

**Accelerating HIV prevention programming
with and for most-at-risk adolescents:
Lessons learned from the first global Technical
Support Group**

Kiev, Ukraine 24 – 26 July, 2006

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral treatment
CEE/CIS	Central and Eastern Europe and the Commonwealth of Independent States
CRC	Convention on the Rights of the Child
DFID	Department of International Development
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
IATT	Interagency Task Team
IDU	Injecting drug use
MARA	Most-at-risk adolescents
MARP	Most-at-risk populations
MTCT	Mother-to-child transmission
MTSP	Medium-term strategic plan
NGO	Non-governmental organization
RC	Regional Consultation
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TSG	Technical Support Group
UA	Universal access
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations country teams
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary counseling and testing
WHO	World Health Organization

Executive Summary

Only one in five people at-risk of HIV infection has access to basic prevention services.ⁱ Twelve percent of individuals at-risk of HIV infection have access to voluntary counseling and testing, 19% to harm reduction for injecting drug use, 24% to AIDS education, and 42% to condoms.ⁱⁱ According to UNAIDS, low coverage of essential HIV prevention services for populations most in need and the slow rate of scale-up to make services available is the central reason why recent HIV prevention efforts have shown insufficient results worldwide.ⁱⁱⁱ The World Bank analysis of national strategic plans shows that prevention efforts are not always prioritized or focused on the populations with higher risk and rates of HIV infection.^{iv}

Based on current evidence and a midterm review of UNICEF's medium-term strategic plan (MTSP), 2002-2005, UNICEF recognized that in a number of regions its HIV prevention programming was not effectively reaching adolescents who were most-at-risk and especially vulnerable to HIV infection. To strengthen UNICEF's support to national HIV programmes, the 2006-2009 MTSP set a target for country offices in low prevalence and concentrated epidemics to review, revise, and implement a comprehensive HIV prevention strategy for adolescents most-at-risk by 2007. As a member of the Interagency Task Team (IATT) on Young People and HIV, UNICEF proposed to its partners the establishment of a global Technical Support Group (TSG) to enhance the technical capacity of UNICEF offices and key partners to assist national HIV programs to increase effective and focused coverage of HIV interventions for adolescents most-at-risk.

The first global TSG on "Accelerating HIV Prevention Programming with and for Most-at-Risk Adolescents" was held in Kiev, Ukraine from 24 to 26 July, 2006. Based on successful programming experiences with and for most-at-risk adolescents, UN country teams (UNCT) from Pakistan, Vietnam, Syria, Brazil, and Ukraine were asked to attend the TSG to share their national HIV prevention response, including how an enabling and protective environment is being created for those most in need, gaps in services, and obstacles to scale up of coverage. Due to competing meetings, the Vietnam country team could not participate. More than 60 participants from over ten countries attended the global TSG meeting, including youth service providers working with most-at-risk adolescents; international experts; global resource people from partner organizations such as International Planned

Parenthood Federation, Save the Children UK, Global Youth Coalition on HIV/AIDS, and the International Harm Reduction Network; and four country delegations made up of representatives from civil society, governments, and UN agencies. (Annex 1, participants list)

The main objective of the first TSG meeting was to create a global resource group to assist UNICEF offices and key partners to more effectively support national HIV programmes to reach and work with most-at-risk adolescents (e.g., sex workers, injecting drug users, men who have sex with men, and prisoners). At the TSG meeting, it was determined that the global TSG will have several functions. First, it is a resource network by which UNICEF country offices and key partners in regions experiencing low-prevalence / concentrated HIV epidemics can exchange practical lessons on HIV programming and receive ongoing technical guidance and support on how to accelerate their countries' national prevention response for and with most-at-risk adolescents. Second, as the four UN country teams (UNCT) were expressly selected because of their prioritization of HIV prevention efforts for and with most-at-risk adolescents, they will help guide and stimulate broader regional response. In other words, as the four UNCT benefit from the continuing exchange of ideas, lessons learned, technical know-how, and other resources of the TSG network, they will in turn pass on this knowledge to their counterparts in their respective regions. One of the ways in which this can be done is to ensure the focus on most-at-risk adolescents is integrated into existing regional coordination structures or through the creation of regional TSG mechanisms on most-at-risk adolescents. These can work analogously to the global TSG, creating resource networks that draw on differing perspectives, experiences, and insight, and can match the cadre of country-level global TSG members charged with disseminating programming guidance on most-at-risk adolescents with their counterparts in non-TSG countries.

To ensure that the work of the global TSG was in line with and reflected the community-level prevention response, a pre-TSG Regional Consultation (RC) with adolescents who work with most-at-risk adolescents was conducted prior to the TSG meeting. In attendance were twenty-three young people representing seven countries in the Central and Eastern Europe and the Commonwealth of Independent States (CEE-CIS) region, one young person from the United States, and three from Brazil, as well as six resource

people from UNICEF, UNFPA, and WHO. The outcomes of the RC were presented at the TSG and served as a springboard to generate discussion. The youth service providers were asked to identify HIV activities for most-at-risk adolescents which they believe are missing or are poorly implemented. Five priority areas were identified, as well as specific actions that youth service providers can contribute to each area. (Annex 2, youth RC outcome PowerPoint)

The five priority areas are:

- Improve research and evidence
- Improve legislation, policy, and implementation
- Improve access to and the quality of comprehensive services
- Reduce stigma and discrimination
- Improve the coordination of services

The TSG peer reviewed the four country HIV responses, highlighted positive aspects of each, and offered suggestions by which to improve targeted HIV programming for most-at-risk adolescents.

Youth service providers in attendance throughout the RC and TSG presented feedback on the TSG process and on each country's national response (Annex 3, youth feedback PowerPoint).

International experts (e.g., IATT on Young People and HIV members, social scientists, and representatives of international NGOs) outlined what they believed were positive approaches and lessons learned, as well as issues which need further discussion, suggestions as to how to translate TSG outcomes into actions, and how they can provide technical assistance to national teams (e.g. linking Hepatitis C (HCV) to HIV prevention, the development of effective "one stop shop" models, actions for scaling up harm reduction interventions) (Annex 4, NGO feedback PowerPoint).

With this information in hand, country teams devised time-bound action plans with short, intermediate, and long-term goals, as well as outlined key partners with whom to work (Annex 5, country action plans).

The UNCT have been requested to report the outcomes of the TSG to the UN Theme Groups in their respective countries. At the second TSG meeting, proposed for Fall 2007, the TSG will gauge the progress country teams have made toward implementing their action plans, as well as the type and extent of intra-regional knowledge sharing. In the interim, the TSG is available to offer technical assistance, in a variety of areas, to the UNCT to strengthen their national HIV response with and for most-at-risk adolescents. Though we are still in the process of determining how best to use the TSG's collective experiences, expertise, and resources to

strengthen HIV programming for most-at-risk adolescents, by creating partnerships and networks, the TSG country teams are certain to better understand the programming needs of most-at-risk adolescents, have a place to turn to for technical assistance, and be able to use their expertise to strengthen targeted HIV programming in their countries and throughout their regions.

Introduction¹

According to the UNAIDS publication, *Practical Guidelines for Intensifying HIV Prevention*, “the key to prevention success is to begin with (i.e. to prioritize) those which will have the most direct impact on epidemic spread in the specific country in question.” The paper calls on national governments to prioritize “epidemiologically important populations and settings” and to recognize that governments “...cannot, and do not need to provide...services to the entire population, or with equal intensity.” These priority populations, which for a variety of biological and behavioral reasons put them at a differentially higher risk of acquiring and/or transmitting HIV (relative to others in their context) globally, are sex workers and their clients, injecting drug users, men who have sex with men, and prisoners.^v Evidence-informed, well-designed HIV prevention programmes among these populations have proven decisive in slowing and even stopping the epidemic in its track.^{vi}

Although adolescents are a substantial sub-set of these four key populations (as well as vulnerable populations such as street-involved youth) and despite evidence that the combination of being young and a sex worker or an injecting drug user can increase risk of HIV infection,^{vii, viii, ix, x} research and evidence on the needs of adolescents most at risk, protective policies and legislation for adolescents, adolescent-specific HIV interventions, and adolescent-friendly social and health services are often not prioritized by national responses. Unlike adult high risk populations, most-at-risk adolescents lack the experience to mitigate harm related to risk behaviors and to access and navigate social and health services, if legally able to do so. The World Health Organization estimates that 70% of premature deaths among adults are largely due to behaviour initiated during adolescence.^{xi} Notwithstanding, some policy makers question the need for interventions designed exclusively for adolescents, especially for specific subgroups; interventions that take into account age, gender, risk behaviors, context, youth sub-culture, the underlying causes of vulnerability, and the period of transition, rapid development, and experimentation, that defines adolescence itself.

The majority of national HIV programmes recognize young people are a priority population, but evidence-

based prevention efforts focused specifically on most-at-risk adolescents still need to be strengthened. If young people are truly at the center of the HIV epidemic and are the key to changing the tide of infections, as is repeatedly declared, then HIV interventions for adolescent in general and for most-at-risk and especially vulnerable adolescents in particular should be at the top of the global agenda.

It is clearly evident that Brazil, Pakistan, Ukraine, and Syria’s national programmes are in the process of a concerted paradigm shift, re-directing most of their prevention resources and efforts to reaching most-at-risk adolescents and decreasing structural and social vulnerabilities. There is still a need for national strategies to consider the geographic locations of where risk behaviors are occurring, where vulnerability is most acute (e.g., institutional settings), and to focus interventions in these settings. Though, measuring the dynamics around gaps in adolescent coverage and barriers to improved access has proved particularly challenging, country teams grasp that the majority of the most-at-risk adolescents in their respective countries are not being reached by HIV prevention programmes and there is more recognition on what are the gaps in services and the obstacles to scale up of coverage than ever before.

One of the overarching themes at the TSG was the importance of government support of and commitment to the national HIV response for

Low Level Epidemic

Principle: although HIV infection may have existed for many years, it has not spread to significant levels in any sub-population. Recorded infection is largely confined to individuals with higher risk behaviour: e.g. sex workers, injecting drug users, men who have sex with men. The epidemic state suggests that networks of risk are rather diffuse (with low levels of partner exchange or use of non-sterile drug injecting equipment), or that the virus has been introduced only very recently.

Numerical proxy: HIV prevalence has not consistently exceeded 5% in any defined sub-population, and is less than 1% in pregnant women (proxy for the general population).

Concentrated Epidemic

Principle: HIV has spread rapidly in at least one defined sub-population, but is not well established in the general population. The epidemic state suggests active networks of risk within the sub-population. The future course of the epidemic is determined by the frequency and nature of links between highly infected sub-populations and the general population.

Numerical proxy: HIV prevalence consistently over 5% in at least one defined sub-population. HIV prevalence below 1% in pregnant women in urban areas.

Source: UNAIDS, *Practical guidelines for intensifying HIV prevention: towards universal access* UNAIDS, Geneva, 2007.

¹ This document is not intended to be a play-by-play account of the TSG meeting, rather the aim is to present reflections on the five priority areas and common themes around obstacles to HIV programming for most-at-risk adolescents faced by the four country delegations.

most-at-risk adolescents, including the allocation of resources and the development of protective policy and legislation. In Brazil, for example, a comprehensive, multi-sectoral national response, including free distribution and wide-availability of condoms, universal access to anti-retroviral treatment, HIV prevention education in schools, access to voluntary counseling and testing (VCT) and medical services for adolescents 14 years and over, and broadly implemented needle and syringe exchange programs has helped to contain the country's epidemic while creating a protective environment for those most-at-risk. Ukraine's "National Road Map" which identifies injecting drug use as the top priority in the national response and outlines coverage targets for most-at-risk populations, youth-friendly poly-clinics established by the Ministry of Health, and the state-run needle-exchange and counseling points ("Trust") demonstrates that the government's major thrust to curb its growing epidemic is to provide targeted interventions to adolescents most at risk. A government's commitment to the development and implementation of such measures as evidenced-informed policy and legislation, advocacy campaigns, and adolescent-friendly health and social services, can help decrease risk factors and strengthen protective factors and allow for the creation of an enabling and protective environment.

Despite epidemiological differences in the various countries, **several common themes emerged at the global TSG**, which reinforced the potential for inter-country collaboration and knowledge-sharing.

1. *Research and evidence*

While there is a greater understanding of the comprehensive HIV needs of most-at-risk adolescent than there was a decade ago, there is still an urgent need for data to be collected on adolescents and, if available, for it to be disaggregated by, among other things, age, sex, and risk behaviour, as well as data that distinguishes between individual and contextual factors that increase an adolescent's probability of engaging in risk behaviors. In other words, data is needed on who are the most-at-risk adolescents? What are the behaviours that put them at risk of being infected or passing infection to others? Where are the settings in which risk behaviors occur or are promoted?

2. *Policy and legislation*

The need to strengthen policies, legislation, and advocacy strategies around stigma and discrimination, alternatives to incarceration and institutionalization, human rights, criminalization of drug user, ensuring medical confidentiality for

adolescents, and decreasing the age of consent to social and medical services is acknowledged by all TSG members. The social and legal status of marginalized populations can create situations in which individuals have little control over the conditions in which they work and live, and present obstacles to the use of health and social welfare services. Research and evidence on the situation and needs of most-at-risk adolescents should be used to advocate for the reform, development, and/or enforcement of legislation and policy, which addresses the social and structural vulnerabilities and risk behaviors of these populations.

3. *Comprehensive health and social services*

Most-at-risk adolescents face an array of challenges accessing social and health services. When services are provided for them, it is preferable that they be delivered under one roof, with as few referrals as possible, include a mobile, outreach component to increase coverage, and offer harm reduction, counseling, and a minimum package of HIV-related services (e.g., distribution of condoms, treatment of STIs, education, and other context-specific services). Services need to address not only their multiple risk behaviors, but also their more immediate needs such as shelter, hunger, and security. All of which should be provided in a safe, protective, non-judgmental setting where most-at-risk adolescents are given the opportunity to rest and interact with their peers.

4. *Stigma and discrimination*

Marginalized populations are often discouraged from accessing services by health care providers, teachers, social workers, psychologists, and the community at-large due to stigma and the resulting discrimination. For most-at risk adolescents this is compounded by their lack of experience navigating services and, in some countries, legal obstacles to using them. Much discourse at the TSG meeting centered on developing the capacities of parents, families, community stakeholders, religious leaders, and service providers to create a protective environment which de-stigmatizes "risk groups" and provides the space in which youth can talk openly about risk behaviors, can receive accurate and appropriate information from youth and adults in their community, and can access services without fear of being maltreated. It was also recognized that a spectrum of services may be necessary to address the diverse needs and risk behaviours of youth.

5. Coordination of services

Establishing, maintaining, and coordinating partnerships can be challenging. UNCT country offices can play a strategic role in synchronizing and harmonizing the actions of government sectors and civil society working on HIV prevention with and for most-at-risk adolescents by bringing partners together to minimize duplication of efforts and gaps in services, ensure all activities are evidence-driven, and to help determine the most effective role for each partner. Moreover, UNCT can advocate, facilitate, and monitor the active participation of most-at-risk adolescents in the development and/or tailoring of the national HIV response.

Improve research and evidence

There is an urgent need for more research and evidence, qualitative and quantitative research, on the situation and needs of adolescents in general and most-at-risk and especially vulnerable adolescents in particular. There are obvious challenges related to collecting data on most-at-risk and especially vulnerable adolescents that demand innovative youth-friendly research methods (e.g., tape recorder-assisted interviewing), as well as deliberation on how and where the data is being captured. Data on the dynamics of risk behaviors (e.g., the context in which they occur, types of drugs being used, multiple risk taking, etc.), structural determinants of vulnerability, and access to and quality of health services are scant even for adult risk groups. It is evident that governments need to focus more effort on collecting this type of data and, if they are, it is rarely disaggregated by age and sex.

The lack of disaggregated data makes it nearly impossible to understand the magnitude and dynamics of the HIV epidemic and sub-epidemic, to target and prioritize interventions, to allocate resources appropriately, and to monitor and evaluate interventions. It is important to note, however, that though disaggregated data is critical to understanding the drivers of epidemics, according to UNAIDS "...all countries have enough information to support the basics of prevention planning: defining the epidemiologically important populations and places, and the "who," "what," and "where" for populations most in need." And, therefore, "...the desire for detailed data on HIV should not delay review and refinement of prevention activities."^{xii}

The UNAIDS *Guide to monitoring and evaluating national HIV prevention programmes for most-at-risk populations [MARP] in low-level and concentrated epidemics* outlines measurement methods and

recommended key indicators for most-at-risk populations (see Appendix A), including indicators of programme coverage, knowledge, and HIV-related risk behaviors. The guide also provides monitoring and evaluation tools, which can be used by national and sub-national level partners to steer research and programme planning. It also delineates the role of sentinel surveillance, estimations of population size, and rapid assessments, as well as fundamental procedures to ensure protection of human rights, confidentiality (e.g., coding), safety, and security when conducting any research on most-at-risk populations. The MARP guide is meant to supplement the 2005 UNAIDS publication; [Monitoring the declaration of commitment on HIV/AIDS: Guidelines on construction of core indicators](#), which charts core indicators of national commitment such as HIV-related expenditures and national policies. Similarly, the [National AIDS programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people](#) provides guidance for the selection of indicators and for monitoring and evaluating policies and programmes specifically for HIV prevention among young people and outlines core programmatic, determinant, behavioral, and impact indicators for generalized, concentrated, and low prevalence epidemics.

Improve research and evidence/Resources*

- [Behavioral surveillance surveys: Guidelines for repeated behavioral surveys in populations at risk of HIV](#) (Family Health International, 2000)
- [Priorities for local AIDS control efforts: A manual for implementing the PLACE method](#) (The Measure Evaluation Project, 2005)
- [Rapid assessment and response: Adaptation guide for work with especially vulnerable young people](#) (World Health Organization, 2004)
- [Ethical approaches to gathering information from children and adolescents in international settings: Guidelines and Resources](#) (Pop. Council, FHI, 2005)
- [HIV/AIDS prevention and care among especially vulnerable young people: A framework for action](#) (WHO, DFID, 2004)
- [Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003](#) (USAID, UNAIDS, WHO, CDC and the POLICY Project, 2004)
- [The National AIDS programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people](#) UNAIDS, 2004)
- [Monitoring the AIDS Pandemic, Reports from the MAP Network](#)

Though a number of examples of country-level projects were outlined at the TSG meeting, few have been adequately evaluated. Little or no distinction can therefore be made between which interventions are ineffective and which effective. There is a call for national programs to review the knowledge base, especially in their specific regions, in order to categorize and prioritize effective interventions for most-at-risk adolescents.² This will be essential to determine which interventions should be taken to scale and will help governments make the most use of limited funds to achieve global goals and targets. *Steady, Ready, Go* assesses HIV prevention interventions for young people, and from the mass of evidence prioritized a range of interventions, including youth-friendly health services, and media interventions, based on their effectiveness.³ The goal of the review was to determine which interventions work best with respect to increasing knowledge and skills, reducing vulnerability, and decreasing HIV prevalence among young people. (See [WHO's Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries](#).) The review noted that evaluations of HIV interventions for most-at-risk young people are scarce and stressed the need for interventions to be well planned, to collect operational data, and have a strong evaluation component.

In June 2003, the Committee on the Rights of the Child issued General Comment No.4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child which states:

"Health-care providers have an obligation to keep confidential medical information concerning adolescents, bearing in mind the basic principles of the Convention. Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult's confidentiality. Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment." (para. 11)

As has been done in the CEE-CIS region, an inter-country consultation with UNAIDS regional monitoring and evaluation officers and HIV officers was suggested as a means by which countries can discuss their monitoring and evaluation strategies related to most-at-risk and especially vulnerable adolescents. UNICEF regional offices can help facilitate inter-country consultations with key

2 While there is some evidence on the effectiveness of HIV interventions for older groups of sex workers, men who have sex with men, and injecting drug users, little of this evidence explores whether the intervention would prove effective with younger populations or how approaches need to be tailored to address the specific concerns of adolescents.

3 See [Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries](#).

countries from their region, partners, and research experts.

Of the five priority areas, improving research and evidence is conceivably the key to the successful adoption and implementation of the four other priority areas. The national responses should strive for *data-driven* development of: policy and legislation; quality services; coordination mechanism based on the effectiveness of organizations to implement activities; and advocacy strategies to reduce stigma and discrimination.

Additional learning points:

- The Ukraine delegation included the prevalence of sexually transmitted infections (STIs) in their national response overview. This is noteworthy as testing and treatment for STIs may be a more acceptable entry point to HIV prevention interventions than HIV testing.
- Syria is collecting data on the children of sex workers (this is significant as the children of sex workers and drug users are often not included as vulnerable groups). There is some evidence that suggests that children of sex workers enter the sex trade themselves and, thus, some reflection should be given to collecting data on children of most-at-risk and especially vulnerable populations.
- With more and more people having access to ART, collecting national data on the number of AIDS cases or deaths instead of the number of HIV cases can lead to a false assumption that HIV incidence is declining. Since new patterns of infections will not be detected, programming based on AIDS cases often will not reflect the current epidemiology of the epidemic.⁴

4 Reporting on AIDS cases is based on AIDS case detection used by health services for a number of years to project backwards to estimate the year of initial infection. Data based on AIDS cases, which shows trends (e.g., decrease in AIDS cases) and makes statements related to risk behaviors and/or risk groups is not accurately reflecting the current HIV situation, but on the causes of infections 8-10 years from the date of the reported AIDS case. Determining HIV prevalence, from sentinel surveillance, as opposed to incidence, has the similar issue, as time of infection cannot be determined. This is why infections among young people 15-24 years of age are used as a proxy indicator to determine the rate of new infections. Lastly, if behaviours are highly stigmatized, whether national programmes collect the number of AIDS cases or HIV incidence and prevalence rates, often the data will not reflect the true face of the epidemic or sub-epidemic because individuals might be fearful to report their risk behavior(s).

Improve legislation, policy, and implementation

As noted earlier, research and evidence on the situation and needs of most-at-risk adolescents should be used to advocate for the reform, development, and/or enforcement of protective legislation and policy. Brazil, which, out of the four country delegations has perhaps the best laws around privacy and confidentiality, age of consent, and access to HIV testing, prevention, care, and treatment, can offer some examples of policies and lessons learned in reforming and implementing legislation. (See: [Human Rights and Legislation concerning people with HIV/AIDS in Brazil.](#))

Advocacy strategies that include documenting violations of laws need to be implemented to ensure the proper application of policies and legislation and to ensure law enforcement is held accountable. The Way Home Charitable Organization in Odessa has had some success documenting human right infringements by law enforcement and medical establishment toward street-involved youth to advocate for healthier practices and cooperation.

Improve legislation, policy, and implementation / Resources*

- [The UN Convention on the Rights of the Child](#)
- [Committee on the Rights of the Child, General Comment No. 4, Adolescent Health and Development](#)
- [Committee on the Rights of the Child, 32nd Session, HIV/AIDS and the rights of the child](#)
- [UNAIDS Global Reference Group on HIV/AIDS and Human Rights, Third Meeting, Geneva, 28-30 January 2004, Issue Paper, HIV Testing of Specific Populations: Children and Adolescents](#)
- [The Center for Alternative Sentencing and Employment Services \(CASES\)](#)
- [Human Rights Watch, HIV/AIDS and human rights](#)
- [The Policy Project](#)
- [The Open Society, Justice Initiative](#)
- [What's preventing HIV prevention? Policy statement to UNAIDS.](#) (International HIV/AIDS Alliance, 2004)
- [Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience](#)

There was a consensus among participants that the policies and legislation governing privacy and confidentiality and the age of consent to social and medical services are obstacles to uptake of HIV prevention services. Medical confidentiality is crucial to adolescents in general and to most-at-risk adolescents in particular. In some countries, for instance, state facilities providing treatment for drug misuse are required to record names and, therefore, drug users avoid seeking care or treatment out of fear that health care workers might report their use to the police. While it is recognized that parental and other family involvement is desirable, many

minors will not access services if they need parental permission. Moreover in countries where stigma and discrimination is an issue, parents may not be the best advocates for their adolescent children. Little research is available on the relationship between the legal age of consent for social and medical care and uptake of services. It would be interesting to compare the effect on the uptake of services in countries such as Pakistan and Ukraine where the age of maturity is 18 and 17 years of age, respectively, with Brazil where the age of consent is 14 years of age.

Establishing policy and legislation for minors' consent to private and confidential health care is a challenging issue. The UN Convention on the Rights of the Child (CRC), acknowledges the capacity of adolescents less than 18 years of age to make decisions for themselves "in a manner consistent with the evolving capacities of the child" (Article 5). There is ongoing debate concerning the interpretation of evolving capacity and whether providers can objectively assess the capacity of adolescents. Along these lines, in the United States some states have adopted the "mature minor rule" that allows minors who are deemed intelligent and mature enough to understand the consequences of medical treatment to consent without obtaining parental permission.⁵

Mechanisms by which most-at-risk adolescents understand both the international treaties and national legislation that govern their rights and access to social and health services, as well as how to claim their rights, needs to be developed and supported. UN agencies can have a key role in disseminating this information. Police, health care providers, teachers, and other professionals must understand the international policies and national laws which outline their ethical and professional responsibilities to most-at-risk populations, as well as to adolescents living with HIV. Trainings to these sectors, especially to law enforcement, on national legislation, international treaties, HIV/AIDS education, and protection of human rights can increase capacity, garner programme support, and help build partnerships. During the Regional Consultation, several youth service providers from Ukraine remarked that trainings and testing should be implemented not

⁵ In the United States, many states authorize minors to make decisions about health care such as testing and treatment of STIs, treatment of alcohol and drug use, and HIV testing and treatment. For an example of public health legislation, see New York State's public health laws, specifically article 2781 and 2305.
<http://www.health.state.ny.us/nysdoh/rfa/hiv/full63.htm>
http://www.wadsworth.org/labcert/regaffairs/clinical/27-F_1_99.pdf

only early in professional training (e.g., medical and nursing school), but also integrated into ongoing and periodic trainings such as at licensing and re-certification exams. Exchange of experiences, training materials and other technical resources between countries, such as Pakistan's training curriculum with religious leaders and Brazil's training on legislation around access to services for institutionalized youth, as well as Syria's efforts in working with immigration and travel authorities are perhaps some of the simplest methods by which UN country teams can support each other.

In many countries there is an immediate need to reform policies and legislation around institutionalization and incarceration of children and adolescents. Violations of children's rights in institutions and prisons are widespread. In some circumstances, the wholesale abolition of the institutionalization system might be unrealistic. Therefore, national efforts must advocate for a prevention-oriented juvenile justice system and alternatives to incarceration and institutionalization (See: [The Center for Alternative Sentencing and Employment Services](#)), while simultaneously delivering prevention activities in state-run facilities to ensure adolescents are equipped with HIV information, risk reduction skills, and referrals to transitional residential care when reintegrating back into the community.

Additional learning points:

- According to UNAIDS, when framing HIV testing policies for adolescents, governments should consider two overarching principles of the CRC (1) the best interests of the child, and (2) a child's right to participate in decisions affecting his or her life as a function of his or her evolving capacities.
- In Pakistan, Project Smile offers registration cards to street kids in their program to present to law enforcement, which has been shown to provide youth with a sense of empowerment and has even warded off police harassment.

Emerging Issues

- Varying patterns of drug use, including crack cocaine, and amphetamines (crystal meth or speed) re-emerging and the popularity of inhalants and solvents as well as the transition to injecting drug use.
- The distribution of Narcan, a narcotic antagonist used to treat overdoses, to injecting drug users.
- The use of the internet to tap into networks of men who have sex with men.
- Some research indicating that children of sex workers enter the sex trade themselves.
- High incidence of the hepatitis C virus among young injection drug users.
- Children of sex workers and drug users should be considered vulnerable groups.

- Where adult sex workers have organized, they have been key partners in identifying sexually exploited children as well as effective exit strategies for them out of sex work. Sex workers' rights advocates call for the decriminalization of sex work (the removal of laws against sex work), which would allow them to work as any other service providers, to organize, and to choose how to manage their services. Where sex work is decriminalized, sex workers pay income taxes at the same rate as any other small business owner. Advocates of decriminalization argue that legalization is putting the control of sex work in the hand of governments. Laws regulate the lives of sex workers: prescribing health checks, registration with law enforcement, and regulate where they may or may not live and work. TSG meeting participants noted that under legalization, the control of the sex trade is often in the hands of law enforcement, and, in many countries, there is a well documented history of exploitation and abuse by the police. Therefore, it appears that by legalizing rather than decriminalizing sex work, one exploitive system might be exchanged for another.
- Despite the interplay between injecting drug use and HIV and the proven strategies for reducing HIV transmission associated to injecting drug use, most countries have failed to introduce comprehensive programmes to mitigate drug-related harm, including interventions intended to reduce the demand for drugs. Regardless of the availability and quality of harm reduction programs, discriminatory policies and practices such as incarceration and/or forced institutionalization reinforces stigma, makes drug users, especially adolescent drug users, reluctant to access services, and can have the unintended result of accelerating the epidemic. Evidence-informed advocacy strategies for the reform of drug policies for drug-related crimes should be supported. Evidence shows that stringent drug policies do not deter drug use and may have the unintended effect of increasing crime, use of syringe sharing, and HIV transmission. Annex 6 outlines the "how", "what", and "why" of an HIV prevention strategy for adolescent injecting drug users.

Improve access to and the quality of comprehensive services

HIV prevention services for most-at-risk and especially vulnerable adolescents need to address, as a whole, the complex issues faced by these population, including poverty, homelessness, hunger, security, discrimination, and general mental and physical well-being. A comprehensive approach to HIV prevention with and for most-at-risk adolescents needs to focus on reducing their risk behaviors by addressing their basic needs, which has the dual aim of reducing risk and facilitating their access to services.

Basic needs such as food and shelter are often the reason why most-at-risk adolescent initially access these types of services. Though the need for food and shelter might bring them in the door, what keeps them returning is a non-judgmental, enabling and protective environment where each individual is respected and treated with dignity. Once connected (i.e., “in the door”), adolescents can access a variety of social, medical, and legal services under one roof. For example, the Streetwork Project, a drop-in center for the most street-involved youth 13-23 years of age in New York City, offers a range of free services such as youth-specific needle exchange; medical, legal, and psychiatric services; individual and group counseling; advocacy help in obtaining transitional housing; HIV prevention; HIV, STD, and Hepatitis C testing; as well as hot meals, bag lunches, showers, clothing, and the opportunity to socialize with peers in a safe environment. A variety of group activities are also provided by the Streetwork Project, which, when combined with the other services, provides multiple ways for most-at-risk adolescents to “plug into” the Project.

Outreach and/or mobile services are critical components of the “one-stop shop” models in order to provide interventions where risk behaviours are occurring and to increase coverage. As has been documented in Porto Alegre, Brazil, decreasing time adolescents spend “on the street” can lessen the occurrence of risk taking behaviour. Consequently, interventions such as night shelters for vulnerable adolescents that decrease exposure to environments in which risk taking behaviour might occur should be considered.

The “minimum package” of services to provide most-at-risk adolescents will be context-specific and will depend on available resources, but should aim to mitigate harm related from risk behaviour(s). For injecting drug users, for example, activities should be geared toward an individual’s injection and drug

use practices, addressing HIV and Hep C transmission, bacterial infections/vein care, and substitution and maintenance therapy. Services must be confidential, private, non-judgemental, and adolescent-friendly.

Several entry points to services were discussed; STI testing (e.g., Syphilis), treatment, and care as a doorway to HIV testing and prevention, since it might be less stigmatized. Likewise, Hepatitis C testing and prevention as a possible entryway to HIV testing and prevention needs to be explored (as does the integration of Hepatitis C into existing HIV prevention sites). (Annex 7).

Improve access to and the quality of comprehensive services/Resources

- [At the crossroads: Accelerating youth access to HIV/AIDS interventions](#) (UNAIDS Inter-Agency Task Team on Young People, 2004)
- [Making sex work safe](#) (Cheryl Overs and Paulo Longo, 1997)
- [HIV prevention in the age of expanded treatment access](#) (Global HIV Working Group, June 2004)
- [Protecting young people from HIV and AIDS: The role of health services](#) (WHO, 2004)
- [Adolescent friendly health services: An impact model to evaluate their effectiveness and cost](#) (Family Health International, 2002)

Harm Reduction Resources

- [www.ihra.net](#) (International Harm Reduction Association and Regional Networks)
- [www.soros.org/harmreduction](#) (International Harm Reduction Development organization)
- [www.canadianharmreduction.org](#) (Canadian Harm Reduction Network)
- [www.harmreduction.org](#) (Harm Reduction Coalition)
- [www.idpc.info](#) (International Drug Policy Consortium)
- [www.cfdp.org](#) (Canadian Foundation for Drug Policy)

Hepatitis C Resources

- <http://www.cdc.gov/mmwr/PDF/rr/rr5201.pdf> (Centers for Disease Control and Prevention)
- <http://www.cdc.gov/ncidod/diseases/hepatitis/resource/brochures.htm> (CDC material in English, Spanish, Vietnamese, Russian, and Ukrainian)
- <http://www.hepatitis.va.gov/> (Department of Veterans Affairs)
- <http://www.liverfoundation.org/> (American Liver Foundation)
- http://www.hcvadvocate.org/hepatitis/hepatitis_C.asp#3 (HCV Advocate; materials in a variety of languages)
- http://hivandhepatitis.com/hep_c/hepc_bas.html (HIV and Hepatitis issues)

There has been some debate concerning the amount of resources being allocated to HIV prevention, treatment, and care as compared to other health issues. Health infrastructures, however, can benefit by the prevailing public interest on preventing and treating HIV/AIDS. The recent re-energized global focus on universal

access should be seen as an opportunity to integrate and coordinate scale-up of HIV prevention, care, and treatment programs, which would, ultimately, strengthen national health infrastructures. Mathematical modelling has shown that when prevention and treatment are scaled up jointly the benefits in terms of new infections and deaths are greatest.⁶

Under the most logical assumption, the incremental costs of risk reduction skills training, for example, is outweighed by the medical costs saved. Not only is risk reduction training effective in averting HIV transmission, but also cheaper than HIV treatment, care, and support. The UNAIDS, 2006 Report on the Global AIDS Epidemic, states: “Globally, it is estimated that a response focusing solely on treatment would result in only 9 million averted new infections. In contrast, simultaneous scaling up of both preventions and treatment would avert 29 million new HIV infections by the end of 2020.”

Features of comprehensive service models for most-at-risk adolescent:

- low threshold
- strengths-based
- non-judgmental and an enabling and protective environment
- harm reduction philosophy
- confidential, private, and legally accessible
- address basic needs such as poverty, hunger, security, and hygiene
- youth-specific services, including needle and syringe exchange, voluntary HIV and STI testing, STI treatment, counseling, psychiatric services, and medical and legal services
- outreach and mobile services
- consider the diversity of youth sub-culture
- offer recreational and leisure activities (e.g., art and sports)

Additional learning points

- As the “one-stop stopping” models demonstrated, an enabling and protective environment is the product of an organizational culture in which everyone from the project director to the cook embraces and incorporates it into their daily encounters with clients.
- Seemingly minor gestures as providing street children with their own toothbrush and a personal space to store it or a registration card are small but powerful steps to providing a sense of belonging and agency.

- Often the managers of sex work sites are the gatekeepers to the safety, security, and health of the sex workers they manage. Therefore, services to sex workers should consider strategies and activities aimed at engaging managers of sex work businesses.
- Programmes cannot forget to include sexual risk reduction for injecting drug users.
- As many of the youth service providers noted, programme managers cannot forget to consider the pleasure of sex, which is very often missing in HIV prevention efforts.
- Innovative “exit strategies” such as one-year vocational training programs are needed for most-at-risk adolescents transitioning from institutions and prisons, and when they age out of adolescent-dedicated services.
- There has been a tendency for country programmes to support the development of voluntary counseling and testing programs when, in many cases, most-at-risk adolescents have limited capacity to access these types of services. There is need for national programmes to develop more inventive models such as an outreach counseling and testing model, which builds in referral, care, and treatment interventions.
- It is important to note that UNICEF’s 2006-2009 midterm strategic plan is not promoting a generic life skills based education, but a risk aversion and risk reduction curriculum that can be delivered in various settings (in and out of schools, health facilities, etc.). A generic life skills curriculum, which is delivered in schools, may be appropriate for high prevalence countries as a long-term strategy as it takes time to develop and ensure quality implementation. However, in the short-term, the aim is to reach those adolescents most-at-risk with a “minimum package” of risk reduction information, skills, and services.

Reduce stigma and discrimination

In many countries, a culture of silence surrounds sexuality, reproductive health, condom use, and harm reduction for injecting drug use. Since HIV prevention centers on these issues it is often controversial and uncomfortable for many communities and governments. The testimonies voiced at the TSG reaffirm that stigma and the resulting discrimination remains the greatest obstacles to HIV prevention.

Much discourse at the TSG meeting centered on developing the capacities of parents, families,

⁶ Salomon JA, Hogan DR, Stover J, Stanecki KA, Walker N, et al., (2005) Integrating HIV prevention and treatment: from slogans to impact, *PLoS Med* 2:e16.

community stakeholders, religious leaders, and service providers to create a protective environment in which youth can talk openly about risk behaviors, can receive accurate and appropriate information from peers and adults in their community, and can access services without fear of being maltreated or fear of negative consequences. Parents, as well as community and religious leaders are perhaps the most important conduits of information on risk behaviors and HIV prevention since they are generally trusted and respected by youth. The UN Convention of the Child (Article 14) provides that “State parties shall respect the right of the child to freedom of thought, conscience and religion” which includes freedom to evaluate whether to observe religious restrictions to methods of contraception. Therefore, in theory, parents or guardians cannot veto their children’s access to medical procedures based on their own conscience or religious beliefs.

“The United Nations Commission on Human Rights, in its resolutions 19, has declared that the term ‘or other status’ in the various international human rights instruments should be interpreted to cover health status, including HIV/AIDS. The United Nations Commission on Human Rights has further confirmed that discrimination on the basis of HIV/AIDS status (actual or presumed) is prohibited by existing human rights standards.”

“A human rights framework provides avenues for people who suffer discrimination on the basis of their actual or presumed HIV-positive status to have recourse through procedural, institutional and monitoring mechanisms. Since HIV/AIDS-related discrimination constitutes a violation of human rights, persons who discriminate are accountable by law and redress can be provided, where appropriate. Procedural, institutional and other monitoring mechanisms exist to ensure accountability at national, regional and international levels. At national level, these include courts of law, national human rights commissions, ombudsmen, law commissions and other administrative tribunals.”

Source: A conceptual framework and basis for action: HIV/AIDS stigma and discrimination, UNAIDS, 2002.

As the UNCT from Pakistan and Syria pointed out, religious leaders can play a catalytic role in addressing stigma. Estimates suggest that about 80 percent of the world’s population identifies with some established religion. Religious leaders can alter the ways in which communities view sex or drug use and, subsequently, indirectly assist in the prevention of HIV. Additionally, religious organizations can contribute to HIV prevention by connecting individuals to services, creating networks, and providing congregants with appropriate information on risk behaviours. Inter-faith dialogue to share information on practices can help local religious organizations tap into innovative approaches being used in other religious communities. Reviewing religious texts for passages that dispel misinterpreted customs and beliefs should also be explored. In Pakistan, providing training-of-trainers workshops on prevention of HIV to religious scholars

to implement in their communities has had some success in engaging leaders. Due to the early nature of the epidemic and the more recent involvement of religious scholars, Syria is well-positioned to learn from Pakistan’s experience working with religious leaders. Similarly, Pakistan might also learn from Syria’s techniques of working with local hotel owners and tour operators to provide condoms and HIV information.

There is a need for ongoing, sustained, evidence-informed advocacy, social communication, and social mobilization activities, which address stigma and discrimination. (The role of adolescent and young people living with HIV and AIDS and of religious and political leaders in such activities cannot be underestimated.) These activities should ensure:

- individual risk reduction behaviours and practices are valued and normalized;
- leaders call for the protection of most-at-risk adolescents and publicly address and discourage “risky” behaviours such as having multiple and concurrent sexual partners, extramarital relationships, inconsistent condom use, and intergenerational sex/transactional sex;
- messages and interventions are developed in partnership with most-at-risk adolescents and not censored by parents, religious, political, and cultural leaders; and
- messages and advocacy interventions are carefully designed to reduce stigma and to dispel myths about certain groups, which are often wrongly blamed to be vectors for HIV infection.

Additional learning points:

- Syria’s “action plan” item to establish a hotline for vulnerable groups is a quick, easy, and feasible strategy (where most-at-risk adolescents have access to phones; this is increasingly the trend with wireless pay as you go service) to disseminate information to adolescents, especially vulnerable girls, who are stigmatized and is a step toward eliminating the silence that surrounds societal misconceptions related to HIV and AIDS.

Reduce Stigma and Discrimination / Resources*

- [A conceptual framework and basis for action: HIV/AIDS stigma and discrimination](#) (UNAIDS, 2002)
- [HIV, AIDS & Islam](#) (Positive Muslims, 2004)
- [The ILO Code of Practice on HIV/AIDS](#)
- [UNAIDS Protocol for Identification of Discrimination against People Living with HIV](#) (UNAIDS, 2000)
- [Making waves: Stories of participatory communication for social change](#)
- [Sex workers health and rights: Where is the funding?](#) (Open Society Institute, 2006)

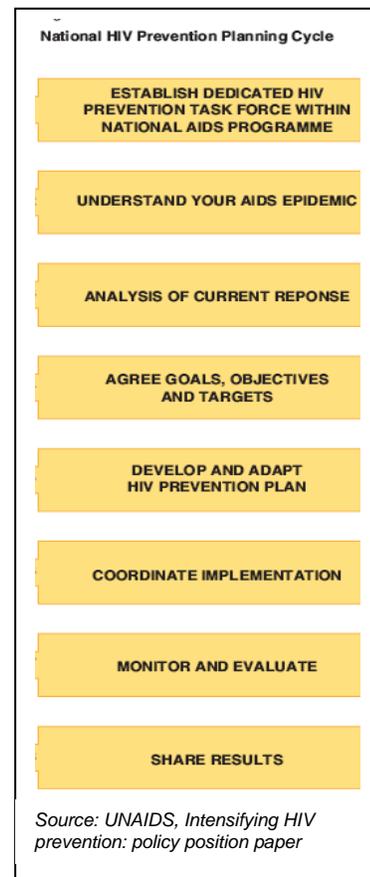
For a detail description of each resource see Annex.

- There is a need to strengthen the capacity of most-at risk adolescents to organize and engage with policy makers and participate in the national responses as key advocates, programme designers, implementers, and managers.
- Mass media can be a critical means by which to address social norms. In Brazil, for example, it has been used effectively to challenge social norms that stigmatize same sex relationships.
- Civil society organizations working on HIV prevention with and for most-at-risk adolescents should develop strategic partnerships with human rights organizations to monitor and challenge discrimination.

Improve the coordination of services

There are established mechanisms by which governments can coordinate HIV services for those populations most-at-risk. The “Three Ones” approach, for example, calls for one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad based multi-sector mandate; and one agreed country-level monitoring and evaluation system. Although many countries have yet to establish an effective “Three Ones” structure, the critical issue for the TSG and for accelerating HIV programming with and for most-at-risk adolescents is for UNCT to ensure there is participation of and a focus on most-at-risk adolescents in the development, implementation, coordination, and monitoring of the national HIV response.

The UNAIDS *Intensifying HIV prevention: policy position paper* outlined several national-level actions, which need to be implemented to intensify HIV prevention efforts. (These are outlined in the figure to the right.) UNAIDS advocates for the establishment (or revitalization) of an HIV prevention task force, which would report to the national AIDS authority. This Task Force should include civil society, the private sector, as well as a “core group that drives the process, and which should be involved in all steps of planning and monitoring of the national HIV prevention response.” UNCT in low prevalence / concentrated epidemics should use this guideline; along with the national-level coordinating mechanisms related to the “Three Ones” principles, to create a Working Group within the Task Force on most-at-risk adolescent, which would assist the national AIDS authority target and prioritize interventions.



Division of labour on HIV prevention among UNAIDS cosponsors

Technical Area	UN technical support plan ¹³	HIV prevention action plan	Main Partners
Overall policy and coordination	UNAIDS Secretariat	UNAIDS Secretariat	All cosponsors
Health sector including voluntary counselling and testing, blood safety, (integration with treatment)	WHO	WHO	UNFPA, UNICEF, UNHCR, ILO, UNODC, UNDR, World Bank
Prevention of mother-to-child transmission of HIV	UNICEF/ WHO	UNICEF/WHO	UNHCR, UNFPA, WFP
Young people out of school	UNFPA	UNFPA	UNESCO, UNICEF, UNHCR, ILO, WFP, UNODC, WHO
Young people in educational institutions	UNESCO	UNESCO	UNFPA, UNICEF, WHO, UNODC, ILO, WFP, UNHCR, World Bank
Injecting drug use/ prisons	UNODC	UNODC	WHO, UNFPA, UNESCO, UNICEF, UNAIDS Secretariat

Source: UNAIDS action plan on intensifying HIV prevention 2006-2007

Most-at-risk adolescents must be included as equal members of the Working Group. This is in line with the Convention on the Rights of the Child, which requires States to ensure adolescent children, especially those most marginalized, can participate in making decision on the issues that affect them. UNICEF country-offices may need to assist the national programme to develop the capacity of most-at-risk adolescents to engage with policy makers and participate in the national response as key advocates, programme designers, and managers.

The successful multisectoral national response of the Brazilian government is in part due to coordinating success of the National AIDS Council. Civil society agencies, for example, are able to vote on components of the national AIDS programme. UNCT from other countries can advocate for similar mechanisms, as well as the establishment of a network of civil society organizations to deliver services, which governments might be reluctant to provide or lack the credibility or capacity to undertake.

Ensuring the meaningful participation of most-at-risk adolescents in all aspects of program design and implementation is repeatedly touted by program managers and others working with these populations. However, there appears to be a dichotomy between theory and practice, between advocating for inclusion of beneficiaries in the development of HIV prevention programmes and policies, and genuinely being able to do so. Often most-at-risk adolescents have spent their time stigmatized and exploited by others, are understandably distrustful, and may not have the needed social and emotional support to participate and/or engage with programme managers and planners. TSG participants recognized this disconnect. In addition, they noted the availability of toolkits for working with adult high risk groups, such sex workers, and acknowledged a gap in practical models on how to engage and work with most-at-risk and adolescents

UNCT are also well-placed to assist national programmes establish and/or strengthen and coordinate the participation of most-at-risk adolescents in the planning and implementation of the national prevention response. This could be done by helping civil society develop networks of young sex workers, injecting drug users, and men who have sex with men to advocate for policy reform, to improve access to and quality of services, to reduce stigma, and to strengthen self-help and group support. Networks, as a large unified entity, can generally exert more influence than an individual can, can enhance legitimacy, and can offer individuals a sense of empowerment and belonging. In many cases, these networks already exist, but they often do not have adolescent representatives or a specific focus on the needs of most-at-risk adolescents.

TSG participants fittingly remarked that there is a need to assess UNICEF's and UN partners regional and country-level roles and capacity for accelerating HIV prevention for most-at-risk adolescents. UNAIDS and the Brazilian government, for example, launched an International Center of Cooperation to support capacity building at multiple levels and this might be a useful initiative to explore in other regions.

Improve the coordination of services with the participation of most-at-risk adolescents / Resources

- [Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors](#)
- [NGO support toolkit](#)
- [The "Three Ones" in action: Where we are and where we go from here.](#)
- [Intensifying HIV prevention: UNAIDS policy position paper](#)
- [UNAIDS action plan on intensifying HIV prevention 2006-2007](#)
- [UNAIDS Costing guidelines for HIV prevention strategies](#)

Conclusion

Under the work plan of the IATT on HIV and young people, one of the priority areas in low prevalence and concentrated epidemics is building the capacity of UN teams, national programs, and partners to work with and for most-at-risk adolescents. With this in mind, one of the objectives of the first global TSG meeting was to build a TSG network and determine what type of technical assistance people working at the global, regional, and country-level can provide each other.

Now that the global resource network has been initiated, there are several follow-up actions that need to be taken to ensure the positive outcomes of the first global TSG meeting are put into practice. At present, the inter-regional partnerships that were established at the TSG are in their infancy, they are fragile, and must be strengthened. UNICEF HQ is currently working with UNICEF IT staff to figure out the best mechanism by which internal UN staff and external partners can share resources electronically. In the meantime, global TSG members are urged to start exchanging resources such as lessons learned; good practices; protocols on standards for health care professionals; training curriculums; policy and legislation on age of maturity, privacy, and confidentiality, drug policies, and stigma and discrimination; and effective advocacy strategies and media campaigns. Syria, for example, with an HIV prevalence of less than 0.1%, can benefit from the experiences of Pakistan on how to engage and work with religious leaders, from Brazil on government involvement and coordination, and from Ukraine on targeting interventions to most-at-risk adolescents and, ultimately, restructure their response to maintain their low prevalence.

To expand the TSG network and to strengthen regional programming for and with most-at-risk adolescents, regional offices of all of the IATT members need to be asked to consider how existing inter-regional, intra-regional, and interagency mechanisms can be leveraged to support accelerated action for most-at-risk adolescent. If such regional structures are not in place or lack the capacity to coordinate and accelerate efforts, another option can be to organize a regional TSG meeting on most-at-risk adolescent to exchange and develop intra-regional programming experiences, as well as disseminate the lessons learned from the global TSG. Regional support for a regional TSG process for accelerating HIV prevention programming with and for most-at-risk adolescents is critical. The second meeting of the global TSG, proposed for June 2007; will gauge regional progress toward accelerating programming for and with most-at-risk adolescents, as well as provide a

platform to share and learn from experiences in countries outside of the global TSG network. To be effective, regional level mechanisms need to facilitate inter-regional and inter-country TSG partnerships to share experiences, lesson learned, expertise, and possibly even resources. Feedback from the four UNCT to their regional offices on the implementation of their action plans, as well as lessons learned from the TSG process, can help to garner support for the TSG process in the global and regional 2007 work plans.

To increase support for the TSG process, the outcomes and lessons learned from the global TSG meeting need to be disseminated. IATT co-sponsor representatives at the TSG meeting were asked to brief their HQ HIV Teams and a note for the record on the key outcomes of the first meeting was circulated to senior UNICEF staff and members of the IATT on HIV and Young People. This report and follow-up to the TSG meeting will be discussed at the next IATT meeting and reflected in the 2007 IATT work plan.

The global TSG efforts are in line with the UNAIDS recent call for policy makers and practitioners at national and sub-national levels to prioritize HIV prevention efforts and resources differentially to those populations at high risk of acquiring and transmitting HIV. Moreover, the push to scale up toward universal access (UA) by 2010 will require national governments to focus on and reach those adolescents most-at-risk in order for them to reach the requisite UA targets.

The TSG can be a unique mechanism by which regional and country-level partners have the opportunity to share their programming successes with and for most-at-risk adolescents and benefit from the successes of other countries. In many ways, the outcomes of the first global TSG on accelerating HIV prevention programming with and for most-at-risk adolescents will determine whether the process is an effective means by which to strengthen the capacity of partners in this programming area and accelerate the response by national programmes within and across regions.

As stated earlier, to accelerate HIV prevention interventions for adolescents most at risk, UN agencies and national partners to reassess their current assistance to the national prevention response to ensure there is a focus on reaching and scaling-up efforts for most-at-risk adolescents. This will require national programmes to:

- Generate disaggregated data on most-at-risk adolescents, as well as undertake research on the gaps in the current national response.

- Use data on their current HIV epidemic and the situation and needs of most-at-risk adolescents to develop or revise advocacy and behavior social change communications strategies to address stigma and discrimination. Critical to this process is to make certain most-at-risk adolescents have the capacity to organize (within existing high-risk group networks) and participate in the national response (e.g., represented in the prevention task force).
- Review and reform policies and programmes to ensure the intensification of prevention with and for populations at-risk have a focus on adolescents most-at-risk.
- Ensure that existing coordination mechanisms for scaling up the prevention response includes both a focus on and partnership with most-at-risk adolescents.
- Ensure that all partners working on HIV prevention with and for most-at-risk adolescents look for opportunities to scale-up coverage of services; aligning, linking and harmonizing their interventions in the process. This might include integration of services for HCV, as well as other STIs.

At both global and regional-levels, the TSG challenge is two-fold. The first challenge is to ensure that all partners continue to align their focus on accelerating HIV prevention programming with and for most-at-risk adolescents. Secondly, in order for the TSG to achieve results it requires a commitment to the TSG process itself; a commitment to maintain a consistent exchange of experiences at both the global, regional, and national levels. It is important to note that the TSG is a process, not the creation of a new structure. Many TSG participants expressed that in the early stages, UNCT may need assistance starting and maintaining cross-country dialogue and exchanges. The key is not to depend on the establishment of a new mechanism for exchanging and disseminating experiences, but to explore and utilize existing processes.

The success of the TSG process hinges on national level partners undertaking a critical assessment of their current HIV response with and for most-at-risk adolescents. The measure of success will be a reduction in new HIV infections. To ensure this result, most national programmes and partners will not require additional resources, but will need to reprioritize, reprogramme, realign, and harmonize their HIV prevention response to focus on working with and for most-at-risk adolescents.

*Coming together is a beginning.
Keeping together is progress.
Working together is success.*
Henry Ford

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vii Zhusupov B, *Behavioural surveillance among injecting drug users in nine cities of Kazakhstan (Almaty, Pavlodar, Shymkent, Karaganda, Temiirtau, Astana, Petropavlovsk, Uralsk, Ust Kamenogorsk) within the framework of HIV epidemiological surveillance*. Almaty, Center on Research of Public Opinion (CRPO), 2002.
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