



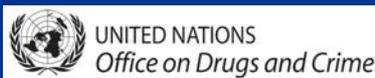
**PROTECTING YOUNG PEOPLE  
FROM HIV AND AIDS**

# **THE ROLE OF HEALTH SERVICES**

World Health



Organization



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***PROTECTING YOUNG PEOPLE  
FROM HIV AND AIDS***

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**THE ROLE  
OF HEALTH  
SERVICES**



## Acknowledgments

WHO is grateful to the many people who contributed time and information towards this publication and the meeting that inspired it.

**Front cover pictures:** *Top left:* A doctor at the Future Threshold Adolescent Center in Ulaanbaatar, Mongolia, talks to 14-year-old peer educator, Munkhnaran. Between June and September 2003, 500 adolescents used reproductive health services at the centre, and 86 adolescents attended for counselling. (Don Hinrichsen/UNFPA *Options and Opportunities for Adolescents*)

*Top right:* Child at Kalobeyei Primary School. Turkana, Kenya (PANOS Pictures)

*Main picture:* Adolescents from Gomvira village, Bangladesh, watch a drama with reproductive health and family planning messages. (Don Hinrichsen/UNFPA *Options and Opportunities for Adolescents*)

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# Foreword

## The evidence for action

In March 2003, researchers and practitioners from across the world met in Montreux, Switzerland, with representatives of UN agencies. Their task was to review the evidence for priority health service interventions that would help countries better protect young people against HIV and AIDS, in line with their global goals.<sup>1</sup>

They reviewed innovative experiences from countries that are setting the agenda for fighting HIV and AIDS in Africa, Asia, Latin America and Europe. A number of approaches emerged to protect young people within a variety of circumstances in different countries.

There was a consensus that many governmental and civil society organizations need to be involved to turn the tide on AIDS. There was also a consensus that the health system has a vital role to provide a range of effective, evidence-based interventions for young people. The health sector is responsible for clear and accurate epidemiological information about the spread of HIV, and for identifying the underlying factors that make young people vulnerable. It has a key role in developing policies to combat HIV and AIDS and in delivering health services.

The meeting acknowledged that all young people need access to preventive services to help them avoid risk of HIV infection, that many young people also need interventions to reduce their vulnerability, and that young people who are infected need focused support to prolong active life and minimize the risk of further transmission. Young people must have confidence in health-care providers to be able to access services and obtain the supplies that they need.

There is an urgent need to define at country level an essential package of interventions that can be delivered through health services to meet the needs of young people.

This document summarizes the evidence for effective action, and encourages policy makers and programmers to turn concern and commitment into effective and sustainable action. It is based on an understanding that HIV infects people when they are young, but AIDS affects and kills people at an age when they would be parents and workers who sustain society and domestic and family life. Helping young people to protect themselves against HIV and AIDS protects people now and in the future. It protects the future of family life and the economic prospects of countries in development.

1. Global goals are outlined in the Declaration of Commitment of the UN General Assembly Special Session on AIDS. These goals and targets have additionally been endorsed during the ICPD+5, and the UN General Assembly Special Session on Children, and are reflected in the Millennium Development Goals.



*Part of a session at the consultation on the health services response to the prevention and care of HIV and AIDS among young people, held in Montreux, Switzerland, in March 2003.*

For World Bank assessments of the economic impact of HIV and AIDS see *The Long-run Economic Costs of AIDS: Theory and an Application to South Africa* (July 2003) and *AIDS Crisis in Eastern Europe and Central Asia* (Sept 2003) at <http://web.worldbank.org>

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# Summary

## The role of the health system

**E**very day, 5,000 to 6,000 young people aged 15-24 become newly infected with HIV. It is increasingly apparent that the key to turning back the pandemic is to enable young people to protect themselves against its transmission.

Risks vary with culture, age, sex and individual circumstances. In countries with high levels of infection, HIV and AIDS represent a communal disaster causing individual and family tragedies as well as social and economic devastation. In other countries, pockets of infection expose vulnerable young people to extreme risk and threaten to explode into the wider community.

Those who make policies and organize services need a clear vision of where to put their efforts and resources, to build on the sense of urgency expressed at the UN General Assembly Special Session on HIV/AIDS in 2001. World leaders set global targets and promised support to the most affected countries. The Declaration of Commitment included a target to reduce HIV prevalence in young people by a quarter in the most affected countries by 2005, and in all countries by 2010. The target dates for commitments fall due soon and unless the scale, precision and effectiveness of actions increase, they will not be met.

AIDS requires a broad response from the whole of society — governmental, non-governmental, education, social services, business, cultural and religious, and not least by young people themselves. The health system has a critical role within this response to ensure that high quality, effective health services for prevention and care reach young people. It must ensure that policies and programmes are based on the best evidence about patterns of infection and about what works. The health system sets the agenda for key interventions. All countries have a network of health workers who could intervene more effectively with young people if they knew what to do and how to do it.

The world has learned from creative programmes in countries that were hit first and hardest by AIDS. But a widespread response within countries is often missing. Adolescents need interventions that go beyond demonstration projects to reach broad populations, and which:

- develop young people's knowledge about the transmission of HIV, and their personal skills in daily life to avoid the risks of infection,
- increase access to services and supplies to avoid or treat infections,
- create a safe and supportive social environment that, for example, reduces levels of sexual violence,
- provide opportunities for young people to participate and contribute.

**FROM THE UNGASS  
DECLARATION OF  
COMMITMENT**

Prevention must be the  
mainstay of our response

...to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25% and by 25% globally by 2010, and intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys.

The most significant services for the prevention and care of HIV and AIDS among young people are those that:

- strengthen the ability of young people to avoid infection, including information and counselling interventions,
- reduce risks, by providing condoms for those who are having sex, and clean needles and syringes for those who are injecting drugs,
- provide diagnosis, treatment and care for sexually transmitted infections (STIs) and for HIV and AIDS.

The right of young people to health, healthy development and protection from harm is guaranteed by the UN Convention on the Rights of the Child (CRC). The 1994 International Conference on Population and Development (ICPD) reaffirmed the right of adolescents to counselling, information, education, communication and services, and called on member states to recognize and protect these rights.

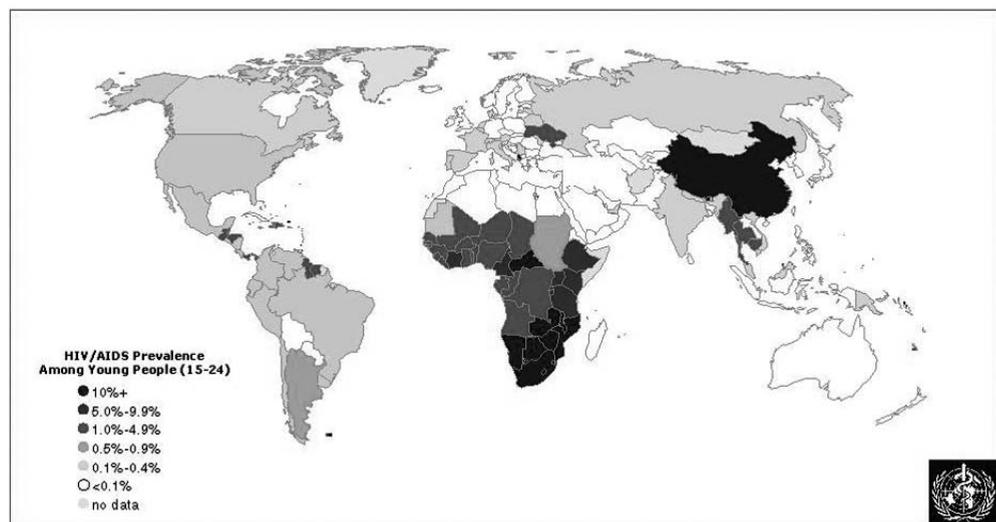
Prevention and treatment are complementary strategies to deliver on these rights. WHO is committed to assist member states to provide antiretroviral (ARV) treatment and care to three million people in the developing world by the end of 2005, and to accelerate HIV prevention. This '3x5' investment in treatment for people who are HIV-positive will place health services at the centre of efforts to turn back HIV and AIDS and will increase the credibility of health providers. This gives these same health providers an opportunity to intervene to strengthen prevention and risk reduction strategies.

A strategic approach specific to each country is essential to ensure that services are inclusive of young people both in coverage and acceptability, and that they address the needs of those who are hard to reach, who are usually the young people most in need of effective interventions. Quality improvement initiatives for health systems, training programmes and supportive supervision for health workers on HIV and AIDS are needed to create comprehensive and effective national responses.

**FIGURE 1**

*About 11.8 million young people (15-24) are living with HIV or AIDS*

Darker shading shows areas with greater levels of HIV infection.



Source:  
UNAIDS/UNICEF 2002

# 1 Patterns of infection

During 2003:

2.5 to 3.5 million people died as a result of HIV or AIDS.

There were 14,000 new HIV infections a day worldwide — more than 5 million during the year.

Half of new infections were in people aged 15-24 years old — 5,000-6,000 young people (15-24 years) were infected each day.

Of the 40 million people living with HIV:

More than a quarter (more than 11 million) were aged 15-24.

Of whom, 60% (more than 6.6 million) were young women.

## *MOST CANNOT NAME 3 WAYS TO AVOID HIV*

Surveys in Africa, Asia, the Caribbean and South America show that fewer than half of adolescent girls aged 15-19 can identify three main ways of avoiding HIV infection:

- ◆ delay initiation of sex,
- ◆ reduce number of partners,
- ◆ consistently and correctly use condoms.

Fewer than half of girls this age know that someone who looks healthy may be infected.

**A** complex mix of factors makes young people vulnerable to HIV transmission. Risks for young people have been detailed extensively elsewhere<sup>1</sup>, and are summarized here.

- The risk is greater if someone starts sex at a young age and has multiple partners. Young people mature earlier but marry later. Many young people have sex before marriage with more than one partner.
- Young people lack the knowledge, power, means or ability to delay the onset of sexual experience. Many young people do not feel at risk, or they lack the knowledge to reduce risks. The first sexual experience for many girls is forced or coerced. Many boys have their first sexual experience with a sex worker.
- Girls who have sex with older men are vulnerable: immature bodies are more susceptible to HIV, infection passes more easily from men to women, and an older man is more likely to be infected. Married adolescents are often put at risk from older husbands.
- Condoms and health services for sexually transmitted infections may not reach sexually active young people. Young injecting drug users often cannot access services to help them to reduce harm.

## Generalized epidemics and special risks

In generalized epidemics, where HIV levels are above 1%, there is an urgent need to improve protection for the general population, especially for young people, among whom 50% of transmissions occur. In other countries, although the overall level of HIV is below 1%, infection spreads rapidly in vulnerable groups with high risk behaviours. The whole population is threatened as concentrated pockets of infection form a bridge into the wider community. Young people are at the

## *GENERALIZED AND CONCENTRATED EPIDEMICS*

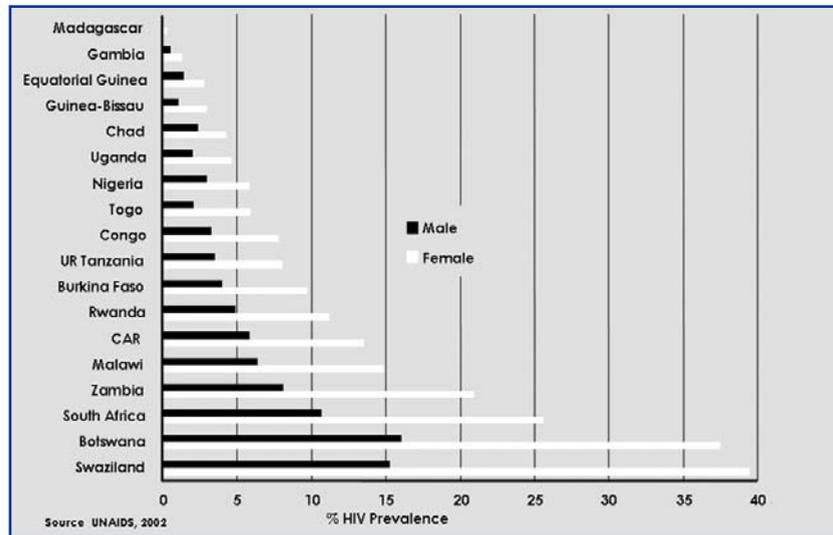
- ◆ Generalized epidemics are those where HIV is over 1% in the general population.
- ◆ Concentrated epidemics are those where HIV is over 5% in any sub-population at higher risk of infection, such as drug injectors, sex workers, men who have sex with men, migrant workers and young people who are living without parental support.
- ◆ Low-level epidemics are those where relatively little HIV is measured in any group in the population.

<sup>1</sup> For example, UNICEF, UNAIDS & WHO, 2002. *Young People and HIV/AIDS, Opportunity in Crisis*

## HIV in generalized epidemics and in vulnerable groups

**FIGURE 2**  
*HIV prevalence  
 15-24 year olds  
 Sub-Saharan African  
 countries 2001*

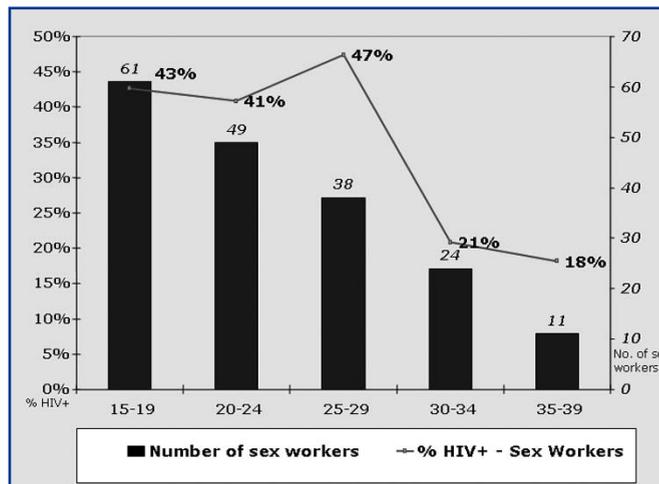
The epicentre of the HIV epidemic remains Sub Saharan Africa. In many African countries HIV infects more than 1 in 10 young people aged 15-19. In some countries, a quarter to a third of young people are infected. Girls acquire HIV at 2-3 times the rate of males.



**FIGURE 3**  
*HIV prevalence amongst  
 young sex workers in  
 Myanmar 2000*

A third of sex workers in Myanmar are girls aged 15-19. More than four in ten are infected with HIV. Surveys in the Congo, Guyana, India and Cote d'Ivoire among others also show high rates of infection among young sex workers, most of whom are forced or coerced into the sex industry.

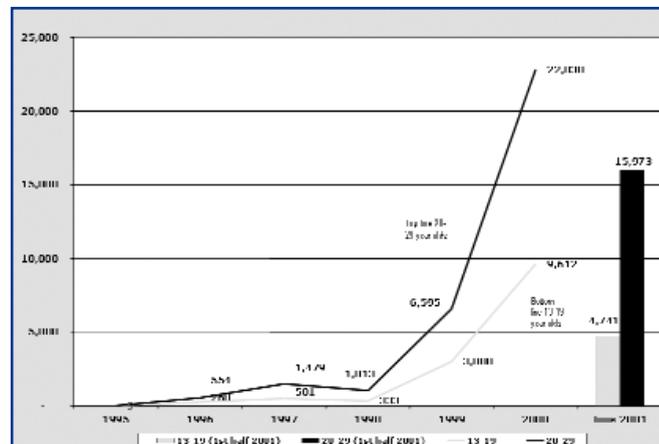
Source: USBC Dbase



**FIGURE 4**  
*HIV amongst injecting drug  
 users, Russia 1995-2000*

HIV infection amongst injecting drug users rose from virtually zero in 1995 to more than 30,000 new infections in 2000. A quarter of infections were in young people aged 13-19. HIV infects more than 9,000 young injecting drug users a year in Russia.

Source: European Drug Centre for the Epidemiological Monitoring of AIDS. HIV/AIDS Surveillance in Europe, 2001



centre of transmission in both generalized and concentrated epidemics. Especially vulnerable are:

◆ *Injecting drug users*

The practice of sharing needles to inject drugs has spread HIV rapidly in cities such as Odessa, Moscow, New York, Edinburgh, Bangkok, Ho Chi Minh City and Santos, and whole regions including Manipur province in India, Yunnan province in China and parts of Myanmar. A WHO study in 12 cities in five continents showed that the vast majority of injecting drug users started the practice below the age of 25 years. In Nepal, half the country's injecting drug users were aged between 16 and 25. In central Asia, the Russian Federation and Central and Eastern Europe an estimated 70% are under 25 years of age.

◆ *Sex workers*

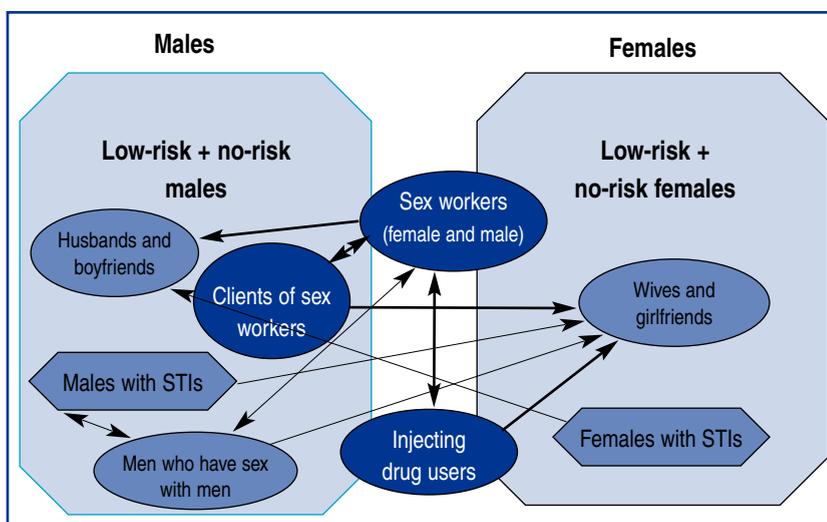
Sex workers have a high number of partners who themselves can have multiple partners. Social and economic pressures and violence coerce significant numbers of adolescent girls and boys into sex work.

◆ *Men who have sex with men*

Sex between men is a significant driver of HIV infection in some countries. Even where homosexual acts are illegal or culturally unacceptable, sex between men and adolescent males occurs, even if it is not spoken about. HIV can also spread quickly in prison and other settings where young males can be coerced into having sex.

### Combinations of risk factors

In concentrated epidemics, overall infection levels may rise through interaction between people involved in high risk activities and others. Figure 5 illustrates how infection can spread. For example, injecting drug users may fund their drugs through sex work, while clients of sex workers may transmit HIV infection to wives or girlfriends. In this context, married adolescent girls are especially at risk if they marry older men who are sexually experienced and have other partners.



**FIGURE 5**  
*Potential pattern of HIV spread between high risk groups and the general population in 'low prevalence' countries.*

Source: Txema Calleja, WHO/HIV Montreux, March 2003

## 2 Strategic role of health systems

### SHARED VISION

“Promoting healthy development in adolescents requires a shared vision with complementary action by different ‘players’ ...”

**Consensus statement 1**  
**WHO global consultation on adolescent friendly health services 2001**

**A**IDS requires a response by broad sections of government and civil society, including education, social care organizations, religious organizations, and the justice system. Every country needs to make young people a priority in its response to HIV and AIDS both for prevention and, in countries where a high number of young people are becoming infected, for treatment and support. In this broad approach the various actors need to work together. Education, for example, takes place mainly in schools, but teachers are not the only people who should inform young people about HIV and schools are not the only place where they will learn.

Within this broad approach, the health system has a leading role. Health takes the lead in collecting and analysing information about the spread and impact of HIV, in contributing to evidence-based policies, in mobilizing and supporting other sectors to provide interventions and in providing health services that reach young people in need. The health system must act as an intelligence centre to inform policy makers, the mass media, and others about risk-taking behaviour of young people and the importance of protective measures. Information must be based on the best evidence, so that policies and programmes are grounded in fact, rather than opinion.

There is an urgent need for young people to increase their access to prevention and treatment services, which are patchy or non-existent in most countries. A WHO global consultation in 2001 concluded: “For a variety of reasons, adolescents in many places are unable to obtain the health services they need.”

Services need to become:

- **Available** — information and counselling, condoms, safer equipment for injecting drug users, diagnosis and treatment for STIs, testing and treatment for HIV and AIDS, all need to be available to young people, depending on their circumstances.
- **Accessible** — laws, policies or social pressure may make services inaccessible to young people. Services that cost too much or are not in the right place at the right time are effectively out of reach.
- **Acceptable** — young people place great store by privacy and confidentiality. They avoid health workers who are unfriendly, unsympathetic or judgmental.

- **Appropriate** — services must meet young people’s specific needs. and may therefore need to be organized and delivered in different ways in order to ensure that they are ‘youth friendly’.
- **Effective** — Health providers need experience and skills to inform and counsel adolescents effectively. They need skills, equipment and supplies to diagnosis and treat STIs and HIV.

### **Adolescents need services to protect themselves and others**

To protect themselves and others, adolescents need access to:

- **Prevention services**
  - Information and counselling — all young people need to avoid or change behaviours that can put them at risk of HIV. They need to learn skills to help them to use information, to assess risks and to make informed choices.
- **Risk reduction services**
  - Sexually active young people need access to condoms to protect themselves against HIV infection, STIs and unintended pregnancy.
  - Injecting drug users need access to safe injecting equipment and other harm reduction measures.
- **Diagnosis, treatment and care**
  - Management of sexually transmitted infections (STIs).
  - Treatment and care for STIs and TB.
  - Testing for HIV with pre- and post-test counselling.
  - Young people with HIV and AIDS need care, support and treatment with antiretroviral medicines (ARVs), as they become available and according to protocols.

Pioneering work has been done in many countries which have begun to get to grips with the AIDS epidemic. Over the last decade a great deal has been learned about what are the most effective things to do, and about how they should be done. The key interventions for HIV prevention and care services for young people are summarized in the box above. They are mutually reinforcing and should be linked.

## 3 Information and counselling

### UNGASS DECLARATION OF COMMITMENT – INFORMATION, EDUCATION AND SERVICES

The United Nations General Assembly Special Session on HIV/AIDS in June 2001 included in its Declaration of Commitment, these global goals:

52 By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; ...

53 By 2005, ensure that at least 90%, and by 2010 at least 95% of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life-skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers.

**Y**oung people need accurate information about HIV and AIDS presented in ways that they can access and understand. Reaching vulnerable groups of young people is particularly important to help them to delay the onset of sexual activity or to protect themselves. Information plays a critical role in helping adolescents to address issues and foresee dangers, but rarely, on its own, leads to changed behaviour. Adolescents need to integrate information into their own set of knowledge and beliefs, and they need life skills so that they can use it to make good choices. Adolescents cannot always distinguish between accurate and inaccurate information, but are more likely to take notice of information from a trusted source. As part of the process of development adolescents question what they are told, and respond poorly to being lectured, told what to think or given instructions. They need opportunities to question and to develop the skills that allow them to make use of information. Health services are unlikely to be the main source of information about HIV and AIDS, but health workers can be an important source of information and guidance.

### Who needs information?

Young people need information and guidance about HIV and AIDS before they become sexually active. Information is best presented within a broad framework of sexual and reproductive health education, and the rights of children and young people. Key messages for this age group are the benefits of delaying sexual activity and their right not to be sexually assaulted or coerced. Giving young people accurate information about sex, pregnancy, HIV and other sexually transmitted infections does not encourage earlier onset of sexual activity. A programme of age-appropriate information and skills should therefore begin at primary school and continue through secondary school. Vulnerable young people not in school also need these interventions.

All young people need information about the prevention of HIV and AIDS, but each adolescent's need for information varies according to age, sex and personal circumstances. A 13-year-old boy has a different level of understanding from a 17-year-old married girl. Young people in rural areas lead different lives from those in a city. Children in school need a different approach from children who are working. Approaches need to be tailored for broad categories of young people:

- all adolescents before they become sexually active,
- adolescents who are already sexually active,

- adolescents who are sexually active and concerned, such as those who are seeking help to avoid pregnancy, or who attend a clinic because they may be pregnant or have an STI.

Some adolescents are in especially vulnerable situations. They have the same information needs but may require a particular focus to ensure they are reached, and may require targeted guidance. Examples of young people who could be more vulnerable include:

- AIDS orphans and others who are without adult protection,
- young people who are not in school,
- adolescents who are displaced, have become refugees or are caught up in conflict or war,
- those involved in domestic work or other forms of child labour,
- married adolescents whose needs may be overlooked,
- young people drawn into prostitution,
- young injecting drug users,
- young people in prisons or other correctional facilities, who are at risk of injecting drugs or coerced sex,
- young men who have sex with men.

### Policy makers and information givers

Policy makers and health providers also have their own information needs, for example, accurate data about sexual activity and injecting drug use among young people. Health providers and other information givers need detailed and accurate information about HIV and AIDS so they can inform and guide adolescents with confidence.

### What information do adolescents need?

Adolescents need to access information about HIV in the context of their lives, linked to their other related information needs, such as how to prevent pregnancy and sexually transmitted infections. All adolescents need information on how HIV spreads, how it can be prevented and how you cannot tell when someone is infected. Sexually active

### SEX BEFORE THE AGE OF 15

In Haiti, Poland, Latvia, Hungary, Gabon, Malawi, Kenya, Tanzania, Mozambique USA, and Finland more than 20% of boys said they had had sex before they were 15. Countries where more than 20% of girls said they had had sex by the age of 15 included: Hungary, Gabon, Mozambique, USA, Finland, Guinea, Cameroon, Togo, and Niger.

Source: UNAIDS

### YOUNG MARRIED WOMEN

Young married women are often excluded from programmes. An African Youth Alliance survey on youth friendly services in Uganda, Ghana, Botswana and Tanzania found that young married women make up 60% of clients, but were no longer officially counted as 'young' if they had a child, were pregnant or were married.

In Mexico only 36.4% of married women between the ages of 15 and 19 use some kind of contraceptive.

Source: Mexfam [www.mexfam.org.mx](http://www.mexfam.org.mx)

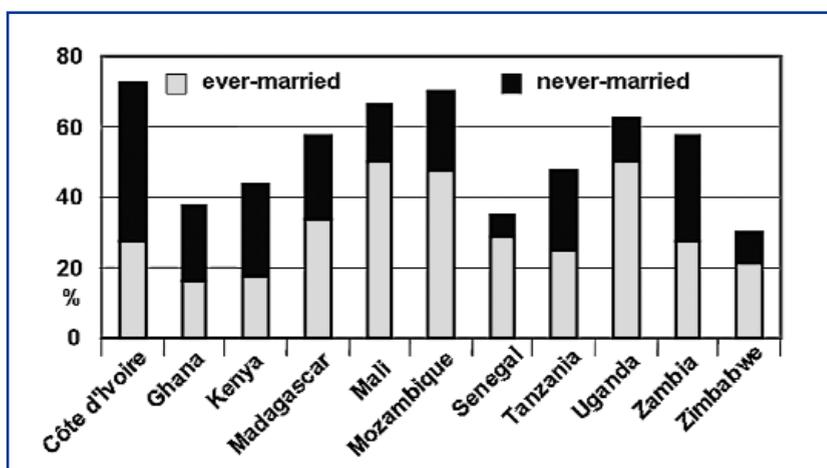


FIGURE 6  
Proportion of young women aged 15-19 in selected African countries who have had sexual intercourse

Source: DHS

### **INFORMATION ABOUT SERVICES**

In an Indonesian study, four out of ten adolescents did not know what reproductive health services were available in their area.

young people need information about health services, how they relate to young people and how to access them, and they need to know how to obtain condoms. Young people who are infected or who have a parent, close relative or friend who is infected, need information about living with HIV infection and the likely progress of disease. They need to learn about options for treatment and care, including interventions to prevent mother-to-child transmission, and about diet and lifestyle.

### **The role of the health system in providing information**

Young people accept information where they find it — from friends, family, teachers, religious leaders and increasingly from the mass media. The health system has to work with these partners to achieve a coherent package of information for young people about HIV and AIDS. Although health providers and health workers are not the main source of information for young people, they have a critical role that is currently not being met in many countries.

The health system is responsible for ensuring that information being used by this network of sources is accurate and up to date. Health providers should be closely involved in drawing up information programmes and materials. Adolescents value accuracy, and there is evidence that they trust information given by non-judgmental and friendly health workers. As health services become more accessible and acceptable to young people, the role of health workers in giving information and providing counselling will increase.

Health workers have unique opportunities to provide specific information about HIV to adolescents who are already seeking contraceptive services, treatment for sexually transmitted infections or who attend clinics for antenatal care. Clinics should have relevant, up to date leaflets and other information resources. Clinics can become the hub for a local information group that involves young people, community based workers and volunteers. Giving a young person a leaflet can be the entry point for a broader discussion about risk activities, and a chance to listen to the young person and to provide guidance. The role of health workers is to oversee this process, validate the information and ensure that counselling is available.

The primary and secondary school curriculum should provide appropriate sexual and reproductive health education. School nurses can play a significant role by training teachers and being available for consultation. Clinics can be arranged at or near school at convenient times for young people, and linkages between schools and health services can be strengthened. Health workers should also be involved in outreach teams that take information and counselling to young people who are not in school, and to vulnerable groups such as injecting drug users and sex workers. Health workers may have an input into infor-

### **CAMPAIGN HAS IMPACT ON YOUTH**

loveLife in South Africa uses high profile television, radio and poster campaigns to break down barriers to talking about sex. More than three quarters (78%) of sexually experienced youth say that the campaign influenced them to use condoms, and six out of ten young people say they have been more assertive about the use of condoms.

(Source: loveLife Evaluation Report)

mation given through sports, drama or dance groups as well as by religious and community leaders. Private health-care providers, pharmacies and street kiosks can also be important sources of information for young people, particularly because they are seen as more anonymous and easier to access.

## **Counselling helps young people make use of information**

To act on information, adolescents need to be able to make it relevant to their lives. Young people need to develop life skills to stand up to peer pressure, to delay having sex, to negotiate the use of condoms or to seek help if they have a problem. Health workers (and others) can respond to adolescent concerns with guidance or counselling as well as with information. In addition to technical knowledge and capacity, health workers need a sense of compassion and a non-judgmental approach: they need to listen as well as talk.

### **Zambia: Health board works with young people on media campaign**

The HEART campaign in Zambia uses TV, radio and posters to promote abstinence or consistent condom use amongst young people. The content and design of the media campaign is drawn up by a group of 35 young people aged 15-22 who meet for a week four times a year. They work closely with the Central Board of Health on the content and wording of key messages. Radio spots feature young people making decisions about sex, with slogans such as "AIDS - You cannot tell by looking", "Abstinence is Ilich" (cool), and "Virgin Power, Virgin Pride". The Central Board of Health checks scripts for accuracy. HEART also uses mass media to train health workers and neighbourhood health committees about malaria, TB and eye-health.

Holo Muchangwe Hachonda IV, Youth Communications Co-ordinator for the HEART Programme, says: "You have to form partnerships with young people to identify points for information giving and for behaviour change. You have to work with them on risk perception because they do not think that they are at risk of AIDS."

*Helping Each other to Achieve Responsibility Together (HEART) is backed by the Ministry of Health, the Central Board of Health, UNICEF, the Zambia field office of John Hopkins University and Population Services International (PSI).*

### **Key actions to improve information and counselling for adolescents**

Each country should set targets with a timetable for achieving improvements in:

- The number of district health facilities able to provide information and counselling for young people.
- The proportion of staff trained in informing and counselling adolescents.
- The proportion of all adolescents who have access to information and counselling.
- The proportion of particularly vulnerable adolescents, such as sex workers, or injecting drug users, who have access to information and counselling.
- Mobilizing and training programme partners in information and counselling, such as youth workers, religious leaders, sports coaches and young people themselves.

#### **THE RIGHT TO MAKE DECISIONS**

"The rights perspective is the most important. We need to recognize different sexual attitudes, different sexual behaviours and different needs in accordance with age and sexual orientation. Most important is not how you use a condom, but how you make your own decisions about your life, and your own reproductive and sexual health."

**Marcela Rueda Gomez,**  
Latin American and Caribbean  
Youth Network for Sexual and  
Reproductive Health Rights

Counselling can be provided by a wide range of supportive adults who interact with young people. Health workers cannot provide the majority of this counselling. However, every health worker who interacts with adolescents should develop the skills to be able to encourage young people to communicate their feelings and fears, and to guide them towards making decisions. An adolescent who has unprotected sex, an STI or an HIV diagnosis needs to understand risks and choices, and to see a practical way forward to make decisions and to put them into effect. The health sector and others must aim to:

- provide accurate, relevant and accessible information,
- ensure that adolescents understand and internalize information,
- ensure they understand choices available to them,
- support young people to make decisions,
- avoid blaming young people for the situations in which they find themselves,
- refer adolescents for further help when necessary.

## 4 Reducing risks

Information and counselling are important for reducing young people's risks and vulnerabilities. However, on their own they are not enough, especially for adolescents who are already engaged in risk activities. A comprehensive approach includes the provision of condoms for young people who are sexually active, and, for injecting drug users, measures to reduce the risks of sharing needles.

Gaps in services for risk reduction may occur because of lack of awareness or denial that there is a problem, political uncertainty about public support for protective measures, economic constraints on services or because of lack of reliable and planned delivery systems. Some tension may be perceived between advising young people to avoid risk behaviours, and providing the means to reduce risk. However, providing condoms to protect young people who are having sex and introducing measures to protect young people who are injecting drugs are both proven methods of saving lives. Helping young people to reduce risk behaviours is vital; it is also vital to protect those who are at risk.

### Condoms – safe and effective when used consistently and correctly

Measures to reduce the vulnerability of young people and to reduce risk are complementary and part of a continuum. In terms of the sexual transmission of HIV this is well expressed as:

- **DELAY**— your first sexual experience,
- **REDUCE** — the number of your sexual partners,
- **PROTECT** — yourself and your partner by using a condom.

This approach encourages those who are at no or low risk to remain safe, and encourages all others to move in the direction of greater safety. It helps to create a climate where adolescents can more easily delay the onset of sexual experience, which is the only 100% effective way of avoiding HIV. It addresses the need to reduce the number of sexual partners, since risks rise rapidly with multiple partners. It emphasizes the need for consistent and correct use of condoms.

Without condoms, those young people who do not succeed in abstaining are left unprotected at very high risk, and there would be little prospect of reducing HIV levels in the community. Millions of young people would be left to their fate, including girls who are powerless to abstain because sex is forced or coerced. Promoting abstinence and promoting condoms are not alternatives — but complementary parts of an effective approach. Condom use is promoted in order to

#### UNGASS DECLARATION OF COMMITMENT – SERVICES

The United Nations General Assembly Special Session on HIV/AIDS in June 2001 included in its Declaration of Commitment: (paragraph 52)

By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including ... expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections

protect those who are having sex, not to undermine those who are not.

### Condoms for sexually active young people

Sexual encounters by adolescents are often unplanned, spontaneous, and even opportunistic. Young people tend to think in the short-term and not weigh longer-term consequences. Girls may live in fear because pregnancy can lead to stigma within their communities, damaging their hopes of education or training, while early and unwanted pregnancy can even lead to permanent ill-health or death. Condoms offer dual protection — not only against HIV and sexually transmitted infections, but also against unintended pregnancy. For young people who are sexually active, consistent condom use is the responsible option, implying a long term commitment to look after their own health and that of their partner. It is an empowering option because it enables young people to take more control over their own lives.

Programming condoms for HIV prevention means ensuring that sexually active young people have easy access to good quality condoms, know how to use them correctly and consistently, and are motivated to use them. Condom use by young people is increasing, but not as rapidly as the increase in young people having sex: there is still a large unmet need. Programmes must include actions to address both the demand for condoms and their supply, and must ensure that young people who need male or female condoms can access them easily. Condoms should be used for all first time sex and for every subsequent occasion, except when a couple are trying to conceive a baby.

Issues that influence effective demand include:

#### ■ Perceptions of personal risk

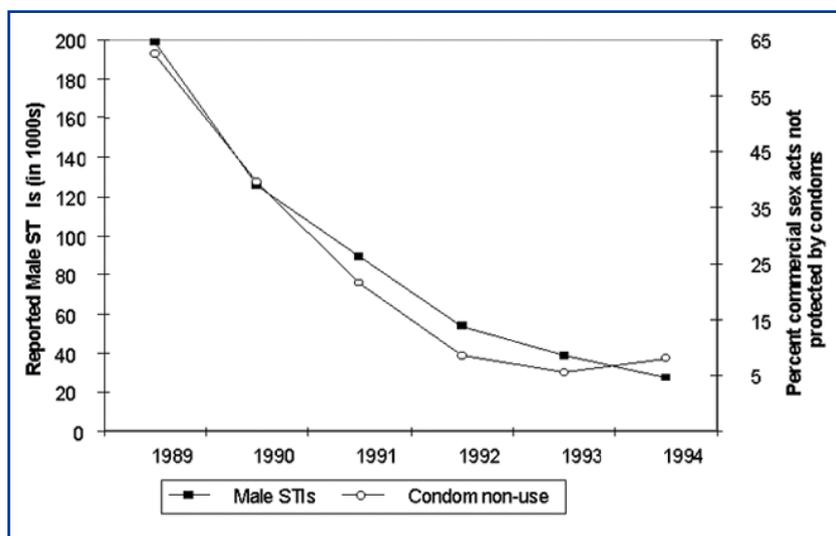
Sexually active young people may not regard themselves as being at personal risk of STIs or unwanted pregnancy.

FIGURE 7

#### Thailand: STIs fall as condom use increases

In Thailand a campaign sought to ensure that condoms were always used by sex workers and clients in brothels. Sexually transmitted infections seen at government health clinics fell by more than 70% over four years — matching the fall in unprotected sex acts. There was also evidence of a fall in the number of men visiting sex workers during the campaign.

Source: UNFPA



## Are condoms effective?

The question 'how effective are condoms?' is really several questions rolled into one. In theory one can say that condoms are (almost) 100% effective — if they were made perfectly, kept in perfect condition and used perfectly.

In the laboratory, HIV cannot pass through male or female condoms.

Real life studies however do not take place in a laboratory: they measure everything from commitment to condom use, to practical skills in using them.

Some trials show that condoms are about 90% effective when used consistently and correctly, and infection rates can be cut by almost 95%. Other trials suggest that if they are used inconsistently a smaller reduction will be achieved.

Figure 7 shows that in a controlled setting, there is a close relationship between condom use and a decline in sexually transmitted infections.

### ■ Negative beliefs about condoms

Condoms often get bad publicity. One common claim is that people who use condoms must be ill or promiscuous. They are also often perceived as interfering with a natural process. In a 14-culture study 'loss of pleasure' was the main reason given for not using a condom. There are also myths, such as the belief that condoms are manufactured with holes so that people become infected. Misinformation can be countered, but negative images of condoms as 'unnatural' or 'uncool' cannot be brushed aside and need to be explored with adolescents. A UNAIDS supported survey of young urban Zimbabweans aged 14-20 found that many believed that condoms were not part of their culture and that their promotion could open the door to increased sexual activity. Young people saw condoms as ineffective, unreliable, unpopular and 'western'. Other people have religious or cultural objections to sexual activity outside marriage, and sometimes transfer this disapproval from the sexual act to the condom. However, the evidence shows that many young people are engaged in sexual activity before marriage, and condoms can protect these young people from HIV infection, other STIs and unwanted pregnancy.

### ■ Knowledge and skills

Young people need to know where to get condoms at a price they can afford. They need to talk to a partner about using them before sex takes place, and be able to use them correctly. Life skills programmes need to practice negotiation skills and teach skills in condom use, especially as adolescents may be reluctant to confess to inexperience.

### CONDOMS ARE EFFECTIVE

"Condoms, when used correctly and consistently, are the single most efficient available technology to reduce the sexual transmission of HIV and other STIs. Condoms are the key preventive tool to avoid sexual exposure to HIV. They have therefore played a decisive role in HIV prevention efforts in many countries.

Laboratory studies show that male latex condoms are impermeable to infectious agents contained in genital secretions, including HIV. Condom use is more likely when people can access them at no cost or at greatly subsidized cost. Along with other population groups, condom promotion particularly targets young men and women and addresses their needs. HIV Programmes need to ensure that high quality condoms are accessible to all those who need them and when they need them, and that people have the knowledge and skills to use them correctly."

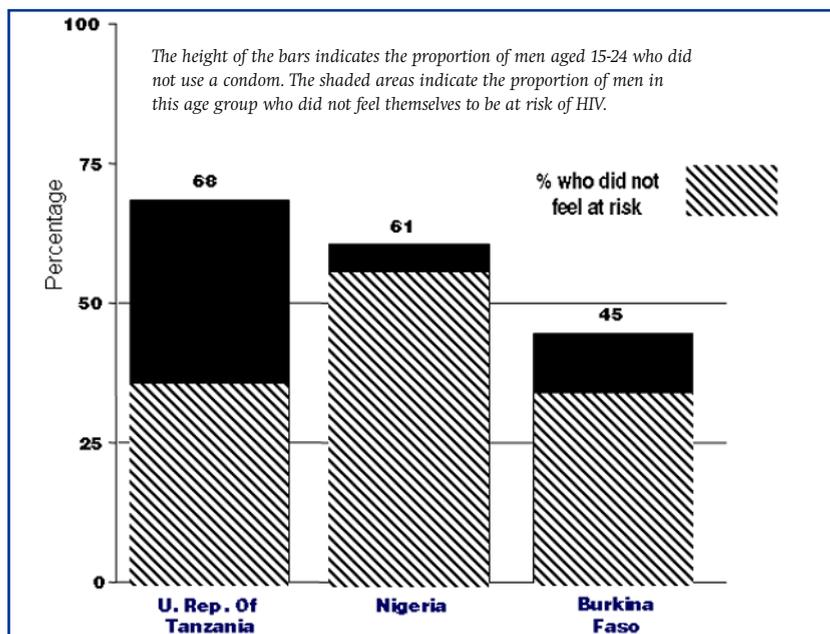
**Extract from  
WHO/UNAIDS/UNFPA  
Position Statement on  
Condoms, July 2004**

**FIGURE 8**

**Perceptions of risk:  
Sexually active men  
aged 15-24 who did not  
use a condom last time  
they had sex.**

The percentage of young men who did not use a condom the last time they had sex ranged from 45% in Burkina Faso to 61% in Nigeria and 68% in Tanzania. In Burkina Faso and Nigeria most did not feel at risk of HIV. In Tanzania about half did feel at risk, but this alone was not enough for them to use a condom.

Source: DHS 1999



There are also other obstacles to providing and using condoms.

- The political and cultural environment may not support increasing young people’s knowledge and skills about condoms, or making them available to young people.
- There is an overall lack of supplies worldwide, with a shortfall in low and middle-income countries of 40% of what is required.
- Gender inequalities create a double standard whereby it may be acceptable for boys to use condoms, but not for girls. It may be seen as a male responsibility to acquire condoms but a female responsibility to negotiate their use.
- Condoms are not affordable for adolescents who have no income.
- Lack of privacy and confidentiality inhibit young people from obtaining condoms at health facilities or in other settings.

**MIXED RESULTS FOR  
CONDOM USE BY  
YOUNG MEN**

DHS figures for 1999-2001 show that in four African countries (Burkina Faso, Malawi and Tanzania) sexually active young men aged 15-19 were much less likely to use condoms than older men.

However, data from 27 countries in Africa and Latin America showed higher use of condoms by 15-24-year-olds than 25-49 in every country. Figures of condom use do not by themselves explain why young people do or do not use them.

Source: DHS 1999-2001

**Distribution of condoms**

Health workers should be willing and able to offer condoms, and providers in other settings must also have access to a reliable source of supplies. A comprehensive distribution system will ensure that condoms are available in a variety of settings, including:

- ◆ public sector clinics and hospitals,
- ◆ private sector health facilities,
- ◆ pharmacies and kiosks,
- ◆ school-based settings,
- ◆ community based distributors,
- ◆ work-place settings,
- ◆ youth and community centres,
- ◆ peer educators, friends,
- ◆ village health workers,
- ◆ vending machines,
- ◆ social gatherings such as discos and football matches.

The distribution of condoms through mainstream health and non-health youth services will improve if young people are consulted about where they should be provided and involved in their distribution. The

## Targets for adolescent condom use

Countries and health systems should set targets so that they can monitor progress towards improving the distribution of condoms and their use by adolescents.

In setting targets for condom distribution, health systems should consider:

- The number of district health facilities which provide free or affordable condoms for young people.
- The number of health workers who can promote and demonstrate use of condoms.
- Distribution methods in the community, including non-formal channels.
- Involving young people as advocates of condom use.

public and private sector can also be involved in social marketing, which uses the mass media and marketing techniques to promote social aims, in this case to promote the use of condoms.

## Harm reduction for injecting drug users

Drug abuse is largely a problem of the young, although there is now a global trend amongst young people away from injecting drug use. However, there are significant pockets, for example in parts of eastern Europe and central Asia, where the HIV epidemic is being driven by young populations of injecting drug users. It is important to design and implement interventions that cater to their specific and pressing needs. Young people need clear, accurate information about how to avoid negative health behaviours, like drug use, particularly injecting drug use, and unprotected sex, that put them at risk of HIV infection.

If injecting drug users share needles, one infected person can infect the rest. They are therefore at higher risk of HIV, and at risk of spreading HIV to their sexual partners. Some injecting drug users have multiple partners, particularly if they finance their habit through sex work, and there is a danger of HIV spreading into the broader population. Intervening at a young age is effective because young people experimenting with drugs may stop if they are motivated and receive support.

In many countries, reducing or containing levels of injecting drug use is a political and social priority, especially because many drug users turn to crime to fund their habit. Combating drugs is high on the agenda of law enforcement and health authorities. Key programmes include voluntary or involuntary rehabilitation and outreach programmes that contact drug users in the community.

#### NEPAL PROGRAMME

◆ In Nepal, 50% of injecting drug users were HIV positive: half of them aged 16-25. The Lifesaving and Lifegiving Society (LALS) provided education, counselling and primary health care in Kathmandu, along with bleach, sterile water, condoms and new needles and syringes. Levels of unsafe injecting declined.

### What is the evidence?

Research indicates that an HIV epidemic among injecting drug users can be prevented, stabilized and even reversed. Evidence-based, comprehensive interventions are vital to discourage and prevent initiation of drug use, and the transition to injecting; address the harmful health consequences of injecting drug use; discourage and prevent use or sharing of contaminated injection equipment; provide services that minimize and reduce risks, and lead young injecting drug users to a healthy, drug free life.

- There is strong evidence that increasing the availability and use of sterile injecting equipment contributes substantially to a reduction in the rate of HIV transmission.
- There is only limited evidence supporting the effectiveness of programmes that promote use of disinfectants for the prevention of HIV transmission.
- Substitution therapy has been linked to lower rates of HIV transmission.
- Needle and syringe programmes alone are not enough to control the spread of HIV amongst injecting drug users. They must be supported by risk reduction information, referrals to drug treatment and primary care services, as well as preventive education.

Health Outcomes International. *Return on Investment in Needle and Syringe Programmes in Australia*, Canberra, Commonwealth Department of Health and Ageing; 2002. [www.health.gov.au/pubhlth/publicat/document/roireport.pdf](http://www.health.gov.au/pubhlth/publicat/document/roireport.pdf)  
Hurley SF, Jolley DJ, Kaldor JM. *Effectiveness of needle-exchange programmes for prevention of HIV infection*. *Lancet* 1997; 349 (9068): 1797-1800.

Depending on the target audience (potential drug users, non-injecting drug users, or injecting drug users), a comprehensive package of prevention and care has been shown to be most effective. For potential drug users, interventions could include information, education and life skills training, and, depending on their age, condom distribution. For active non-injecting drug users, voluntary and confidential HIV testing and counselling and referrals to a variety of treatment options would be appropriate. For injecting drug users it is usually necessary to provide sterile injecting equipment and to offer substitution treatment. A substitute drug, such as methadone, is usually offered orally under supervision, which eliminates the need for injecting. Such programmes should be regarded as complementary to, rather than as competing

### **Key considerations for harm reduction for injecting drug users**

Countries need to balance programmes for law enforcement, compulsory rehabilitation and voluntary harm reduction.

- If programmes are not committed to reducing levels of drug taking they lose public and political support.
- If programmes are too repressive they do not attract drug users to services.

The health system and the law enforcement system need to reach an understanding and, preferably, a common approach. The debate will be better informed by involving young people, including those who have in the past been injecting drug users.

Health providers who manage harm reduction programmes must understand how these fit into the overall national strategy for drugs, and must win political and public support for them.

### *INVESTMENT IN HARM REDUCTION PAYS OFF*

Australia invested \$150 million during the 1990s in harm reduction programmes. There have been claims that this helped to forestall 25,000 new HIV infections.

In many cities around the world, senior police officers allow harm reduction programmes to coexist with strong law enforcement policies to decrease the supply of drugs, because they have been impressed by the evidence that harm reduction works.

with, strategies to help people to stop using drugs, and to prevent the use of drugs in the first place. There is evidence that providing clean needles and syringes does not increase the number of drug users, nor does it lead non-injecting drug users to start injecting. However, needle and syringe programmes on their own are not enough to control the spread of HIV. Drug users also need the support of a comprehensive range of prevention and care interventions. Effective programmes and interventions aimed at reducing the adverse health consequences of drug abuse typically include a variety of measures from information on risk reduction to drug dependence treatment and referral to the other services outlined above. Interventions also need to be designed to meet the needs of specific target groups such as prisoners and sex workers who inject drugs.

It is important that efforts aimed at minimizing risk also focus on helping people to reduce or stop using drugs, especially in the case of adolescents for whom the prospect of a drug free and healthy adulthood should not be marred by a pattern of substance abuse. It is also important that efforts to reduce demand for drugs do not criminalize harm reduction programmes. A comprehensive package of this sort works best if there is treatment for those convicted of minor drug offences, since incarceration can increase the risk of HIV transmission.

## 5 Diagnosis, treatment and care

**P**rospects for the treatment of HIV and AIDS have been revolutionized by the commitment to deliver antiretroviral treatment (ARV) to three million people in the developing world by the end of 2005. This WHO/UNAIDS initiative targets life-saving medicines towards those who currently do not have access to them. ARVs represent an opportunity to prolong life and to improve the quality of life for people living with HIV and AIDS. The '3x5' campaign will also help to prevent the spread of HIV in two main ways. Those who receive the medicines will experience a reduction in their HIV viral load, making them less infectious, while the hope of obtaining treatment will encourage more people to seek testing for HIV, which is a key opportunity to increase access to prevention services.

It is important that treatment programmes support prevention campaigns and do not lead to complacency. ARVs do not 'cure' HIV infection. Treatment regimes are demanding of individuals and health systems and involve a lifelong commitment. If ARV treatment was to dilute the focus on prevention, it would reduce the impact of resources. This is especially true for adolescents, since every HIV infection that is prevented avoids the need for many years of treatment.

Diagnosis, treatment and care for people with STIs and HIV or AIDS can be seen as links in a chain. The first aim is to prevent the infection spreading. Subsequently, treating disease and caring for people who are sick generates opportunities to strengthen prevention messages. Prevention is important for those who are HIV positive, as well as for those who are not infected, both to protect their own health and to prevent onward transmission.

### Diagnosis and treatment of sexually transmitted infections (STIs)

The diagnosis and treatment of sexually transmitted infections in adolescents can play a significant role in reducing the transmission of HIV. About 110 million STIs are diagnosed each year in people under the age of 25. The vast majority of STIs can be treated. Left untreated, STIs can lead to disability or infertility in young women, and the transmission of infection to babies in the womb. Adolescent girls with ulcerative STIs such as genital herpes (HSV-2) are more likely to acquire HIV. Symptoms are intermittent and many people with genital herpes do not know they have it.

## Target setting for diagnosis and treatment of STIs

Health systems should aim to:

- Improve the awareness of young people about sexually transmitted infections.
- Improve access to information, access to diagnosis and treatment.
- Improve the quality of treatment.
- Improve the availability of medicines and supplies.
- Provide appropriate services in high and low prevalence settings, and in rural and urban areas.

Clinical trials have shown that detection and treatment of STIs can reduce levels of HIV infection when linked to other services such as information and counselling and the provision of condoms. The Cochrane Centre, which reviews worldwide evidence, says that improving STI treatment can be an effective strategy in an emerging HIV epidemic. The evidence also suggests that this is most cost effective when combined with condom promotion.

STI services for adolescents need promoting. Adolescents are often unaware that they are infected and may find services unacceptable either because they are designed for older people or because they fear being stigmatized.

- Clinics must have well trained staff and a reliable supply of effective STI medicines. Staff must be welcoming and guarantee privacy and confidentiality. Antenatal and family planning clinics should also become skilled at detecting and treating STIs.
- Referral between health services needs to be strengthened so that adolescents receive relevant services at whatever point they enter the system.
- Information should be available in community settings, such as youth clubs and sports venues, to tell young people where they can go for testing and treatment. Service providers need to think about groups who are generally missed, including young males. School health programmes should be reviewed to ensure that they contain information about sexually transmitted infections.
- Staff at clinics should be trained to talk to young people about adopting safer sexual behaviour.
- Service providers should be more proactive. Better information about STIs and the availability of treatment will encourage more young people to use services. Providers also need to reach out to adolescents in vulnerable groups, such as sex-workers and girls who are pregnant.

### *HIV REDUCED BY ONE THIRD*

In Mwanza, Tanzania, people attending STI clinics were given accurate diagnosis, on the spot treatment and follow up medicines. They were also counselled about safe sex and offered condoms. This trial was conducted in a setting where there was a high level of STIs. It produced a 38% reduction in HIV rates in the target population. The reduction was greatest in the 15-24 year-old age group.

### **MORE SEEK TESTING**

- ◆ In Zambia more youth seek testing, especially just before getting married. Non-clinic testing locations are three times more popular than clinics. In Uganda and Zambia, 1 in 7 people attending a testing centre is aged 15-19. Counsellors say that young people are unaware that they can refuse an HIV test
- ◆ In Brazil, every HIV positive young person has a legal right to antiretroviral drugs. More young people seek tests as a result. Testing in Botswana rose fourfold following a Government pledge to meet 80% of the cost of medicines.

### **JOINT UNAIDS/WHO POLICY STATEMENT**

A joint UNAIDS/WHO Policy Statement on HIV Testing was published in June 2004. The statement can be found at <http://www.unaids.org/EN/resources/publications.asp> or <http://www.who.int/hiv/pub/vct/statement/en/>

### **IPPF AND UNAIDS GUIDE ON TESTING**

*Integrating HIV Voluntary Counselling and Testing Services into Reproductive Health Settings* provides programme planners, managers, and providers with information to integrate voluntary counselling and testing for HIV within sexual and reproductive health services. The guide, published in February 2004 by UNFPA and IPPF South Asia Regional Office, can be found at <http://www.unfpa.org/publications/detail.cfm?ID=164&filterListType=>

## **Testing and counselling for HIV**

Few adolescents who are at risk of HIV infection know whether they are infected. Testing with counselling allows adolescents to decide whether to take an HIV test, to discover their status and to receive support. After an HIV test, whatever the outcome, a young person needs counselling on HIV prevention and appropriate services.

- A negative test offers an opportunity to reassess risk behaviours, and to renew a commitment to avoid becoming infected.
- After a positive test result, adolescents need counselling to protect their own health and to protect others from HIV. Counselling aims to ensure that adolescents living with HIV protect themselves from reinfection and other STIs, protect their sexual partners from HIV and take action to prevent mother-to-child transmission. It covers issues such as informing others of the diagnosis, retaining a positive attitude, eating healthily and responding to opportunistic infections.

These are good reasons for at-risk adolescents to consider an HIV test, but there are also disincentives. An HIV test should be a pathway to informed decisions and support; not a short cut to exclusion, stigma and depression. A positive test may be a psychological hammer blow, and lead to loss of family or friends. Parents may decide not to pay school fees, or may even turn a young person out of home.

Fear of stigma is one reason why the reach of HIV testing services remains poor. According to UNAIDS/WHO, only 10% of those who may have been exposed to HIV infection in low and middle income countries have access to HIV testing and counselling. Young people are more likely to seek an HIV test if it is a pathway to prevention services, treatment and care, and if tests are accurate and confidential. Adults and young people alike seek testing centres which ensure that their status does not become known in their communities.

A joint UNAIDS/WHO policy statement (see side panel) says that individual HIV testing must be underpinned by principles known as the '3Cs' so that testing is Confidential, accompanied by Counselling and conducted with informed Consent. Testing with counselling, as part of a prevention package, can engage adolescents in thinking about issues and consequences. This sense of engagement is critical so that a positive test leads a young person to reduce risks, and a negative test strengthens his or her desire to remain free from HIV and does not generate a false sense of security.

HIV testing should routinely be offered by health care providers to young people who are assessed in STI clinics, or who are seen in the context of pregnancy. Where HIV is prevalent and antiretroviral treatment is available, testing should also be offered to all young people seen by clinical or community based health services. A guide from IPPF and UNFPA (see side panel) suggests that integrating testing and counselling into existing reproductive health settings is effective in reaching young people and less costly than new stand-alone services.

## Target setting for testing and counselling

- ◆ Policies and procedures should ensure that young people are not excluded from testing. Age of consent issues need to be addressed.
- ◆ Testing should include referral to further counselling or services:
  - ❖ after a positive test, for treatment, care and prevention,
  - ❖ after a negative test to reinforce prevention messages.
- ◆ Services need to be sensitive to the concerns of young people — especially regarding confidentiality.
- ◆ The voluntary aspect of testing needs to be emphasized, or young people will be scared off.
- ◆ Pregnant girls need to be tested to assess and reduce the risk of passing on HIV to their babies.

## Age of consent

Young people below the age of consent for medical treatment need special consideration. It may be a legal requirement for clinics to tell parents that a son or daughter has HIV or needs treatment for TB or pneumonia. Some countries have found innovative solutions (see side panel). Where a legal requirement remains, adolescents need help in disclosing their status so that they are supported by their families.

## Pregnant girls and the risk to babies

Adolescent girls who have unprotected sex are a key concern. They are at extra risk of HIV and of pregnancy, and, if infected, can transmit HIV to their babies before, during or after birth. Testing and counselling should be available for pregnant adolescent girls in antenatal clinics. Without intervention, a third or more of infected mothers will pass on HIV to their baby. ARV prophylactic treatment, delivery by elective Caesarean section and not breastfeeding has reduced mother to child transmission to around 2% in developed countries. In resource poor countries, a short course of ARVs, safer delivery, infant feeding counselling and support for safer feeding practices can reduce transmission to about 15%.

## Treatment and care

WHO and UNAIDS estimate that 5-6 million people in developing countries need ARV treatment. By the end of 2002, only 5% of people who needed these medicines were receiving them, falling to 4% in Asia and 1% in sub-Saharan Africa. In 2003 WHO declared this lack

## PROVIDERS UNDER STRESS

"The lack of clear policies around testing in many countries, coupled with the overall lack of clarity about providing youth with reproductive health services, places providers in a stressful position."

### Voluntary counselling and HIV testing

Horizons Programme  
Montreux, March 2003

## AGE OF CONSENT

In **Malawi, Mozambique, Tanzania, Zambia and Zimbabwe**, the legal age of consent for medical procedures is 18.

**Brazil and Uganda** allow medical professionals to provide care to adolescents under the age of consent if the professional deems this to be in the best health interests of the young person.

In **Kenya** providers can deliver services to 15-17 year-olds if they believe the young person is mature enough to give consent. Married or pregnant youth are deemed to be 'mature minors' who can decide for themselves.

### **CARE FOR YOUNG PEOPLE**

In Uganda an adolescent club started at the Mildmay care and rehabilitation centre to tackle psychosocial and economic problems. The club arranges ways to earn money, carries out peer education and strengthens links with families. TASO supports a peer run AIDS Challenge Youth Club which offers both prevention and care services.

of access to HIV treatment to be a global health emergency. WHO has simplified technical guidance based on fixed-dose combinations, simpler medicine regimes and basic laboratory tests, which reduce the cost per patient to less than US\$1 a day. A global AIDS Drugs and Diagnostic Facility will help developing countries obtain high quality ARVs. WHO is working to support countries in training thousands of health workers to deliver these treatments, and to mobilize resources to meet this commitment.

The '3x5' initiative presents an opportunity to train health workers in the principles of adolescent friendly services and in giving prevention messages. Training must address the special needs of young people, who may need support to reveal their HIV status to families and who may find it more difficult to comply with long-term treatment regimes.

Treatment and care for opportunistic infections is also needed. WHO estimates that one third of the 42 million people infected with HIV also have TB. In sub-Saharan Africa TB is the leading cause of death amongst people with HIV infection. Treating such infections allows people with HIV to continue to work, study and take care of the home.

### **Support for families**

Most care, including palliative care, is provided by families and faith based groups at home, as hospital services are overwhelmed by AIDS related diseases. Policies are needed to support these families, communities and NGOs. Policies should also combat stigma and discrimination. Support from family, community and self-help groups can give young people who become infected with HIV a sense of optimism and purpose. Young people who are living positively with HIV can become a resource to help break down stigma and to improve care. More generally, young people can stimulate communities to organise care, and can themselves contribute to the care and support of people living with HIV and AIDS.

#### **Principles for setting care targets**

- ◆ National programme activities to scale up access to treatment, care and prevention should include a focus on the specific needs of young people.
- ◆ Each country should put in place policies and procedures for HIV treatment and care that do not exclude young people because of their age.
- ◆ Policies and programmes are needed to support families and community organizations in providing home care.
- ◆ Young people need support to live with HIV. They are also a resource for community mobilization, care and support.

## 6 Strategies to increase the use of services

**T**he health system has an urgent need to increase access to services and supplies for young people at risk of HIV, by stimulating and meeting young people's demand for health services. The health sector has a critical role in defining standards and providing health services, encouraging adolescents to use them, and enabling a range of partners, including private and not-for-profit providers, to stimulate demand and to increase provision. Health services currently offer little to adolescents. When young people are at risk, worried or ill they are likely to turn to friends, family or informal providers. To change this and engage with adolescents, health services need to meet quality criteria for adolescent friendly services.

### **Juventa at hub of youth friendly services in Russia**

The Juventa reproductive health service for adolescents and young people in St Petersburg is set in a former prison hospital – but the doors that once locked people in have been thrown open. Young people are welcomed by staff who are trained to understand their fears and to provide effective, sensitive services including information, health education, psychological and social support, and medical care. Doctors, including gynaecologists, STI specialists, therapists, and a neurologist, pool resources. Each young client is first met by a nurse who decides if specialist examination or treatment is needed, and who should see them. A family planning clinic offers contraceptive advice and counselling for emotional difficulties to boys, girls and young couples.

Juventa has become a hub for youth friendly services in Russia, Ukraine and Belarus. The St Petersburg model was established in 1993 as the first health clinic in the Russian Federation with an exclusive focus on adolescents' reproductive and sexual health needs. It was followed in 1994 by the Juventus centre in Novosibirsk (Siberia), and is now replicated in nine regions of Russia. The model is succeeding in making public health services more accessible to young people. The St Petersburg centre alone records 240,000 to 290,000 visits a year by 30,000 to 40,000 young people aged 15-18.

### **ADOLESCENT FRIENDLY HEALTH SERVICES GUIDE**

*Adolescent Friendly Health Services – An agenda for change* is available from WHO at [www.who.int/child-adolescent-health/publications/ADH/WHO\\_FCH\\_CAH\\_02.14.htm](http://www.who.int/child-adolescent-health/publications/ADH/WHO_FCH_CAH_02.14.htm)

### **CARIBBEAN FRIENDLY**

Caribbean youth said they wanted centres that:

- ◆ offer health, social, sports and personal development services under one roof,
- ◆ do not look like clinics,
- ◆ are open to both sexes,
- ◆ open outside school hours,
- ◆ have knowledgeable, trustworthy and empathetic counsellors,
- ◆ provide an instant advice telephone 'hotline',
- ◆ encourage parents to be involved.

### **Making services adolescent friendly**

Adolescent friendly health services have credibility with young people. They have competent staff. They offer privacy and confidentiality. They are conveniently placed and open when young people can reach them, for example, outside school hours. They allow young people to drop in without an appointment, at least on their first visit. They are affordable and have reliable supplies of antibiotics and condoms. See side panel for details of a WHO guide.

### **Quality improvement and training**

The health system, service providers and young people all benefit from a quality improvement programme that identifies, prioritizes and introduces improvements. The health system needs better information about the health problems of young people and a sharper focus on their needs. Services need technical improvements so that staff work to evidence based protocols and have access to reliable and effective supplies. Services need to be accessible, acceptable and effective in order to qualify as 'adolescent friendly'. Effective pre- and post-qualification training for doctors, nurses, and other health workers should help them to understand and respond to the specific needs of young people. Evaluation programmes provide feedback so that providers can monitor and improve skills. Youth themselves should be involved in reviewing services, setting quality standards and evaluating change.

## **South African clinics aim for the Gold Standard**

### ***Quality improvement programme to improve standards***

In South Africa, the National Adolescent Friendly Clinic Initiative aims to make health care more accessible to adolescents. Clinics sign up for a 'Going for Gold' programme which sets quality criteria for sexual and reproductive health. To achieve accreditation clinics must have:

- Management systems that support adolescent friendly health services.
- Policies and processes that support adolescents' rights.
- Appropriate, available and accessible adolescent health services.
- A conducive physical environment.
- The right drugs, supplies and equipment.
- Information, education and communication on adolescent sexual and reproductive health.
- Systems to train staff.
- Guidelines and protocols for psychosocial and physical assessment and care.
- Continuity of care.

Each health team plans how to improve the quality of its services and how to work with local groups. A pilot scheme will expand to 3,000 clinics over five years.

Staff clarify their values and think about their personal attitudes. They discuss public health priorities and what they should be doing. The programme sets standards and criteria.

However, it is young people and clinic staff who give the programme its vibrancy.

## Youth participation

Youth participation implies the meaningful involvement of young people in all aspects of a programme, from planning to evaluation. For example, the West African Youth Initiative in Nigeria and Ghana has involved youth, not as problems to be solved, or as recipients of direction from adults, but as partners in a process. Although there is no firm evidence from research to link youth participation to improved health outcomes, many organizations report that involving young people increases reproductive health knowledge, attitudes and practices, and makes programmes more credible and relevant. Young peer educators benefit from the skills they learn, and adults are reinvigorated by working with adolescents.

## YOUTH INVOLVEMENT

- ◆ Young 'mystery clients' tested services in Senegal, asking staff about a sexual concern.
- ◆ Young people in Namibia helped to design, co-ordinate and implement *My Future, My Choice*.
- ◆ Young people occupy five of the 30 places on The International Planned Parenthood Federation (IPPF) Governing Council.

## Rio health workers draw lessons from their own lives and values

The Adolescent Health Program In Rio de Janeiro City set out to improve health services for adolescents, addressing domestic and sexual violence, STI/HIV, adolescent pregnancy and sexual and reproductive rights. Activities aim to promote adolescents' rights and autonomy. Initiatives include peer educators and a voucher scheme to promote adolescent access to health services. Partners include schools, NGOs, universities, outreach workers, theatre groups, youth centres and adolescent leaders.

Health workers pay attention to young males and aim to improve their perception of health needs and use of health services. Posters and slogans give condoms a positive image, and a 'green light' to health services for young people.

Dr Viviane Castello-Branco, co-ordinator of adolescent health services in Rio, says that training health staff at the 90 clinics in Rio has been the key to transforming services.

"Recently, we have been focusing on the self-development of health professionals. We give health workers opportunities to reflect on their own adolescence, their own lives and the feelings and perspectives they have. They look at their own values, and the meanings they give things. This helps them think about adolescents in a different way. As professionals develop skills and discover their own potential, they can see the potential in others.

"We have been running this training for ten years and each year the health workers feel more confident. As they become more experienced they feel ready to engage in more challenging work, like outreach programmes for high-risk adolescents. They form partnerships with youth centres or work with an organization for homeless youth. They work with others, but health workers are the main actors. We value their creativity."



*Vista essa camisinha ('dress the shirt') is the message from Rio health workers to young people.*

### **Community mobilization**

Community mobilization encourages parents, community leaders and important groups within society to support programmes. At the same time, it informs the public about the content and method of operation of key programmes to combat HIV. As there is considerable stigma surrounding HIV and adolescent sexuality, community acceptance of HIV-related services, of condoms and of STI/HIV treatment and care can be critical to their success. The support of ‘community gatekeepers’ strengthens programming and helps to win over those who are wavering or doubtful. It is important to gain the support of traditional and cultural leaders, elders, parents, faith-based groups, education-based and work-based groups, traditional healers and young people themselves. Although (as with youth participation) it is not easy to evaluate the links between community mobilization and better health outcomes for young people, it is clearly important. In Uganda strong political commitment and support from political leaders, faith based and other groups helped to win acceptance for interventions to reduce levels of HIV among young people. Experiences of campaigns for the Integrated Management of Childhood Illness (IMCI) and Roll Back Malaria (RBM) suggest that publicizing the need for services increases service use among target client groups. It is all the more important to gain community acceptance for services for young people to overcome any existing opposition to young people accessing reproductive health services.

### **Innovative approaches to increasing service use**

A number of innovative approaches have been devised to increase demand from young people who do not currently use services but who may be vulnerable and in need of such services.

### **Outreach**

Outreach is necessary for any at-risk population of young people who cannot be reached through existing health facilities and who are not being served by existing providers. Trained staff or volunteers take information, services or commodities out to a defined community or population, often with the help of trained peers from the target population. A mobile clinic may provide services in rural remote areas. Outreach work is also needed in towns and cities because street youth, young people involved in sex work, and young injecting drug users are unlikely to access mainstream health services, even when they are close at hand. Outreach is also appropriate for dispersed vulnerable groups such as young people in rural areas, orphans looking after families, and isolated or hidden young people living with HIV and AIDS.

Outreach may be used to deliver specific services, such as condoms, to tackle risk behaviours or to promote access to prevention and care services. Outreach services should be able to make linkages between a

range of service elements including information, treatment for STIs, testing for HIV, and a reliable source of supplies. Successful outreach teams are often multi-disciplinary, and health workers are a valuable part of such teams, bringing expertise and credibility. The challenge is to deliver services in a sensitive manner to marginalized client groups and build a relationship based on trust, so that the target audience responds positively.

Outreach programmes have shown some success in increasing risk perception and condom use amongst sex workers, and in reducing HIV prevalence rates. Young people drawn or coerced into sex work may respond more favourably if the team includes a (former) sex worker. There is evidence that peer educators and community outreach programmes can encourage behaviour change amongst injecting drugs users. Former drug users may be useful members of such teams.

Outreach work was a common factor in a study of five cities where HIV levels remained below 5% among injecting drug users. Research identified some essential steps in outreach programmes that were successful in influencing injecting drug users. These included:

- discovering where and when young people gather,
- gaining trust among younger IDUs by becoming a 'familiar face',
- gaining trust among gang leaders and dealers,
- gaining the trust and confidence of police and authorities,
- ensuring privacy and confidentiality,
- attending to immediate needs, such as medical ailments, before attempting to provide bleach or sterile injecting equipment,
- forming a genuine relationship with service users,
- making time to respond to the problems raised by service users,
- knowing legal responsibilities and the Criminal Code.

It is important to clarify the legal status of outreach teams who work with people involved in illegal activities. It is also important to win public support for such interventions. For this reason, it may be better to inform communities and the media rather than to keep a low profile.

### ***Social marketing and social franchising***

'Social marketing' uses commercial techniques to promote supplies such as condoms, which may be branded and advertized to make them attractive to young people. Social marketing can promote commodities supplied by the public sector, but more usually promotes products sold commercially by the private sector, often at a subsidized price. Vendors at kiosks, pharmacies or clubs are willing to sell condoms cheaply so long as they make some profit and attract young people to their business. Such products are attractive to youth who want confidentiality, but out of reach for young people with no income. Social marketing can involve private pharmacists in promoting emergency contraception, or private clinics in promoting safer sex.

'Social Franchising' goes one stage further, and draws together

### ***THE BEST TEAM***

In Moscow and Dhaka many outreach workers in programmes for injecting drug users were ex-drug users themselves. In Kathmandu, teams comprised ex-drug users, nurses and social workers.

### ***WINNING SUPPORT***

In Indian states, local leaders, the police commissioner, church leaders and government health professionals on an advisory committee created a supportive environment for outreach teams.

In Indonesia, all parties involved in preparing outreach work, agreed on a common medical approach and were able to win co-operation for the work from relevant agencies

### **SOCIAL FRANCHISE SERVICES ARE YOUTH FRIENDLY—AT A COST**

In **Madagascar**, private medical practitioners banded together under the Top Reseau franchise run by Population Services International (PSI). Staff at 17 clinics received training and support to provide youth friendly services for young people aged 15-24. The franchise set quality standards and promotes the Top Reseau 'brand'. Practitioners have agreed referral systems. Staff value the training they receive in youth friendly services. One practitioner reported a 25% increase in business, with 60-70% of his clients being youth.

**Kenyan** NGO K-MET launched the Private Providers Health Franchise Network to develop good practice in reproductive health. The network includes 250 private clinics throughout Western Kenya. Schools, churches, government agencies and NGOs market, publicize and sustain the network. It is developing a reproductive health and a youth HIV and AIDS prevention programme.

A survey of social franchises concluded that they have the potential to increase the number of youth using clinical services. However, there is tension between the need for profit and the commitment to social goals. All the projects required donor funding and many were concerned about their future when this ended.

See Youth Net: *Applying Social Franchising Techniques to Youth Reproductive/ HIV Services*. Youth Issues Paper 2 Published by Family Health International 2003.

### **Social marketing to raise awareness**

Social Marketing for Adolescent Sexual Health encouraged young people to protect themselves from STIs and HIV in Botswana, Cameroon, Guinea and South Africa. Young people age 13-22 designed and implemented marketing campaigns using positive names like *Youth Horizon*. They used mass media and peer educators to talk about sexual and reproductive health in schools, youth clubs and public meetings. Retailers and clinics displayed stickers with the campaign logo and slogans, *Let's Chose Life, My Future First*, and *Passport for the Future*.

The campaigns succeeded in reducing negative attitudes attached to condoms but had less impact on young people's perceptions of their own personal risk and therefore on their actions. There was evidence that young women in Cameroon delayed their first sexual experience, or were more likely to use condoms.

Results suggest that social marketing can change knowledge and attitudes relatively quickly, but needs more time to bring about changes in adolescent behaviour, such as consistent condom use.

Programme run by Population Services International (PSI) and funded by USAID

providers under a franchising agreement to provide youth friendly services. Vendors remain independent, but adopt a common logo as a quality mark. Social franchises draw together private or NGO providers and seek to maximize social aims — such as youth friendly health services. They may share training programmes and data, and agree common guidelines and quality standards.

Social franchises have been successful in expanding family planning services for adults. However, relatively few franchises currently target youth with reproductive health and HIV prevention services. Some of these have succeeded in providing high quality youth friendly services and have also succeeded in reaching large numbers of young people (see side panel). However, all such schemes rely to some extent on donor funding, and none has yet demonstrated its ability to become self-sufficient.

Social marketing and social franchising schemes encourage private clinics to increase services and to create new 'markets' for sexual and reproductive health services among youth. However, they can be controversial because they channel public money to the private sector, and because charges, even if subsidized and low, exclude low income and

### **Voucher schemes: Sex workers in Nicaragua**

A voucher scheme in Nicaragua is helping to reduce sexually transmitted infections amongst sex workers, and raise standards in private clinics. Vouchers, that entitle the holder to a test for STIs and to treatment, are distributed through outreach workers to sex workers. Clinics that join the scheme compete to attract customers from this marginalized group. Clinics have to reach high standards of care and keep within cost limits.

The vouchers offer choice, equity, quality and efficiency — since health purchasers only pay for vouchers that are redeemed. Over a period of seven years, more than 19,000 vouchers have been distributed, resulting in 7,000 consultations and the detection and treatment of 3,200 STIs. Amongst sex workers who visited a clinic more than once, incidence of STIs fell from 30% at the first visit to 17% on their most recent visit.

*Sources: Dr Anna Gorter, Review paper on evidence for using competitive voucher schemes, Montreux April 2003. Senderowitz, J., and C. Stevens. 2001. Leveraging the For-Profit Sector in Support of Adolescent and Young Adult Reproductive Health Programming. Futures Institute for Sustainable Development.*

### **KENYA: VOUCHERS OPEN DOOR TO REPRODUCTIVE HEALTH CHECK**

In Kenya, 'friends of youth' educators distribute vouchers to young people. The voucher entitles them to sexual and reproductive health care from any one of 12 youth-friendly providers who offer subsidized services. These providers already had a good reputation amongst young people. They received extra training and are paid according to how many vouchers they collect. About 2,800 vouchers were given out to young people in need, and those who did not use the voucher were followed up. As a result almost all the 2,800 vouchers were used, 55% of them for STI services, 15% for family planning and 15% for male circumcision.

This is part of the Nyeri Youth Health Project, a collaborative venture between the Population Council and the Family Planning Association of Kenya (FPAK).

no-income youth. Subsidized providers often include NGOs. The Gold Star Project in Egypt is an example of a social franchise that also includes public sector health clinics.

### **Voucher schemes**

Voucher schemes provide options for improving access to treatment for hard to reach groups. Vouchers distributed to the target group can be redeemed at private, public sector or NGO clinics that meet quality standards. Voucher schemes have three main benefits:

- vouchers can be precisely targeted to hard-to-reach groups,
- the voucher entitles the holder to a no-cost service, for which the provider receives an agreed fee from the public sector or donor,
- they make good use of public subsidy since providers only receive payment for work done.

Schemes which channel public money to the private sector have to be well run, with clear and rigorous accounting systems to prevent fraud or corruption. As public sector services become more responsive and can compete on quality, they too can join voucher schemes.

## 7 Making a difference in 2005 and beyond

**M**ost countries need to scale up their national responses to the AIDS pandemic amongst young people. There is widespread agreement about the elements that make up an effective package for health services to offer adolescents in the general population, and to vulnerable groups of adolescents. By harnessing the commitment of health workers and the energy of young people, health systems can make a significant contribution towards slowing the spread of HIV. Countries need to understand the importance of focusing on young people and of taking core interventions to scale, using strategies that have been shown to be effective. These steps will help countries to achieve their Millennium Development Goals and the UNGASS Declaration of Commitment on HIV/AIDS. In many countries, the implications of international and national commitments have not been fully considered by key sectors.

### Selecting a package of interventions

To define what needs to be done and to assess progress, every country has a need for baseline data about HIV and AIDS, risk behaviours and what young people do if they are concerned about their health. The health system has to select the package of interventions that will be delivered to adolescents, by whom and how. Within the health system there is need to describe effective strategies and the essential characteristics of services. In most countries services should include:

- information and counselling to reduce risky behaviour,
- interventions to reduce the harmful effects of risky behaviour,
- testing, treatment and care of adolescents with STIs, HIV or AIDS.

### Strategy group

A national strategy group is needed to integrate the work of the health sector with education, youth services, social services and other agencies and government departments. This group can identify and address policy issues that deter adolescents from seeking services. It can establish a means of obtaining information and advice from young people.

### Advocacy at national and local level

Advocacy can win support for policies to expand youth friendly health services, increase resources to improve the coverage and quality of such services, and remove legal obstacles that impede adolescents who need to access them. Youth can help to win support from political leaders, legislators, religious leaders, youth icons and the mass media.

## National assessment

Policy makers need good information. A national assessment of young people's sexual and reproductive health and the capacity of health services to meet their needs should at least include:

- Prevalence and incidence of HIV infection.
- Young people's knowledge and beliefs about HIV and risks.
- Trends in sexual initiation and adolescents' sexual behaviour.
- Levels of STIs amongst adolescents.
- High-risk behaviours (e.g. drug injecting) in vulnerable groups.
- Current health seeking behaviours of young people.
- Information and counselling services available to young people inside and outside the health system.
- Supplies of and delivery systems for condoms.
- Current strategies for reducing HIV transmission among injecting drug users and other vulnerable groups.
- STI treatment services for young people.
- HIV testing and counselling for young people.
- Treatment and care options for young people with HIV and AIDS.

### Information and counselling

The health sector provides information through clinics, health centres, and pharmacies, and mobilizes others to provide information broadly in the community, schools and the media. Guidance and counselling are widely available. Health systems give leadership and validate information.

### Reducing harm

Condoms for sexually active young people are widely available free and at low cost at clinics, health centres, community outlets, 'hang out' places, kiosks, vending machines, clubs etc.

Adolescents who inject drugs access harm reduction measures through specialized outreach teams, clinics, pharmacies etc. with links to cessation and rehabilitation services

### Diagnosis, treatment and care

Treatment and management of STIs for young people is widely available through a range of service providers.

Confidential and adolescent friendly HIV testing and counselling is available through clinics and outreach services.

Care at home and in hospitals for those who are infected and become ill.  
ARV treatment as appropriate.

**FIGURE 9**

### *Service model to meet young people's needs*

A 'gold standard' pattern of services meets the needs of all adolescents, and includes specialized services for those especially vulnerable to HIV. The health sector ensures that information is accurate and all health workers have basic counselling skills. Sexually active young people can obtain and use condoms. Those who inject drugs can obtain clean needles. Treatment and management of STIs is seen as an important health system responsibility. Adolescents access confidential HIV testing and counselling and follow up services. HIV prevention becomes part of all these services and there are links and referrals between them. Services for prevention, harm reduction and treatment are accessible by adolescents.

### Where will services be provided?

Health planners need to decide what will be provided at a rural health post, a health centre or a district hospital, and where outreach services are needed. Which staff will provide these services and what training, support and supervision will they receive? Service specifications should be drawn up for family planning, antenatal, postnatal and mother and child health clinics to ensure that they are accessible by adolescents and that staff are trained to deal with young people's concerns and health problems. NGOs and private providers should also be involved in expanding services. The health sector can set standards, train providers and ensure that the formal and the informal sectors pull in the same direction. Adolescents often seek services from pharmacies, school health services, market stalls or (in urban areas) via the Internet. Such health seeking behaviours by adolescents give important clues as to which services, in addition to government clinics and private practitioners, should be strengthened.

### The benefits of success

Historically, health systems have not been responsive to the needs of young people, and services for sexual and reproductive health have neglected this vulnerable group of the population. HIV and AIDS have created an emergency to which countries are struggling to respond. The health system has to make up lost ground to improve the coverage and quality of services and, at the same time, strengthen linkages with other sectors, such as education, social services, criminal justice and youth services. In many countries the health system is tackling this without significant increases in resources and under conditions where many health workers themselves have been affected by AIDS.

However, this task now has international support, a growing body of evidence for effective actions and a clear path towards making progress. By integrating HIV and AIDS services into existing services for adolescent sexual and reproductive health, and into services to reduce drug use amongst young people, health systems will create a platform for an overall improvement in quality and provision that will have an impact on HIV and AIDS, and beyond. Services that help young people protect themselves against HIV also protect adolescent girls against unwanted pregnancies and reduce levels of sexually transmitted infections. Linkages with other sectors, the engagement of young people in quality improvement programmes, and a focus on training health workers to deliver sensitive, competent and adequately resourced interventions will result in benefits for all services for young people. Success will help to turn the tide against HIV and AIDS and bring rewards beyond the AIDS pandemic, by rebuilding trust in health services and putting health providers in closer touch with adolescents, an important and neglected client group. The health system has nothing to lose and everything to gain by setting out on this journey. ■



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## About this publication

This publication is designed to provide policy makers and programmers with an overview of the health services' contribution to achieving the global goals on HIV/AIDS and young people. These goals were specified in the Declaration of Commitment agreed at the United Nations General Assembly Special Session on HIV and AIDS in June 2001, have been endorsed during the ICPD+5, and the UN General Assembly Special Session on Children, and are reflected in the Millennium Development Goals. This document is based on the outcomes of a global technical consultation organised in Montreux, Switzerland, in March 2003 by WHO in collaboration with UNAIDS, UNFPA, UNICEF and YouthNet. Readers can download the technical report from this consultation, *Achieving the global goals: access to services*, which provides a synthesis of discussions and background papers, as well as technical details and references (see below).

The response of health services to HIV/AIDS cannot be seen in isolation from their responses to a range of other diseases and problems that undermine young people's health. Additional information about how health services can contribute more effectively to young people's health and development can be found in the Consensus Statement from a global consultation on adolescent friendly health services, organised in Geneva in 2001 by WHO and a wide range of partners, and in the related advocacy document *Adolescent Friendly Health Services: an agenda for change*.

The response of the health system to HIV/AIDS has to be seen within the context of other priority interventions by other sectors to achieve the global goals and targets. Further information about these interventions can be found in the UNICEF, UNAIDS, WHO publication *Opportunities in Crisis*.

All these documents can be downloaded from the WHO website.

*Achieving the global goals: access to services*

[http://www.who.int/child-adolescent-health/publications/ADH/ISBN\\_92\\_4\\_159132\\_3.htm](http://www.who.int/child-adolescent-health/publications/ADH/ISBN_92_4_159132_3.htm)

*Consensus Statement on adolescent friendly health services*

[http://www.who.int/child-adolescent-health/publications/ADH/WHO\\_FCH\\_CAH\\_02.18.htm](http://www.who.int/child-adolescent-health/publications/ADH/WHO_FCH_CAH_02.18.htm)

*Adolescent Friendly Health Services: an agenda for change*

[http://www.who.int/child-adolescent-health/publications/ADH/WHO\\_FCH\\_CAH\\_02.14.htm](http://www.who.int/child-adolescent-health/publications/ADH/WHO_FCH_CAH_02.14.htm)

*Opportunities in Crisis*

[http://www.who.int/hiv/pub/prev\\_care/youngpeople/en/](http://www.who.int/hiv/pub/prev_care/youngpeople/en/)



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