others, including support for pediatric-adolescent-adult transition (68); Strengthen national social and child protection system including the provision of information and support to children and their families and caregivers, especially age-appropriate HIV information to assist children living with HIV (82); Promote laws and policies that ensure the full realization of all human rights and fundamental freedoms for young people, particularly those living with HIV (83).
[16] Participating countries include: (Mexico, Puerto Rico, Argentina, Ecuador, Venezuela, Colombia, Cuba, Paraguay, Costa Rica, Panama, Brazil, El Salvador
[17] Colombia, Croatia, Ghana, India, Kenya, Kyrgyzstan, Nepal, the Philippines, Romania, Sierra Leone, Tanzania and UK.
[18] The ICPD review process will feed into the Post 2015 framework.

Element 2: Addressing gaps and expanding successful approaches to working with and for adolescents and youth, as well as supporting their leadership

49. There is an urgent need to fill information gaps and scale-up evidence informed HIV programmes for adolescents and youth to reach the goals of the *2011 Political Declaration*. Programmes and policies must be tailored to their needs and situated in their social reality to be meaningful and have impact.

Gaps in information and guidance

50. The first step in tailoring programmes is to know the epidemic among adolescents and youth. This includes collecting critical information relating to the circumstances of their everyday lives. Strategic information on adolescents and youth within the HIV response is lacking, and particularly from those adolescents and youth among key populations. Acknowledging this problem, from 2006-2010, UNICEF, with government and civil society partners in five Eastern European countries,[19] implemented a 4-year programme aimed at strengthening the evidence base on the needs and vulnerabilities of most-at-risk adolescents and designing tailored interventions to meet their HIV needs, as well as general health and social needs. The programme focused on collecting strategic information on adolescents who inject drugs or engage in transactional sex, young males who have sex with males, street-connected and institutionalized adolescents and those coming from disadvantaged socio-economic or ethnic backgrounds. Results of the programme include the establishment of baseline data on adolescents at higher risk in all countries of the project, the completion of over 20 quantitative and qualitative studies, and the publication of several journal articles. In addition, over 2300 policy makers, programme managers and service providers were trained in the development of programme strategies and implementation of gender-sensitive interventions for adolescent key populations (*67*). Most-at-risk adolescents have also been included in national strategic plans for AIDS, including in the Ukraine, Moldova and Serbia.

51. There is also a strong need for normative and technical guidance on basic HIV programmes for adolescents and youth. To address this gap, the World Health Organization (WHO) developed new global guidelines on HIV testing and counselling for adolescents in 2013. Adopting a participatory approach to develop the guidance, the document make specific recommendations and suggestions on prioritizing, planning and providing HIV testing, counselling, treatment and care for adolescents (*43*). Another neglected area of HIV programming for adolescents living with HIV is the transition for childhood to adulthood. In an effort to address this, the Children and Young People HIV Network in the United Kingdom worked on improving the experiences of young people living with HIV in England and the UK during transition by building capacity and improving partnerships. The Network produced a report for commissioners and practitioners (entitled *Just Normal Young People: Supporting young people living with HIV in their transition to adulthood*), with an accompanying young people's report. It also developed six leaflets for teenagers and young adults who live with HIV, covering topics such as transition in services, work, studying, independent living, sharing HIV information, and rights (*68*). The Network has received feedback that the leaflets, as well as the report, have filled an important gap in the lives of young people living with HIV (*69*).

52. To ensure young people have access to condoms, UNFPA, with the support of UNICEF, has been working to scale-up condom programming in Eastern and Southern Africa (ESA). They produced a *Programme Guidance Note for Condom Promotion and Adolescents* for the region and have supported twelve countries in the ESA region to strengthen

[19] Albania, Bosnia and Herzegovina, Moldova, Montenegro, Romania, Serbia and Ukraine

comprehensive condom programming with a focus on young people. UNICEF and UNFPA also supported skills-building workshops on condoms for young people in Malawi and Swaziland, which were attended by about 100 government officials, service providers and peer educators (*70*).

New and effective methods of working with adolescents and youth

53. In an effort to reach adolescents and youth in the HIV response, UNICEF has been capitalizing on the power of media. In 2012, it led a multi-country initiative in six priority countries with extremely high burdens of HIV,[20] Shuga radio, to support awareness-raising around issues relating to HIV and young people, including sero-discordancy, multiple and concurrent sexual partnerships, sexual violence and related rights to protection, care and support, HIV testing and counselling, and PMTCT. The initiative aimed to support social change and demand creation among young people (*71*). Since the implementation of the project, it has been successful in increasing uptake of HIV testing. For instance in the Democratic Republic of Congo, after the airing of the radio programme, there was a 50% increase in the number of visits from young people aged 20-24 to HIV testing and counselling sites (*72*).

54. Leveraging online technology, la rabita Mohammedia des Oulémas in Morocco has created a website (chababe.ma) for young people to discuss the topics that matter to them, including the issue of sexual and reproductive health. This is the first official website in Morocco that allows young people to discuss this issue online among themselves, as well as with peer educators. The website's peer educators also share information and new developments related to SRH and HIV both through the website and on social networks like Facebook and Twitter. Within the first 3 months of the launch, the website had over 154,000 visitors from Morocco and the Arab world (*73*).

55. Within recent years, cash transfers have emerged as an effective approach to reduce young people's vulnerability to HIV that create incentives to adopt safer behaviours. A study in Lesotho found that a programme of financial incentives reduced the probability of acquiring HIV by 25% over two years. In a separate study in Malawi, cash transfers for schoolgirls were found to reduce new HIV infections by 60%. These studies provide evidence that structural interventions and wider social protection schemes can have an important impact on the reduction of young people's vulnerability to HIV (*6, 74*).

Element 3: Creating enabling legal and social environments for adolescents and youth in the context of HIV

56. In order for adolescents and youth to fully utilize HIV and SRH programmes, the social and legal environments must be conducive to accessing these services.

57. The social environment refers to the immediate physical surroundings, interpersonal relationships and cultural milieu in which people live (*75*). Some aspects of the social environment that can impact the HIV response include HIV-related stigma and discrimination and socio-cultural norms. "Culture" is a complex term that refers to religious, economic, political, and psychological conditions (76*)*. It is fluid and constantly evolving, often reacting to changes in the various conditions of which it is comprised (*77*).

[20] Cameroon, Democratic Republic of Congo, Kenya, Lesotho, South Africa and Tanzania.

58. The legal environment, in turn, is comprised of three elements: law, law enforcement and access to justice. Law speaks to the codification of rules within a country's legal system. Law enforcement concerns the implementation or enforcement of the laws or regulations. Access to justice focuses on ensuring that the justice system protects individuals who have their rights violated. All of these aspects play significant roles in facilitating or hindering adolescents' and youths' access to HIV and SRH services (*78*).

Social Environment

59. The social environment, when enabling, supports young people access HIV prevention, treatment, care and support services. For example, faith-based organizations can play an important role in helping adolescents and youth access services. In Malaysia, the Department of Islamic Development partnered with the Ministry of Health to implement the HIV & Islam programme. This training programme aims to sensitize religious leaders on HIV-related issues, including key populations, and to reduce HIV-related stigma and discrimination within the communities (*79*).

60. Gender norms also significantly impact the HIV response. In many societies, women and girls are often more vulnerable to HIV because of gender inequalities as well as biological factors (*47*). Acknowledging this issue, in 2001, the German-Cameroon Health and AIDS Program launched the Aunties' Project which invites young single mothers to take part in five days of basic training in sexual and reproductive health and to join local associations linked through a national network. After their trainings, single mothers become known as "Aunties" and form local Aunties' associations, through which they become each other's social and moral support. The purpose of the project is to prevent teenage pregnancies, school dropouts, forced and early marriage, unsafe abortions, HIV and other STIs, by empowering young women to protect their sexual and reproductive health and address gender-based violence (*80*). Striving for gender equality also includes sensitizing young men and boys. In South Africa, the Boys 2 Men project, implemented by the Waterberg Welfare Society, aims to work with young men on HIV and AIDS related issues such as gender relations, HIV treatment and care. The programme also encourages discussions on sex, sexuality, masculinity, values and beliefs, rights, responsibilities, as well as discussions on positive support among young men (*81*).

61. Recognizing that young women's and girls' access to their sexual and reproductive health and rights might be hampered by high levels of violence and entrenched gender divisions, patriarchal roles and stereotypes that restrict women's choices, the YP foundation in India launched a youth-led initiative "Know your body, know your rights" (*82*). This peer education and advocacy initiative, with a holistic approach to sexuality, gender, rights, relationships, health and HIV was initially only undertaken the New Delhi National Capital Region for young people aged 18–25, but soon afterwards expanded to other parts of the country.

Legal Environment

62. Under the Convention of the Rights of the Child, States have an obligation to uphold a child's right to the "highest attainable standard of health" (*17*). The Convention also notes that no child can be deprived of her or his right to health. A basic principle of health care is that an individual must give fully informed, voluntary consent before receiving medical treatment (*83*). In many countries, however, adolescents and young people under the age of majority are deemed to have limited capacity to give independent consent due to their age. Such limitations, commonly known as age of consent laws, are usually established with the intent of protecting the best interests of children and adolescents (*8*). Unfortunately, in many cases, the laws effectively inhibit adolescents' and youths' access to services (*8*). The Global Commission on HIV and the Law recognized this issue as a major problem for

children in the HIV response. In the Commission's final report, it calls for "confidential and independent access to health services [for children] so as to protect themselves from HIV" (*84*).

63. Nevertheless, there are good practices in this area that allow for flexibility for each adolescent's individual circumstances. For instance, several countries have adopted the concept of "evolving capacity" for minors, which is a principle that has also been recognized in the Convention on the Rights of the Child (*17, 85*). The principle of evolving capacity recognizes that as adolescents develop maturity, cognitive abilities and capacity for self-determination at different rates, they will be able to make independent decisions on their own behalf, including decisions on accessing treatment and services related to HIV and SRH (*86-87*).

64. Building on the principle of evolving capacity, South Africa re-assessed its age of consent to HIV testing. After a careful legislative review, which included seeking inputs from the public, the South African Law Commission decided to lower the age of consent to HIV testing to 12 years and older; children under the age of 12 may also access testing, provided that it is in the best interests of the child and the child is "sufficiently mature to understand the benefits, risks and social implications of the test" (*88, 43*). The decision was informed by the need to both recognize the realities of the epidemic and recognize the evolving capacity of adolescents. As a result of the change, access to HIV testing has increased (*43*).

65. In an effort to address problematic laws that criminalize HIV non-disclosure, exposure and transmission, GNP+ North America developed the protective legal environment audit for services providers to young people living with HIV. The audit was created in response to increasing criminal prosecutions of young people living with HIV based on their HIV status, as well as study results showing that HIV criminalization creates anxiety and fear for people living with HIV and from key populations when interacting with service providers. Not only does the audit help service providers determine the existence and applicability of state or local laws on HIV criminalization, but it also helps services providers establish productive relationships with local health authorities on this matter. In addition, the audit provides guidance on ensuring young people's confidentiality when they access HIV-related services (*89*).

Key Populations

66. The social and legal environments have a heavy impact on adolescent and young key populations. Young key populations face stigma, discrimination and criminalization. As key populations represent a significant portion of the global HIV epidemic, it is critical to develop good programmes and policies to work with, and ensure access to services for, young people who are most-at-risk of HIV infection.

67. Young key populations remain a priority for the Joint Programme's work with young people. In 2012, the Joint Programme established a Regional Task Team on Young People from Key Populations in the Asia-Pacific region. The Regional Task Team supported Indonesia and Myanmar to increase institutional and member capacity of youth-led and youth serving regional networks to address the needs of adolescent key populations. In addition, to support this initiative, UNICEF, UNFPA and UNESCO, in partnership with the University of Melbourne, developed a short course on young key populations. The aims of the course were to improve implementers' understanding of gaps in strategic information and improve the capacity of policy makers and programme staff to understand the needs of young key populations (*70*). Moreover, the Joint Programme is developing a series of technical briefs on adolescent key populations, with WHO in the lead. The technical briefs will build on the previous guidance that WHO released for key populations in the context of HIV. They will

provide a review of available data on the groups, as well as provide analyses of methods to make proven, effective interventions more youth-friendly.

68. Prioritization of young key populations is also being done at the national level. The Youth Peer Education Network (Y-PEER) in Pakistan implemented a project to provide sexuality education with the target of HIV prevention to young key populations in Lahore. The project was designed to build the capacity of local young key populations to be peer educators and to convey HIV prevention messages through theatre shows. The project provided young people with information on HIV prevention and safe sex practices using a peer-to-peer approach, as well as with information on theatre-based techniques so that young people can not only prevent themselves from HIV infection, but can also continue to spread the message of HIV prevention and safe sex practices. The project has trained over 500 young people as peer educators on HIV prevention and over 250 on theatre-based education techniques. It also organized 80 educational community theatre shows that have sensitized approximately 5,000 young people to HIV prevention and safe sex (*90*).

WAYS FORWARD/CONCLUSION

69. Adolescents and youth are increasingly recognized as a priority on the global agenda as well as in national HIV polices; now action and resources must follow. While there are excellent examples of programmes that address the needs of young people, they are still not taken to the scale required to reach the targets set in the *2011 Political Declaration on HIV and AIDS*. In order to increase the impact of the HIV response for adolescents and youth, the following strategies are needed:

- **Know your local epidemic and scale-up evidence informed, youth-friendly programmes accordingly** for adolescents and youth, especially young key populations and young people living with and affected by HIV; ensure programmes are tailored to the specific needs of girls, young women, boys and young men, included in national strategic plans, and appropriately costed and earmarked in national budgets.

- **Expand efforts to integrate HIV programmes** for young people, young key populations and young people living with HIV into a broader framework of sexual and reproductive health, ensure services are youth-friendly and explore opportunities for stronger linkages between the education, gender equality, social and child protection sectors and HIV prevention, treatment, care and support.

- **Create enabling social and legal environments** for adolescent and youth HIV programmes, including programmes for young key populations and programmes to prevent gender-based violence while addressing harmful gender norms, and consider revising, where appropriate, age- and sex-related restrictions that prevent adolescents and young women and men from accessing effective HIV prevention, treatment and care, as well as sexual and reproductive health services.

- **Young people should be partners and leaders in the AIDS response** and included in HIV-related national, regional and global decision-making and policy processes. Their meaningful participation should be supported throughout the HIV programming cycle, including design, implementation, and monitoring and evaluation.

- **Collect, compile and disseminate age- and sex-disaggregated data** on all relevant Global AIDS Response Progress Reporting (GARPR) indicators, including HIV treatment, and track resources on AIDS spending categories that are relevant to young people for evidence-informed advocacy, policy-making and programming

70. As the world heads towards the development of the Post 2015 agenda, youth voices become even more critical to the HIV response. Youth leaders of today will be the custodians of the Post 2015 world, tasked with implementing the new development agenda. Their partnership and ownership are critical to ensuring that the new framework goes beyond aspirational rhetoric, and includes progressive, concrete and achievable indicators and goals for HIV, SRH and beyond.

REFERENCES

(1) Beyond 2015 Children and Youth Working Group and the Major Group of Children and Youth. Open Letter to High Level Panel from youth partners in development (http://www.restlessdevelopment.org/file/youth-letter-to-high-level-panel-pdf, accessed 7 November 2013).
(2) UNAIDS. 2012 Estimates. Geneva: UNAIDS. 2012
(3) UNAIDS PCB Bureau. Meeting summary. Geneva: UNAIDS. 21 March 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2013/20130416_PCB-Bureau_summary_21March13-meeting_%20final.pdf, accessed 8 November 2013).
(4) Thematic Segment Concept Note. Geneva: UNAIDS; 2013 (On file with the Secretariat, available upon request).
(5) UNICEF/UNAIDS. Unpublished 2011 Estimates. Geneva: UNICEF/UNAIDS: 2012.
(6) Global Report: UNAIDS report on global AIDS epidemic 2013. Geneva: UNAIDS; 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf, accessed on 8 November 2013)
(7) Women Out Loud: how women living with HIV will help the world end AIDS. Geneva: UNAIDS; 2012 (https://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/20121211_Women_Out_Loud_en.pdf, accessed 8 November 2013).
(8) 6th Stocktaking Report - achieving an AIDS-free generation: Responding to HIV among children across the first two decades of life. New York: UNICEF; 2013 (forthcoming).
(9) UNICEF, Futures Institute. The Impact and Cost of the HIV/AIDS Investment Framework for Adolescents. New York: UNICEF; 2013 (forthcoming).
(10) UNAIDS Strategy 2011-2015: Getting to Zero. Geneva: UNAIDS; 2010 (http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc2034_unaids_strategy_en.pdf, accessed 8 November 2013).
(11) Securing the Future Today: synthesis of strategic information for HIV and young people. Geneva: UNAIDS; 2011 (http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110727_JC2112_Synthesis_report_en.pdf, accessed 8 November 2013).
(12) AIDSTAR-One. HIV prevention knowledge Base: emerging areas – intergenerational and transactional sex in hyper-endemic settings. USAID; 2009 (http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_Knowledge_Base_%20Intergenerational_and_Transactional.pdf, accessed 8 November 2013).
(13) Wamoyi J, Wight D, Plummer M, Mshana G, Ross D. Transactional sex amongst young people in rural northern Tanzania: an ethnography of young women's motivations and negotiation. Reproductive Health. 2010;7:2. doi:10.1186/1742-4755-7-2
(14) http://www.unicef.org/aids/index_youngpeople.html
(15) For more information on this topic, please see Women's Refugee Commission, Save the Children, UNHCR, UNFPA. Adolescent sexual and reproductive health in humanitarian settings: an in-depth look at family planning services. 2012 (http://his.unhcr.org/aae/wp-content/uploads/2012/11/Adolescent-Sexual-and-Reproductive-Health-in-Humanitarian-Settings-Understanding-and-Documenting-Good-Practices-December-2012.pdf, accessed 8 November 2013).
(16) UN Declaration on the Right to Development. A/Res/41/128. New York: United Nations General Assembly; 1986 (http://www.un.org/documents/ga/res/41/a41r128.htm, accessed 8 November 2013).
(17) International Convention on the Rights of the Child .1989 (http://www.ohchr.org/en/professionalinterest/pages/crc.aspx, accessed 8 November 2013).
(18) UNAIDS Global Reference Group on HIV/AIDS and Human Rights. Issue Paper: what constitutes a rights-based approach? Definitions, Methods and Practice. Geneva: UNAIDS;

2004 (http://data.unaids.org/Topics/Human-Rights/hrissuepaper_rbadefinitions_en.pdf, accessed 8 November 2013).
(19) Supporting Community Based Responses to AIDS, tuberculosis and malaria. Geneva: UNAIDS; 2011 (http://www.unaids.org/en/media/unaids/contentassets/documents/programmes/programmeeffectivenessandcountrysupportdepartment/gfresourcekit/20110920_JC2170_community_systems_strengthening_en.pdf, accessed 8 November 2013).
(20) CrowdOutAIDS Strategy. Geneva: UNAIDS; 2011 (https://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/JC2338_CrowdOutAIDS_en.pdf, accessed 8 November 2013).
(21) http://www.crowdoutaids.org/wordpress/wp-content/uploads/PACT-4-pages_final1.pdf
(22) DFID, UKaid, SPW, Youth Working Group. Youth Participation in Development: a guide for development agencies and policy makers. London: DFID–CSO Youth Working Group; 2010 (http://www.ygproject.org/, accessed 8 November 2013).
(23) HIV Prevention Now: programme brief no. 6 – Condom Programming for HIV Prevention. New York: UNFPA; 2002 (http://www.unfpa.org/hiv/prevention/documents/hivprev6.pdf, accessed 8 November 2013).
(24) Comprehensive Condom Programming: a guide for resource mobilization and country programming. New York: UNFPA; 2010 (http://www.unfpa.org/public/cache/offonce/home/publications/pid/8017;jsessionid=08FAE7171897594CF0338435928647A2.jahia02, accessed 8 November 2013).
(25) Global HIV Prevention Working Group. Behavior Change and HIV Prevention: (Re)Considertions for the 21st Century. 2008 (http://www.malecircumcision.org/advocacy/documents/PWG_behavior_report_FINAL.pdf, accessed 8 November 2013).
(26) Scott-Sheldon, et al. (2011) Efficacy of behavioral interventions to increase condom use and reduce sexually transmitted infections: A meta-analysis, 1991 to 2010. J. of Immune Defic. Syndr., 58: 489-498.
(27) Cherutich, P. et al. (2012). Progress in voluntary medical male circumcision service provision – Kenya, 2008–2011. Morbidity and Mortality Weekly Report, 61: 957–961
(28) Baral, S., et al. (2012). Burden of HIV among female sex workers in low-income and middle-income countries: A systematic review and meta-analysis. Lancet Infectious Diseases, 380: 367–377.
(29) Beyrer, C. et al. (2012). Global epidemiology of HIV infection in men who have sex with men. The Lancet, 380: 367–377.
(30) UNICEF. Opportunity in crisis: preventing HIV from early adolescence to early adulthood. New York: UNICEF; 2011 (http://www.unicef.org/media/files/Opportunity_in_Crisis_LoRes_EN_05182011.pdf, accessed 8 November 2013).
(31) WHO, UNFPA, UNAIDS, NSWP. Prevention and Treatment of HIV and other Sexually Transmitted Infections for Sex Workers in Low-and-Middle –Income Countries: recommendations for a public health approach. good practice and evidence-based technical recommendations for sex workers in low- to middle-income countries. Geneva: WHO; 2012 (http://apps.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf, accessed 8 November 2013).
(32) WHO, UNDP, UNAIDS, MSMGF. Prevention and Treatment of HIV and other sexually transmitted infections for men who have sex with men and transgender people. Geneva: WHO; 2011 (http://whqlibdoc.who.int/publications/2011/9789241501750_eng.pdf, accessed 8 November 2013).
(33) Enhanced Protection for Children Affected by AIDS. New York: UNICEF; 2007 (http://www.unicef.org/publications/index_39192.html, accessed 8 November 2013).
(34) HIV and Social Protection Guidance Note. Geneva: UNAIDS; 2011.
(35) http://go.worldbank.org/YVMPZBKC00

(36) UNESCO, International technical guidance on sexuality education. Vol. 1. Paris: UNESCO; 2009 (http://www.unesco.org/new/en/hiv-and-aids/our-priorities-in-hiv/sexuality-education/international-technical-guidance-on-sexuality-education/, accessed 8 November 2013).
(37) Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. New York: United Nations General Assembly; 2011 (http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_un_a-res-65-277_en.pdf, accessed 8 November 2013).
(38) ILO (2013): Global Employment Trends for Youth.
(39) ILO. Recommendation concerning HIV and AIDS and the World of Work (No. 200). Geneva: ILO; 2010 (http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/normativeinstrument/wcms_194088.pdf, accessed 8 November 2013).
(40) WHO, UNODC, UNAIDS, Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: WHO; 2012 rev. (http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf, accessed 8 November 2013).
(41) For more information on compulsory detention centers, please see ILO, OHCHR, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UN Women, WFP, WHO UNAIDS, Joint Statement on Compulsory Drug Detention and Rehabilitation Centers. 2012 (http://www.unodc.org/documents/lpo-brazil//noticias/2013/03/2013-03-28UNJointStatementCompulsoryDrugDetentionMarch2012.pdf, accessed 8 November 2013).
(42) UNODC statistic
(43) World Health Organization, HIV and Adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV – recommendations for a public health approach and considerations for policy-makers and managers. Geneva: WHO; 2013.
(44) UNFPA reference
(45) Agwu, A. and Fairlie, L., Antiretroviral treatment, management challenges and outcomes in perinatally HIV-infected adolescents. J. Int AIDS Soc. 2013, 16(1): 18579.
(46) Nachega J, Hislop M, Nguyen H, Dowdy D, Chaisson R, et al. Antiretroviral Therapy Adherence, Virological and Immunological Outcomes in Adolescents Compared with Adults in Southern Africa. J. Acquir. Immune Defic. Syndr. 2009; 51(1):65-71.
(47) Gay, J. et. al. 2010. What Works for Women and Girls: evidence for HIV/AIDS interventions. New York: Open Society Institute. (http://www.whatworksforwomen.org/system/attachments/2/original/what-works-for-women-and-girls.pdf?1278700491, accessed 8 November 2013).
(48) Jewkes R et al. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. The Lancet, 2010, Vol. 376; No.9734, pp. 41–48.
(49) For examples of such barriers, please see Global Commission on HIV and the Law, Regional Issues Brief (Asia and the Pacific): rights of children and young people to access HIV-related services. New York: United Nations Development Programme; 2011 (http://www.hivlawcommission.org/index.php/dialogue-documentation?task=document.viewdoc&id=3, accessed 8 November 2013).
(50) For more information on programmes to reduce HIV-related stigma and discrimination, please see Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses. Geneva: UNAIDS;2012 (http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/Key_Human_Rights_Programmes_en_May2012.pdf, accessed 8 November 2013).
(51) 31st PCB thematic segment on Non-discrimination background paper. Geneva: UNAIDS; 2012 (http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2012/20121111_PCB%2031_Non%20Discrimination_final_newcoverpage_en.pdf, accessed 8 November 2013).

(52) 26th PCB thematic segment on Linking Sexual and Reproductive Health services with HIV interventions in practice background paper. Geneva: UNAIDS; 2010 (http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/basedocument/2010/20100604_26thpcbthematicbackground_final_en.pdf, accessed 8 November 2013).
(53) IPPF, UNFPA, WHO, UNAIDS. Sexual and Reproductive Health & HIV/AIDS: a framework for priority linkages. New York: UNFPA; 2005 (http:// http://www.unfpa.org/webdav/site/global/shared/documents/publications/2005/priority_linkages.pdf, accessed 8 November 2013).
(54) http://www.who.int/tb/challenges/hiv/facts/en/
(55) http://www.who.int/mediacentre/factsheets/fs104/en/
(56) Stapenhurst R, O'Brien, M. Accountability in Governance. World Bank (http://siteresources.worldbank.org/PUBLICSECTORANDGOVERNANCE/Resources/AccountabilityGovernance.pdf, accessed 8 November 2013).
(57) Taken from India NACO submission – Johri, A. Youth Intervention for HIV/AIDS in India. National AIDS Control Organisation: Department of AIDS Control, Ministry of Health; 2013.
(58) Taken from Zimbabwe National AIDS Council submission – Nyamwanza, B. Young People's Network on SRH, HIV and AIDS. National AIDS Council; 2013.
(59) Taken from Norway submission – Remme, A. The Norwegian Youth Network on HIV and Point 7 youth representative. Norwegian Children and Youth Council; 2013.
(60) First meeting of Ministers of Health and Education to Stop HIV and STIs in Latin America and the Caribbean, Ministerial Declaration: preventing through education. Mexico City; 2008 (http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Santiago/pdf/declaration-preventing-education-english.pdf, accessed 8 November 2013).
(61) Hunt F, Monterrosas Castrejón, E. Evaluacion de la Implementacion de la Declaracion Ministerial. New York: IPPF; 2012 (http://www.ippfwhr.org/sites/default/files/EvaluacionDeclaracionMinisterial2012.pdf, accessed 8 November 2013).
(62) Reuters, Brazil Vows to Install Condom Machines in Schools. Washington Post; Feb. 7, 2007 (http://www.washingtonpost.com/wp-dyn/content/article/2007/02/07/AR2007020700761_pf.html, accessed 8 November 2013).
(63) http://www.unesco.org/new/en/hiv-and-aids/our-priorities-in-hiv/sexuality-education/east-and-southern-africa-commitment/
(64) Taken from GNP+ submission – Ngoksin, E. Young People Living With HIV Influencing the High Level Meeting on HIV in 2011. Global Network of People Living with HIV; 2013.
(65) Taken from UNAIDS submission on Y+LAC – Sanchez, A. Consolidation of the Latin American and Caribbean Network of Positive Youth (Y+LAC). UNAIDS; 2013.
(66) Bali Global Youth Forum Declaration. Bali: International Conference on Population and Development Beyond 2014; 2012 (http://icpdbeyond2014.org/uploads/browser/files/bali_global_youth_forum_declaration.pdf, accessed 8 November 2013).
(67) Taken from UNICEF submission – Ferencic, N. Prevention of HIV among Most-at-Risk Adolescents in Ukraine and South-Eastern Europe. UNICEF; 2013.
(68) Taken from Children and Young People HIV Network/National Children's Bureau submission – Hamblin, E. Managing transitions between children's and adults services for young people living with HIV. National Children's Bureau (NCB); 2013.
(69) Gibb J, Blades R. Children and Young People HIV Network Evaluation, 2012-2013. Research Centre: National Children's Bureau; 2013 (http://www.ncb.org.uk/media/1009659/hiv_network_evaluation_-_final.pdf, accessed 8 November 2013).
(70) UN Interagency support to HIV prevention, treatment and care in young people. UNAIDS Inter-Agency Task Team on HIV and Young People; 2013.
(71) Taken from UNICEF submission – Kasedde, S. Shuga Programme. UNICEF; 2013.
(72) Evaluation of Shuga Radio in the Democratic Republic of Congo – on file with the Secretariat.

(73) Taken from la rabita Mohammedia des Oulémas submission – Souidi, Y. Site Web : Chababe.ma. La rabita Mohammedia des Oulémas; 2013.
(74) Baird, S. et. al., Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomized trial, The Lancet, 2012. Vol. 379, No. 9823, pp. 1320 - 1329 (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61709-1/abstract, accessed 8 November 2013).
(75) Barnett, E. and Casper, M., A definition of "social environment". Am. J. Pub. Health. 2001. Vol 91, No. 3. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446600/pdf/11249033.pdf, accessed 8 November 2013).
(76) Kleinman and Benson, Anthropology in the Clinic: the problem of cultural competency and how to fix it. PLoS Med. 2006 October; 3(10): e294 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1621088/, accessed 8 November 2013).
(77) Neuliep, J., Intercultural Communications, 5th Edition, Chapter 2: the Cultural Context; 2012 (http://www.sagepub.com/upm-data/42958_2_The_Cultural_Context.pdf, accessed 8 November 2013).
(78) For more information on the legal environment in the HIV response, please see the 29th PCB thematic segment on HIV and Enabling Legal Environments background note. Geneva: UNAIDS; 2011 (http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/thematic%20segment_final_correction2Dec.pdf, accessed 8 November 2013).
(79) Malaysia AIDS Council, HIV & Islam: responsible religious response to HIV and AIDS in Malaysia. 2011 (http://www.aidsalliance.org/includes/document/hivislambrief2010_1.pdf, accessed 8 November 2013).
(80) Taken from GIZ submission – N'Donko, F. "Aunties" for Sexual Health and Non-violence. Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ); 2013.
(81) Taken from Waterberg Welfare submission – Sekhu, Z. Boys 2 Men Program. Waterberg Welfare Society; 2013.
(82) UNAIDS and Athena Network. Community Innovation: achieving sexual and reproductive health and rights for women and girls through the HIV response, 2011.
(83) http://www.nhs.uk/Conditions/Consent-to-treatment/Pages/Introduction.aspx
(84) Global Commission on HIV and the Law, Risks, Rights and Health. New York: United Nations Development Programme; 2012 (http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf, accessed 8 November 2013).
(85) *Gillick v West Norfolk and Wisbech Area Health Authority and the Department of Health and Social* Service, [1985] UKHL 7 (17 October 1985) (http://www.bailii.org/uk/cases/UKHL/1985/7.html, accessed 8 November 2013).
(86) UNESCO, UNFPA, UNDP, UNAIDS. Young people and the law in Asia and the Pacific: a review of laws and policies affecting young people's access to sexual and reproductive health and HIV services. Forthcoming.
(87) Lansdown, Gerison. The Evolving Capacity of the Child. Florence: UNICEF; 2005 (http://www.unicef.org/india/Evolving_capacities_of_the_child.pdf, accessed 8 November 2013).
(88) South Africa Children's Act 38. 2005 (http://www.justice.gov.za/legislation/acts/2005-038%20childrensact.pdf, accessed 8 November 2013).
(89) Taken from GNP+NA submission – Sprague, L. Protective legal environment audit for service providers to young people. Global Network of People living with HIV, North America; 2013.

(90) Taken from Y-PEER Pakistan submission – Sohail, S. Providing safer sex education to the marginalized young people for the prevention of HIV/AIDS using peer to peer education and theatre. Youth Peer Education Network, Pakistan; 2013.
(91) Intensifying HIV Prevention: UNAIDS position paper. Geneva: UNAIDS; 2005 (http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf, accessed 8 November 2013).

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