Orientation Programme on Adolescent Health for Health-care Providers

Handout for

Module N

Young people and HIV

This Handout for participants provides information that complements the material on *Young people and HIV*. The facilitator will ask you to refer to this Handout during the sessions.

This handout provides information on the following:

1. HIV and AIDS

HIV (Human Immunodeficiency Virus) is the virus that causes AIDS, which is a lifelong infection. A *positive HIV test* does not mean a person is ill with AIDS; it means that he/she is infected with the virus (HIV) and that HIV antibodies are detectable in that person's blood.

AIDS stands for Acquired Immune Deficiency Syndrome, "acquired" referring to the fact that the virus was caught; "immune deficiency" means that the person's immune system is weakened against infectious and non-infectious diseases. The word "syndrome" describes a group of symptoms indicating a particular disorder. The syndrome in AIDS is a set of infections or illnesses that occur because HIV has damaged the immune system.

Correct understanding of the terms HIV and AIDS and their different meanings is important. This module uses the term HIV – and occasionally AIDS – to describe all stages of HIV infection, including AIDS. The expression "people living with HIV" (PLHIV) is used for people living with all stages of HIV infection, including people living with AIDS.

When a person gets infected with HIV, the body tries to fight the infection by producing antibodies. Testing *positive* for HIV means that the individual has been infected with the virus and the body has produced antibodies against HIV. An *HIV test* measures the presence or absence of HIV antibodies in the blood; it does not measure the virus.

BOX 1

The window period

After a person becomes infected with HIV, it takes an average of six weeks for him/her to test positive (by seroconversion) because this is the time needed for antibodies to develop to levels where they can be detected in the blood. During this "window period" or time before antibodies can be detected, the person can transmit HIV to others as the virus is already in his/her body fluids.

In situations where exposure to HIV may have been only hours or days before (e.g. following condom breakage, rape), the health worker needs to be aware that the person may be in the window period (i.e. when HIV antibodies are not yet detectable). The person should be counselled and asked to return for HIV testing six weeks after the date of possible exposure and to use precautions to prevent transmission to others during this period.

However, if the person is going to receive Post-Exposure Prophylaxis (PEP), this must begin less than 72 hours after unprotected sex. For information on Post-Exposure Prophylaxis, see Box 7.

WHO has developed a system of clinical staging, with four well-defined stages of HIV illness:

- WHO Clinical Stage I : asymptomatic
- WHO Clinical Stage II : mild disease
- WHO Clinical Stage III : moderate disease
- WHO Clinical Stage IV : severe disease (AIDS).

Staging is helpful for making decisions on when to begin treatment, especially in situations when the only laboratory test available is an HIV test. The signs and symptoms that are used in clinical staging can be found in *Chronic HIV Care with ARV Therapy*, Integrated Management of Adolescent and Adult Illness (IMAI), WHO. There are IMAI training courses to prepare health workers for chronic HIV care, including ARV therapy.

Most individuals infected with HIV look and feel healthy and lead normal lives for many years before experiencing HIV-related symptoms. Worldwide, the majority of *people living with HIV* (PLHIV) do not know they are infected. However, anyone who is infected with HIV can transmit the virus to others.

HIV and AIDS raise many difficult issues that can challenge moral and societal values. When working with HIV, it is important to be able to talk openly about sensitive issues, in particular

about sex. Health workers need to be able to talk about these issues with young people and feel confident that they have the knowledge to discuss the behaviours that carry a high risk for HIV transmission.

These behaviours, and the people who practise them, may provoke strong feelings. As health workers, it is important to maintain a professional and respectful manner, without using blame, stigma or personal values to judge a situation.

Transmission routes for HIV

The blood, vaginal fluid, semen and breastmilk of persons infected with HIV have the potential to transmit HIV to others. Exchange of these body fluids can cause transmission of HIV.

HIV is transmitted through four different infection routes:

- Sexual intercourse
- Blood and blood products
- Needles and other skin-piercing instruments
- Mother-to-child-transmission (MTCT) from an HIV-infected woman during pregnancy, during childbirth or through breastfeeding.

Globally, sexual intercourse is the most common transmission route for HIV. In some regions, nearly 90% of all HIV transmissions are through heterosexual (man and woman) intercourse. For young people, sexual intercourse and injecting drugs are the most common transmission routes.

There are no documented cases of HIV being transmitted by tears or saliva. HIV is not transmitted via toilet seats, shared towels, mosquito bites, hugging, holding hands or any casual contact with a person living with HIV.

Natural history of HIV infection

The progression of HIV infection and AIDS can vary greatly from individual to individual.

Over the course of time, the virus slowly wears down and damages the immune system, allowing infectious agents that are usually harmless to make the individual very ill. These illnesses include opportunistic infections, neurological conditions, and particular forms of tumours. In many countries tuberculosis is the most common opportunistic infection. AIDS is the end-stage of HIV illness, when the immune system is severely damaged.

There is no cure for AIDS and there is no way of removing all the HIV from the body of an infected person. There are, however, highly effective and life-saving drugs that reduce the rate at which the virus can multiply and that can be used to treat infections and conditions caused by the virus.
Globally, there is a commitment and recognition of the importance of addressing HIV and young people. At the United Nations General Assembly Meeting on AIDS (June 2006), Declaration number 26 states:

"[We] commit ourselves to addressing the rising rates of HIV infection among young people to ensure an HIV-free future generation through the implementation of comprehensive, evidence-based prevention strategies, responsible sexual behaviour, including the use of condoms, evidence- and skills-based, youth-specific HIV education, mass media interventions and the provision of youth-friendly health services". (*www.un.org/ga/aidsmeeting2006/declaration.htm*)

2. The situation of HIV among young people

Estimates of HIV are figures indicating approximately the number of people living with HIV at the end of a stated year. Estimates are not an exact number and that is why ranges are used. The main sources of data for calculating HIV estimates are:

- Sentinel surveillance systems: periodic surveys among specific population groups (e.g. ante-natal women, drug users, sex workers and others).
- National population-based surveys with HIV testing: HIV information is collected from the general population as a whole. The data might underestimate the true prevalence because of greater risk factors among the non-responders (persons refusing or absent). Only a few countries have implemented such surveys.
- Case reporting from health facilities.

The UNAIDS/WHO HIV Surveillance Working Group collaborates with governments to produce regular HIV and AIDS estimates at country, regional and global levels. The summary in the Table below shows estimates published in the 2006 Report on the Global AIDS Epidemic.

TABLE 1

Global summary of the AIDS epidemic in 2005

No. of people living with HIV in 2005	38.6 million (range: 33.4 to 46.0 million)
No. of people newly infected with HIV in 2005	4.1 million (range: 3.4 to 6.2 million)
No. of AIDS deaths, 2005	2.8 million (range: 2.4 to 3.3 million)

Source: UNAIDS/WHO December 2006.

Global situation of HIV among young people

An estimated 39 million people are currently living with HIV worldwide. Of the estimated 4 million new HIV infections annually, almost 50% are women and over 40% are young people aged 15-24 years (UNAIDS/UNICEF/WHO, 2006).

Global data show that young people are central to the HIV epidemic. Some data do not give a breakdown by age groups, making it difficult to separately identify young people in the statistics. In countries with high HIV prevalence rates, young people and especially young women are at particular risk of contracting the virus as soon as they become sexually active.

There are more than 13 million drug injectors worldwide; more than 50% of them in some countries are living with HIV. Sharing of injecting equipment is a highly efficient way of transmitting HIV, and injecting drug use plays a major role in the HIV epidemic in some regions. There have been dramatic increases in the number of young people who inject drugs in some countries (UNAIDS 2004).

Regionally there are differences in the prevalence rates of HIV among young people (15-24 years).

TABLE 2

The global HIV prevalence rate estimates of young people living with HIV by region in 2005

	Women (15-24 years)	Men (15-24 years)
Sub-Saharan Africa	4.3%	1.5%
East Asia	<1.0%	0.1%
South and South East Asia	0.4%	0.6%
Caribbean	1.6%	0.7%
Latin America	0.3%	0.5%
Eastern Europe and Central Asia	0.5%	0.9%
North Africa and Middle East	0.2%	0.1%

Source: UNAIDS/UNICEF/WHO 2006.

The 2006 Report on the Global Aids Epidemic shows that important progress has been made in country AIDS responses, including increases in funding and access to treatment, and decreases in HIV prevalence among young people in some countries over the past five years. It also shows that young people and children are increasingly affected by the epidemic, and efforts to protect these and other vulnerable groups are not keeping pace with the epidemic's impact.

On HIV prevention, the report documents behaviour changes including delaying the first sexual experience, increasing use of condoms by young people, and resulting decreases in HIV prevalence in young people in some sub-Saharan countries.

Young people are a key population group on which to focus prevention, care and support because they represent such a high proportion of the new infections. As with adults, the vast majority of young people who are HIV-positive do not know that they are infected, and few young people who are engaging in sex know the HIV status of their partners.

Diversity of HIV epidemics

The world is now facing a multitude of HIV epidemics which are different in their time sequences, extent and affected populations. An accurate picture of the HIV epidemic in a country is vital for directing national and local responses.

The information in Box 2 is purely to illustrate the different epidemics and is not intended to point fingers at any country or region, or sexual behaviour between consenting partners.

HIV epidemics are dynamic and diverse. They do not start in the same way in all countries and the epidemic within a country can change over time. The course of an HIV epidemic depends on the people's pattern of behaviour which can increase or reduce their risk of HIV, as well as on the local political, economic and social situation. There may also be differences in the epidemic within a country - between regions and between rural and urban areas.

- *Generalized* epidemics are those where HIV prevalence is over 1% in the general population.
- *Concentrated* epidemics are those where HIV prevalence is over 5% in a sub-population at higher risk of infection, but where the prevalence in the general population remains below 1%.
- *Low-level* epidemics are those where relatively little HIV is detected in any group in the population.
- *Young people* are at the centre of transmission in both generalized and concentrated epidemics.

BOX 2

Examples to illustrate the global diversity of the HIV epidemic

- In many Southern African countries – with some of the highest reported HIV prevalence rates in the world – the epidemic is generalized and HIV transmission occurs mainly heterosexually within the population as a whole.
- In some settings in Eastern Europe, HIV began as a concentrated epidemic, primarily through needle sharing among drug injectors; recently HIV infections have moved into the wider community through sexual transmission.
- The high number of single male migrant workers moving to urban areas in Asia and their contact with sex workers has led to increased HIV infection levels. These men then act as a bridge population and sexually transmit HIV to their partners when they return to their rural areas.
- In other countries in Asia, the HIV epidemic began as a number of serious localized epidemics caused by injecting drug use and unsafe blood donations, but sexual transmission of HIV is now increasing.
- In many industrialized countries, men having sex with men continues to be a major cause of the epidemic.
- Drug injecting is also important for HIV transmission. In 2002, IDU accounted for more than 10% of all reported HIV infections in Western Europe and for 25% of HIV infections in North America.
- In some Latin American countries the epidemic was concentrated among drug injectors and men who have sex with men, before moving to the general population.
- In countries with conflicts, HIV can spread rapidly among internally displaced people due to violence associated with war (rape, breakdown of family structure and societal norms).

As young people are at the centre of transmission in both generalized and concentrated epidemics, HIV prevention among young people is the key to slow down the epidemic.

Worldwide the HIV epidemic affects the young, the poor and disadvantaged people. Even when the epidemic is generalized in a country, some groups within the population remain highly vulnerable and deserve specially focused attention. Among 15-24-year-olds, young women are 2-4 times more likely to become newly infected than men. The reason for this is that young women may be less able than men to avoid non-consensual sexual relations (i.e. unable to refuse to have sex or to avoid forced sex).

Fortunately, most young people are not infected with HIV. In fact, during early adolescence HIV rates are the lowest of any period during the life cycle. The challenge is to keep them this way. Focusing on young people is likely to be the most effective approach to confronting the epidemic, particularly in high prevalence countries.

3. How HIV affects young people

There are two groups of young people living with HIV: those who were infected around birth and survived into adolescence and those who became infected during adolescence (usually due to unprotected sex or through injecting drug use). This infection history has an impact on many features of how HIV affects a young person, including their HIV care and management (e.g. progression of HIV disease, treatment with ARV drugs, knowledge and disclosure of HIV status, access to care), and on prevention strategies.

Sexual activity begins in adolescence for the majority of people. In most countries the mean age of sexual debut is 17-18 years. This means that 50% have had sex by that age. In addition, in many countries unmarried girls and boys become sexually active even before the age of fifteen. Studies from many parts of the world have shown that the vast majority of young people have no idea of how HIV is transmitted or how to protect themselves. Surveys in Africa, Asia, the Caribbean and South America showed that fewer than half of adolescent girls aged 15-19 knew about the three main ways of avoiding HIV infection (delaying sex initiation, reducing the number of partners, and using condoms consistently and correctly). More than half the girls of this age did not know that someone who looks healthy may be infected with HIV.

Sharing injecting equipment carries a high risk of HIV transmission and plays a major role in the HIV epidemic in some regions of the world. Globally, injecting often commences during adolescence, the most common age for initiation being 15-19 years. In some countries there has been a dramatic increase in the number of young people who inject drugs. In general, compared to older injectors, young drug injectors have little knowledge about HIV, a lower perception of HIV risk through both drug injecting and sex, and are less likely to identify themselves as being an injecting drug user. Young injectors are more likely to be intermittent users and are less likely to be drug dependent. In their sexual behaviour, young injectors are more sexually active, have more partners and experiment with different sexual practices more than many older injectors. Young injecting drug users are also less likely to use the health services for prevention and treatment. In addition, there are issues of social stigma and illegal use of drugs. Working on HIV prevention with young injecting drug users is an important strategy to reduce the HIV epidemic. This is addressed in detail in the module *Young people and injecting drug use*.

Risk factors and protective factors

There are factors in every society that have an effect on how people behave. Some of these factors relate to the person as an individual (e.g. age, sex, knowledge, attitude, behaviour and practice {KABP}). Other factors, known as contextual factors, relate to the social and environmental context or situation in which the individual lives. Contextual influences include peers, teachers, family and community, as well as poverty, civil unrest, the legal system, and the values and norms in the broader society. Most risk and protective factors are a mix of individual and contextual influences.

- Risk factors include individual and contextual influences that either encourage or are associated with one or more behaviours that may lead to negative health outcomes or may discourage behaviours that could prevent a negative health outcome.
- Protective factors include individual and contextual influences that discourage one or more behaviours leading to negative health outcomes or that encourage behaviours that prevent negative health outcomes. Protective factors can also lessen the likelihood of negative consequences from risk factors.

Scientific studies in adolescents show that the following risk factors are associated with an increase in the risk of becoming infected with HIV (Adapted from *Risk and Protective Factors affecting Adolescent Reproductive Health in Developing Countries.* WHO, 2004):

- Increased age
- Commercial sex work
- Early age at becoming a commercial sex worker
- Commercial sex work in a brothel
- High numbers of sexual partners
- Current or past history of genital ulcer
- Unprotected anal sex
- Current or past history of STI
- Early age of sexual debut.

Protective factors that are statistically significant in avoiding HIV infection are:

- Regular use of condoms
- Usual partner circumcised
- Reduced number of sexual partners.

Other studies have identified protective factors that help adolescents avoid behaviours that put them at risk of HIV (*Young People and HIV/AIDS: Opportunity in Crisis*. UNICEF/UNAIDS/WHO, New York, 2002). These include:

- Positive relationships with parents, teachers and other adults in the community
- Feeling valued
- Positive school environments
- Exposure to positive values, rules and expectations
- Having spiritual beliefs
- Having a sense of hope for the future.

The term "risk groups" is no longer used because it can give the impression that these groups are to blame for HIV. Also "risk groups" often do not have a clear identity; for example, men who have sex with men (MSM) may not identify them selves as homosexual, or persons who occasionally use intravenous drugs may not identify themselves as an injector.

Vulnerability to HIV

Even when HIV infection rates are generalized in a country, some groups within the population remain highly vulnerable. The concept of vulnerability recognizes that they may not have a choice as to whether they engage in behaviour that puts them at risk of acquiring HIV.

BOX 3

Vulnerability to HIV

For most young people, the important messages that will protect them from the risk of HIV are: delaying sexual debut, reducing the number of sexual partners, and using condoms correctly and consistently. Vulnerability is a measure of an individual's or community's inability to control their risk of HIV infection. Vulnerability recognizes that they may not have a choice as to whether they engage in behaviour that puts them at risk of acquiring HIV.

Vulnerability increases the likelihood of negative health outcomes. There are social and contextual risk factors that make many young people vulnerable to HIV infection. These include: gender norms, relations between different age groups, race and other social and cultural norms and value systems, location, and economic status.

Behaviour or situations that put young people at risk of HIV include:

- Having sex with older men
- Injecting drugs
- Being sexually violated
- Working in the sex trade
- Living on the street
- For men, having sex with men
- Being a migrant worker
- Living without parental support
- Being orphaned as a child or affected by HIV
- Being caught in armed conflict.

Young people represent a large proportion of these highly vulnerable people and they may need special HIV strategies to be reached.

Studies show that many young people do not believe that HIV is a threat to them, and many others do not know how to protect themselves from HIV. They are vulnerable because they often do not know how HIV is transmitted or what they can do to protect themselves. Surveys from 40 countries indicate that more than 50% of young people have serious misconceptions about how HIV is transmitted. Many adolescents do not go to school, and do not have access to information about AIDS, or do not have the opportunities to develop the life skills that they need to turn this information into action. Frequently they do not have access to prevention services that take their specific needs into consideration. (*Young People and HIV/AIDS: Opportunity in Crisis.* UNICEF/UNAIDS/WHO. 2002).

There is need to pay particular attention to preventing HIV infection of girls and young women, who, in some regions, are almost three times more likely to be infected than young men of the same age. The difference in infection levels between men and women is even greater among young people.

BOX 4 - part 1

Gender and HIV

Gender can be understood as the social construct of masculinity and femininity. In many societies, what is considered masculine is more valued than feminine; so, opportunities are connected to each sex and a relation in which more power is given to men than women may be established.
When the primary mode of HIV infection is heterosexual, young women are the worst affected. However, in countries where HIV is transmitted predominantly among men who have sex with men or by injecting drug use, young men are likely to be more at risk from HIV. Globally, approximately as many women as men suffer from HIV; however, there is a difference in the implications of the disease for men and women. Some of these result from biological differences in sex between men and women, but more result from socially defined gender differences.

In some societies, gender norms allow men and boys to have more sexual partners than women and girls. Society may also accept or encourage older men to have sexual relations with younger women. In combination with the biological factors, where heterosexual sex is the main mode of HIV transmission, infection rates are much higher among young women than among young men. Gender power imbalances, patterns of sexual networking, and age mixing are all important factors, especially for young women.

Young women may remain ignorant of the facts of sexuality and HIV because they are not “supposed” to be sexually knowledgeable, while young men may remain ignorant because they are “supposed” to be sexually all-knowing.

BOX 4 - part 2

Gender and HIV

Young women may want their partners to use condoms (or to abstain from sex altogether), but often lack the power to make them do so. Young women (who are often more socially, economically and physically vulnerable than men) may be unwilling to learn their HIV status or share that information for fear of violence and/or abandonment if the HIV result is positive.
Societies must address issues that affect the vulnerability of women and girls (e.g. gender-based violence, poverty, property rights, and education). Healthcare workers have a role in developing programmes that empower women and girls and reduce their vulnerability and risks for HIV. These should be within comprehensive sexual and reproductive health strategies.

Societies also need to address issues that affect the vulnerability of boys and young men (e.g. sex workers, poverty, injecting drug use, negative attitudes to sexuality).

These factors of inequality are not easily altered but until they are, efforts to contain and reverse the HIV epidemic are unlikely to achieve sustained success.

Adapted from: http://www.who.int/gender/hiv_aids/en/

Biological susceptibility

Biological susceptibility refers to the increased physical risk of acquiring HIV. Women are probably more susceptible than men to infection from HIV because of the greater area of mucous membrane exposed during sex by women than men, the greater quantity of fluids transferred from men to women, the higher viral content of male fluids, and the micro-lesions that can occur in vaginal or rectal tissue from sexual penetration.

Young women may be especially susceptible to infection. A young girl of 14 years may have a higher risk of acquiring HIV than a woman of 30 years (even when exposed to the same situation and viral load) for the following reasons.

- **Immature genital tract in young girls**

  In young girls, inadequate mucosal defence mechanisms and the immature lining of the cervix provide a poor barrier against infection. Once exposed to the virus, girls and young women are more susceptible than young men or adults due to the anatomy of the developing cervix and vagina. Also in young girls, the thin lining and relatively low acidity in the vagina facilitate transmission.

- **Undeveloped genitalia more easily damaged during forced sex**

  Non-consensual sex with undeveloped genitalia can lead to trauma and therefore increase the chance of transmission if exposed to HIV. In some settings there is a high rate of coerced sex among young girls. In studies, many young women report that they were unwilling or coerced into their first sexual experience. Forced sex is always very traumatic. This is even more traumatic on developing genitalia, allowing for increased risk of infection through skin tears.

- **STIs in sexually active young people**

  STIs among sexually active people also increase their chance of contracting and transmitting HIV. The infected partner has heightened infectivity due to the shedding of more viral RNA in vaginal/seminal fluid. Herpes simplex virus (HSV) and genital ulcer disease (GUD) are STIs known to encourage the spread of HIV. Prevention of STIs and early, correct treatment are important components in HIV prevention strategy. The presence of untreated STI (ulcerative

or non-ulcerative) can increase the risk of both acquiring and transmitting HIV by a factor of up to 10. Improvement in the management of STIs can reduce the incidence of HIV infection in the general population by about 40%. (From: WHO 2001: *STIs Overview and Estimates*).

- **Female genital mutilation**

  Female genital mutilation can cause lasting damage to the genital area and can increase the risk of HIV transmission during intercourse. Use of the same instrument to carry out genital mutilation on several girls or circumcision on several boys without sterilization may also cause the spread of HIV.

- **Risk of anal abrasions**

  The tissue around the anus of young girls and boys is fragile. During consensual or forced anal sex (boys with men, girls with older men or boys), anal abrasion can occur, making transmission more likely in the presence of HIV. Anal sex may be chosen over vaginal sex to preserve the virginity of the girl or to avoid the risk of unwanted pregnancy.

Natural history of HIV in young people

Young people differ from adults in the natural history of HIV infection and can differ from each other depending on their infection history (infection around birth or adolescent infection through unprotected sex or injecting drug use).

In young people who were infected around birth and have survived into adolescence, HIV disease may have a rapid progression or a slow progression. In rapid progression they are likely to have begun ART in childhood.

- **HIV acquired prior to puberty**

  Young people who were infected before entering puberty can present with slow skeletal growth, delayed pubertal maturation, and irregular menstrual periods in girls. This is due to the effect HIV has on metabolic and endocrine functions. This delay in growth and sexual maturation may also have an impact on the psychosocial development of the individual.

- **HIV acquired after puberty has begun**

  For young people infected after puberty, the infection can remain asymptomatic for a longer period of time than for adults. There appears to be an inverse correlation between age of infection and length of asymptomatic period (i.e. the younger the age at infection (after puberty), the longer the virus remains asymptomatic).

BOX 5 - part 1

Male circumcision and HIV

Male circumcision is the surgical removal of all or part of the foreskin, the tissue covering the head of the penis. Depending on culture, ethnicity and religion, circumcision is usually performed soon after birth or during adolescence.

Trials are in progress to examine the potential link between male circumcision and a lower risk of HIV acquisition and transmission during sexual intercourse. The trials have shown promising protective effects of adult male circumcision in reducing HIV acquisition. One trial in South Africa found that circumcising HIV-uninfected adult men reduced their risk of becoming infected with HIV by 60%. Trials

BOX 5 - part 2

Male circumcision and HIV

are underway in Kenya and Uganda to confirm the reproducibility of the findings and whether or not the results have more general application. It is also important to clarify the relationship between male circumcision and HIV in differing social and cultural contexts.

In addition, a companion trial is following female partners of the male participants, to determine if circumcising men reduces the risk of HIV transmission to women, as suggested by observational data.

The results of these trials will need to be considered by governments and other key stakeholders in order to determine whether male circumcision should be promoted as an additional public health intervention to reduce the risk of sexual transmission of HIV. The feasibility of such an intervention, particularly with respect to its cost-effectiveness, safety and acceptability, is still to be demonstrated. If male circumcision is confirmed to be an effective intervention to reduce risk of acquiring and transmitting HIV, this will not mean that men will be prevented from becoming infected with HIV during sexual intercourse through circumcision alone. Nor does male circumcision provide protection for sexual partners against HIV infection. It will therefore be essential that it be part of a comprehensive prevention package, which includes correct and consistent condom use, behaviour change, and voluntary counselling and testing. Any new prevention strategies must not undermine existing protective behaviours and prevention strategies that reduce the risk of HIV transmission.

When performed by a trained practitioner, male circumcision is a safe procedure, and analgesia affectively mitigates pain. However, concerns have been raised about the safety of circumcision procedures performed in resource-limited community settings.

Circumcision is an opportunity to make contact with adolescents and provide them with information and counselling about their sexual and reproductive health. Health workers need to know how to respond to a request for circumcision from an adolescent minor, to respond in ways that respect the adolescent's rights to privacy and confidentiality but at the same time do not place the health worker in conflict with the law. Ideally, an adolescent should be accompanied by a responsible adult who can give consent for the operation. However, in practice this is not always possible. Health workers should be guided by human rights principles: all adolescents have a right to use health services, and health workers should act in the best interests of the adolescent, with an understanding of his evolving capacities and his increasing ability to make independent decisions.

Adapted from: UNAIDS statement on South African trial findings regarding male circumcision and HIV. July 2005.

Statement developed by the World Health Organization (WHO), the United Nations Population Fund (UNFPA,) the United Nations Children's Fund (UNICEF) and the UNAIDS Secretariat.

Male and Female Condoms

The major transmission route for HIV globally is sexual transmission. Abstinence and condoms are the only dependable ways of avoiding HIV. For people who are having sexual intercourse, condoms are the surest way to prevent transmission of HIV and other sexually transmitted diseases. When used correctly and consistently, condoms provide an effective barrier, blocking the pathway of the HIV virus during sexual activities.

Condom breakage rates are less than 2%. Almost all breakage is due to incorrect usage (e.g. leaving no air space, improper storage, tearing by fingernails or jewellery, expiry date past, inadequate lubrication, use of oil-based rather than water-based lubricant). Condoms have tiny pores in them and some people think these leak viruses, but this is not the case. Studies have shown that HIV cannot pass through latex condoms.

The female condom has a sheath material and a flexible inner ring, and is inserted similar to a diaphragm. A woman squeezes the ring and inserts it as far as possible into the vagina. The ring covers the cervix. The sheath material lines the vaginal wall and the outer ring holds the condom in place and helps cover the lips of the vagina. The penis must stay within the confines of the female condom or the condom is ineffective.

Female condoms can be inserted up to 8 hours before intercourse and are only effective when placed prior to intercourse. At first, female condoms can be awkward to use, but they are easy with practice. Women should insert the condom before sexual play by standing with one foot up on a chair, sitting with knees apart, or lying down. Water-based lubrication can help keep the condom in place and lessen noise during intercourse. A female condom and a male condom should not be used at the same time.

BOX 6

Violence against women and HIV

Violence against women is an important factor for HIV transmission. Rape, forced sex and coerced sex, which many women (and some men) experience at some point in their lives, can make HIV transmission even more likely, since it may result in more trauma and tissue tearing. Both young women and young men are vulnerable to sexual violence, including abuse and exploitation, but a greater number of girls and young women are affected. Violence interacts with the HIV epidemic in many ways, all to the detriment of women:

- Women can be infected with HIV through forced sex. The chances of a woman contracting HIV via a forced sexual encounter are probably increased since forced sex often involves trauma and tissue tearing which can provide an opening to the virus.
- Sexual abuse in childhood is associated with risk-taking behaviour later in life, increasing an individual's lifetime risk of contracting HIV.
- Violence and fear of violence can prevent a woman, even one in a consensual union, from insisting on condom use or refusing unwanted sex. Since condom use and abstinence are currently the only dependable and widely available means of avoiding HIV infection, this leaves women with no means of protecting themselves.
- Fear of violence, stigma, and abandonment can dissuade women from learning about their HIV status – or, if they do learn it, from sharing the result with their partners.
- Since violence can affect women's willingness to be tested, it can also have a detrimental effect on HIV prevention, treatment, and access to PMTCT (prevention of mother-to-child transmission) programmes.

Adapted from: http://www.who.int/gender/violence/vawandhiv/en/index.html

4. HIV Prevention and young people

HIV prevention is the key to reducing infection rates and slowing the epidemic. Young people between the ages of 15 and 24 are at the centre of HIV epidemics for transmission and impact. They are both the most threatened and the greatest hope for turning the tide against HIV, by changing attitudes and behaviours that contribute to the epidemics.

There is an urgent need for HIV prevention strategies that work for young people because:

- Nearly half of the global population is less than 25 years old.
- Of the new HIV infections annually, about 40% are among young people (aged 15-25 years).
- HIV prevalence among young people is rising rapidly in some countries.
- The future epidemic will be shaped by the action and behaviour of young people.
- A variety of factors place young people at the centre of HIV vulnerability.

It has been shown that young people **can** protect themselves and others if they receive support. The 2006 Report on the Global Aids Epidemic documents behaviour changes, including delays in first sexual experience, increasing use of condoms by young people, and resulting decreases in HIV prevalence in young people in some sub-Saharan countries.

Health workers can use HIV prevention as an entry point for developing a broader adolescent health and development agenda because many other problems are linked to HIV in terms of cause and effect, e.g. too early pregnancy, alcohol, drugs and domestic violence.

Aims of HIV prevention

- To prevent transmission of HIV for all people who are HIV-negative or HIV-positive (whether they know their status or not) in order to reduce the number of new infections.
- To help people who are HIV-negative (whether they know their status or not) to stay negative.
- To promote testing and counselling for people who do not know their HIV status.

Young people need the information and the skills to bring about behaviour change. They need to understand the concepts of risk behaviour, such as unprotected sex and the use of alcohol and drugs, the possible consequences of such behaviour and how to avoid them. They need access to a range of information, life skills, and HIV prevention methods (including information on the advantages of delaying sexual activity, safer sex, negotiation and correct use of condoms, and the importance of sterile needles and syringes) to be able to opt for healthy choices in risky situations. Comprehensive prevention means encouraging young people and supporting them to be aware of their options for a safe life, and assisting them to make the right choices for their individual situation and circumstances.

Young people everywhere report that the education they receive about HIV and sexual reproductive health is too little and too late. Adults are often hesitant to provide young people with the facts about HIV prevention and sexual health, often because they fear this will encourage sexual activity. But there is compelling evidence from studies conducted around the world and in many different cultures that, in fact, sex education encourages responsibility. Knowledgeable young people tend to postpone intercourse or, if they do have sex, to use condoms.

Studies show that sex education does not lead to increases in sexual activity, pregnancy rates or rates of STI. Some studies show that HIV sexual education can delay the onset of sexual activity, reduces the number of sexual partners, or reduces unplanned pregnancy and STI rates. (*Impact of HIV and Sexual Education on the Sexual Behaviour of Young People: A Review Update*. UNAIDS, 1997).

The most significant services for the prevention and care of HIV among young people are those that (*Protecting Young People from HIV and AIDS: the Role of Health Services.* WHO, 2004):

- Strengthen the ability of young people to avoid infection, including information and counselling interventions.
- Reduce risks by providing condoms for those who sexually active, and clean needles and syringes for those who are injecting drugs.
- Provide diagnosis, treatment and care for sexually transmitted infections and for HIV and AIDS.

Who has a role in HIV Prevention?

HIV prevention requires a broad response from all members of society to ensure an environment where young people feel safe and supported and able to protect themselves from HIV at home, school, work and in their community.

- **Young people**

  HIV prevention must focus on young people because they have an essential role in slowing the epidemic. Many young people listen to and believe their peers, so that peer educators and counsellors have an essential role in HIV prevention among young people. Young people can be trained to spread messages and promote responsible behaviour among their friends and colleagues.

- **Parents and other adults in the community**

  All adults have a role to play in their personal capacity as parents, members of extended families and as adult role models. They may also have a professional role as teachers, sports coaches and religious leaders. Studies have identified that having a positive relationship with parents, teachers and other adults in the community and having spiritual beliefs help adolescents to avoid behaviour that puts them at risk of HIV.

  Health workers in all departments of the health service have a critical role in developing and providing HIV prevention services to ensure that effective health strategies are available for all young people.

  There are some young people who have a higher risk of HIV exposure. People in the community need to be trained, given support and provided with the tools to work with young people who are most at-risk. Targeted strategies must be available that focus on their needs. (e.g. harm-reduction strategies for young injectors, information on safer sex and free condoms for young sex workers, and outreach information programmes for out-of-school youth).

- **Public idols who are role models for young people**

  Musicians, film stars and sports figures provide role models for young people through their personal lives and through their performances. The images and messages they portray should encourage young people to adopt and maintain healthy behaviours.

- **Government leaders and the media**

  Politicians, journalists and bureaucrats can influence the social, economic, political and normative factors that determine the HIV risk in the environments where young people live and work. There are policies and_strategies (e.g. free schooling for boys and girls) that can reduce the vulnerability of young people to HIV. The public image of sexuality and HIV in the media also influences young people. There is a need for codes of practice, regulations and education of the media to ensure that they carry out responsible advertising and programming.

- **People living with HIV (PLHIV)**

  PLHIV have a role in HIV prevention. Their personal role is to ensure they do not transmit HIV to any other person. They may also choose to have a role as a supporter or an activist for other PLHIV, as an educator or speaker on living with HIV, as an advocate for the rights of PLHIV or other public or community roles. People living with HIV are frequently subject to discrimination and human rights abuses. A strong movement of PLHIV can develop a network that provides mutual support and a voice at local and national levels and can be a particularly effective method of tackling HIV stigma.

Key HIV prevention strategies for young people through health services

HIV prevention services must be offered to young people when they attend every department of the health services (tuberculosis clinics, STI clinics, ante-natal clinic, family planning clinic, and sexual and reproductive health clinics and services). These services need to be youth friendly (available, accessible, acceptable, appropriate and effective) for all young people.

Key prevention strategies for young people cannot be the same for all but need to be adapted to the different needs of many young people (e.g. boys and girls, children in and out of school, younger and older adolescents, and married and unmarried young people).

- **Information and education on HIV and safer sex**

  Many young people say they need more education on sexuality and HIV prevention to help them practise responsible sexual behaviour. It has been shown that young people can responsibly protect themselves and others if they receive support. Postponing the first sexual activity and reducing the number of sex partners can significantly protect young people from HIV. Behaviour change communication can help young people develop positive behaviours. The messages and the way they are given are very important for young people, they do not only want to hear what they cannot do, but also what they can do.

- **HIV testing and counselling**

  Provider-initiated testing and counselling and voluntary counselling and testing services need to be available at all health services and in the community. In some settings, health workers have held group counselling sessions with young people - PLHIV, HIV-negative or unknown status - to discuss difficult situations in living with HIV and HIV prevention. This method creates a good dynamic because the group looks for solutions to situations, taking the focus away from the individual. This method has been used both for giving information on sexuality and HIV and also for opening the discussion on many sensitive issues faced by young people (e.g. peer pressure, condom negotiation, unwanted pregnancy, decision- making, how to be an adult, disclosure of HIV status).

- **Access to male and female condoms**

  The use of latex condoms to prevent the exchange of body fluids during sex is an essential element of all HIV prevention. Safer sex depends on the correct and consistent use of condoms, so condom provision must be accompanied by clear instructions on condom use for every act of penetrative sex. Female condoms offer women an option that may give them more control but they also require more counselling and assistance with respect to their proper use; they are also more expensive and less available. Condom promotion also supports dual protection, i.e. the simultaneous protection against unwanted pregnancy and the possible transmission of STIs/HIV by either the consistent use of condoms or the consistent use of condoms with another method of contraception.

- **Harm reduction for drug injectors**

  Young drug injectors are particularly at risk of acquiring HIV, since they may not have the knowledge or skills to protect themselves from infection via contaminated injecting equipment. With young injectors it is important to help them to understand the risks, and to assist them to reduce or stop injecting. Harm reduction is about reducing the harmful effects of IDU for those who do not stop injecting. Strategies include education programmes, counselling, drug substitution, and needle-syringe programmes. The strategies need to be acceptable and accessible to young people.

- **STI management**

  STIs greatly facilitate HIV transmission and acquisition between sexual partners, so treating and preventing them is an important step in HIV prevention. In some settings, STI rates among young people are high. Effective and early treatment of STIs is an essential part of HIV prevention.

Questions for the health worker when planning HIV prevention services for young people

- *What is happening in my community with young people and HIV?*

  Talk to young people and young PLHIV to find out what is happening in your community, the risk and protective factors in their lives, where transmission may be occurring, and what they identify as their needs to prevent transmission of HIV. Encourage them to plan and contribute actively to developing HIV prevention services.

- *What contribution can I make to HIV prevention?*

  Look for what you could do. Start small. Learn from what has been done elsewhere. Look for support from young people, other professionals and community members. You can begin by talking about the issues of HIV and young people to colleagues and community members.

- *What barriers are there (in myself, my work environment and my community) that could hinder my contribution?*

  HIV and young people raise many sensitive issues around sexuality and sex. Health workers, young people and community members often feel uncomfortable discussing and addressing these sensitive issues. If health workers are to work successfully with HIV and young people, it is important for them to examine their attitudes and practices and reflect on the material in the Orientation Programme. There is discrimination towards PLHIV among health workers and in health services. Identify and examine reasons why young people cannot or may choose not to go to health services in your community (e.g. legal restrictions, attitudes of personnel, lack of confidentiality or privacy, etc.).

- *What can I do to overcome these barriers?*

  Look for formal and informal ways to discuss sexuality and HIV with members of your community. Help them to see the importance of the issues and the consequences for young people of not addressing HIV prevention. Health workers have an important professional responsibility to address these sensitive issues, even if they if they do not themselves approve or condone the behaviours and life styles of the affected young people. All health workers have a responsibility to act with respect, professionalism and proper procedures towards all people, including PLHIV. Talk with others about what you have learnt and the changes that you plan in your practice. Look for help from others to overcome barriers to developing HIV prevention services in your community.

- *Who else do I need to work with?*

  Contact people who are already working with HIV and young people in your community or region and learn from their experiences (youth groups, nongovernmental organizations, health professionals, teachers, peer support groups, community leaders, etc.). Identify difficult areas of work (e.g. issues of consent and confidentiality with patients who are minors) and discuss what can be done in practical terms. Join or develop networks of people working with these issues for support and for sharing information. Plan together, so that the strategies and HIV prevention messages that youth hear and see are consistent and complementary.

BOX 7

Post-Exposure Prophylaxis (PEP)

Post-Exposure Prophylaxis (PEP) is short-term antiretroviral treatment that is given to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Within the health sector, PEP should be provided as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work.

The risk of exposure from needlesticks and other means exists in many settings where protective supplies are limited and the rates of HIV infection in the patient population are high. The availability of PEP may reduce the occurrence of occupationally acquired HIV infection in healthcare workers. It is believed that the availability of PEP for health workers will serve to increase staff motivation to work with people infected with HIV, and may help to retain staff concerned about the risk of exposure to HIV in the workplace.

Prevention of exposure remains the most effective measure to reduce the risk of HIV transmission to health workers. The priority must be to train health workers in prevention methods (universal precautions) and to provide them with the necessary materials and protective equipment (e.g. gloves, sterilizing equipment).

There is significant debate on the need to use PEP after sexual exposure. PEP must be commenced less than 72 hours after unprotected sex. There are very strong ethical and societal issues for providing PEP following sexual exposure to HIV, especially following rape or condom breakage.

For more information see: http://www.who.int/hiv/topics/prophylaxis/en/print.html

5. HIV TESTING AND COUNSELLING AMONG YOUNG PEOPLE

The current concept of HIV testing and counselling has been broadened from making these available to those who ask for it at, for example, Voluntary Counselling and Testing (VCT) sites, to provider-initiated HIV testing and counselling (PITC). In all testing and counselling situations the patient always retains the right to refuse.

In the PITC approach, each encounter between a patient and a health worker is seen as an opportunity for:

- people who have never been tested (or were previously negative) to know their current status;
- people to discuss options and make choices according to their status;
- health workers to provide the best care and prevention according to the patient's HIV status.

HIV testing and counselling is an important entry point to prevention, care, treatment and support. It is a crucial prevention intervention and is an important opportunity for people who test negative. HIV testing must only be offered with the 4 Cs: Confidentiality, informed Consent, Counselling and Condoms.

Knowing one's HIV status

Knowing their HIV status and receiving counselling and support can enable *individuals* to:

- **Initiate or maintain behaviours to prevent acquiring or transmitting HIV**

  Learning about one's HIV serostatus, with counselling support, can be a time when young people are open to making changes in their risk behaviour. This empowers those who are not infected to remain so, and those with HIV to access care and prevent further transmission. Correct and consistent condom use must be actively promoted by all testing and counselling services. Group counselling of young people can be a way of discussing difficult situations with HIV and the benefits of testing, and taking the focus away from the individual.

- **Gain early access to specific HIV-positive prevention, support, care and treatment**

  Young PLHIV will probably remain asymptomatic for a long period after a positive-HIV test result. They can benefit from the scaling up of antiretroviral therapy only if they know their HIV status. The earlier they know that they are HIV-positive, the sooner they can receive counselling and support and reduce the risk of transmitting HIV, thus protecting themselves, their partners and their loved ones.

- **Access strategies to prevent transmission from mothers to their infants**

  In some settings, mother and child health (MCH) clinics can offer HIV testing and counselling and antiretroviral drug regimens to prevent mother-to-child transmission (PMTCT). However, globally only a small proportion of pregnant women have access to these services.

Knowing their HIV status and receiving counselling and support can help *communities* to:

- **Reduce the denial, stigma and discrimination that surround HIV**

  Communities that normalize the process of including HIV serostatus as part of general health-seeking behaviour have a greater chance of tackling the stigma and discrimination associated with the disease.

- **Mobilize support and appropriate responses**

  Community mobilization can be facilitated if more people know their HIV status. In communities where people have a friend or relative with HIV, the stigma associated with the virus can be less and support for PLHIV can grow. However, we may only reach this level in high prevalence settings.

  All people, including young people, have a right to know their HIV status. However, any coercion to get tested must be strictly avoided.

Special considerations in HIV testing and counselling among young people

- **Do not discount the potential for HIV in young people**

  It is important that health workers look for the possibility of HIV infection among young people because a large number of them are particularly vulnerable. Health workers should therefore encourage them to consider being tested. Even if they don't want the test immediately, they must be invited to come back when they are ready and meanwhile be provided with links to other support services in the community. Young PLHIV will have a long asymptomatic period when early diagnosis is rare without an HIV test, and to assume there is an infection is difficult.

- **Understand the issues of consent and confidentiality in HIV testing and counselling of minors**

  As with any patient, consent and confidentiality are important considerations with under-age young people (minors) who come for HIV testing, especially if they are not accompanied by an adult. Each situation is different. If possible, an assessment should be made of the young person's risk for HIV, the possibility of not returning for testing, and his/her capacity to understand informed consent. Health workers should take into account the best interests of young persons and their evolving capacities. All health discussions with minors should be kept confidential, unless unlawful.

  Parents or guardians should not be informed of an adolescent's HIV status without the explicit consent of the adolescent who is deemed capable of providing the informed consent. The Convention on the Rights of the Child states this clearly: "Information on the HIV status of children may not be disclosed to third parties, including parents, without their consent".

  In many settings, allowances are made for groups of adolescents who are designated "mature" or "emancipated" minors (e.g. those who are married, sexually active or are pregnant) to provide consent for themselves for some services.

  Each situation is different and an assessment should be made of the young person's risk for HIV and the possibility that he/she will not return for testing. HIV testing and counselling without parental consent should be considered, if appropriate; this should be documented in writing and possibly shared between two members of staff. There may be legal restrictions on performing an HIV test without the consent of a parent or guardian and this is a significant barrier in many settings to an adolescent being tested.

- **Remember that your first meeting with a young person may be your only meeting**

  It is important to take advantage of the initial session with young persons, as it may be your only chance to communicate the importance of the reality of HIV and of living "safe". Because they may not come back, make sure that they have educational materials and links to community services and peer support, where they can access further information and support at a later date.

  Community links and referrals need to be checked out in advance, to ensure that they are legitimate. Keep the information in a resource file which you can access easily when you wish

to refer young people. If possible, you can offer to accompany them to the support service. Also encourage them to return to see you. If support services do not exist, you can consider starting a support group.

- **Promote beneficial disclosure**

  All PLHIV need support to cope with living positively. Support from family and close friends can be particularly important, but they can only access this support if family or close friends know their HIV status. Counselling can help them to understand the benefits of revealing their HIV status. They may need to think about this and even to practise, through role play, how to tell friends and family. Peer support groups are especially valuable to share their concerns and experiences, and counselling can help them as regards whom to tell and how to go about it.

  However, health workers need to be aware that there is a risk in disclosing HIV status in an unsupportive setting, particularly for young women who may be at risk of domestic violence. Young people need a lot of support around issues of stigma and disclosure of HIV status, which may involve disclosing their sexual activity and injecting drug use. The final decision on disclosure stays with the young person.

- **Take the opportunity given by a negative HIV test**

  An HIV negative test result provides an opportunity to discuss risk behaviour and promote behaviour change with young persons. Prevention education and risk-reduction counselling can help them to consider, plan and implement changes in their HIV risk behaviour. Promotion of condom use should be part of all counselling sessions, and include distribution of condoms, as appropriate.

- **Promote future counselling of client together with their sexual partner**

  Couple counselling can help to avoid the situation where the partner who receives a positive test result is blamed. It is also an opportunity to discuss condom use. With a discordant couple (when one person is HIV positive and the other is negative or of unknown HIV status), couple counselling can provide support to each partner to help them cope with the situation. However, there are situations where couple counselling is not possible.

- **Promote safer sex and harm reduction**

  Safer sex includes delaying first sexual activity, reducing the number of sexual partners (or delaying sexual activity in a new relationship), and using condoms correctly and consistently. Harm reduction includes strategies and approaches that reduce the physical and social harms associated with risk-taking behaviour. Harm reduction among IDUs can include abstinence, education programmes, counselling, drug substitution and needle exchange. Harm reduction among sex workers includes correct and consistent use of condoms.

- **Promote peer counselling by other young PLHIV**

  Young people need the support and practical experience of other people in their situation who are coping well with living with HIV.

Circumstances in which young people may present for HIV testing and counselling

There are different reasons and situations why a young person may come for testing and counselling.

- **Choice:** the young person makes the decision to come for testing

  Young persons may have recently experienced a situation which makes them think they could have been at risk for acquiring HIV (e.g. rape, condom breakage, unprotected sex, first experience

with injecting drug use). They may have a marker disease (e.g. tuberculosis) or an STI, or be on the brink of something new in their lives (e.g. marriage).

- **Recommendation:** another person advises, the young person decides

  Provider-initiated HIV testing and counselling recommends that health workers offer this service during all routine contacts with patients in healthcare settings. The health worker may be following the health centre's policy or guidelines. All people should be informed and give their consent and the patient always retains the right to refuse the test.

  A health worker may have some reason to suspect that a young person could be HIV-positive, e.g. presence of a marker disease like tuberculosis. Having an STI increases the risk of acquiring and transmitting HIV, so a young person who has an STI or TB should be advised to be tested for HIV. Young people who are vulnerable to HIV (e.g. sex workers) should be counselled to be tested for HIV. Peer counsellors, outreach workers or youth counsellors may have to recommend that the young person comes for HIV testing.

- **Mandatory:** other persons/people make the decision to test the young person

  Mandatory screening of donors is required prior to all procedures involving transfer of body fluids or body parts. There may be other reasons for HIV tests in various situations, e.g. entering the military, before marriage, and applying for a job, visa or scholarship. HIV tests may be carried out in healthcare settings without the patient knowing. Testing without counselling has little impact on behaviour and is a significant lost opportunity for assisting people to avoid acquiring or transmitting HIV.

  WHO does not recommend mandatory HIV testing as an effective public health strategy. Mandatory testing is not ethical and does not respect the human rights of an individual.

For young people who refuse HIV testing, the health worker should:

- counsel them on the benefits of testing;
- identify and discuss their barriers to testing;
- provide emotional support and refer them to peer counselling;
- re-assess their intention to test at a later date;
- offer a follow up appointment.

BOX 8

Rapid HIV testing

Rapid HIV testing with results the same day is recommended for all people, especially young people.

- Rapid testing ensures that the young person gets the result and receives counselling immediately. It took a lot of courage to come to the clinic the first time and he/she may not return a second time, even if that means never receiving the HIV test result.
- Rapid testing allows for same-day results. Most tests can be read within 20 minutes. If the first test result is positive, another Rapid HIV Test must be performed (confirmatory test). With a second positive result, the patient can be counselled for a positive result. If the second test is negative, then the result is considered inconclusive and the algorithm is repeated. This situation happens very rarely.
- There may be an algorithm for HIV testing in your national guidelines for HIV Testing and Counselling. WHO has developed an HIV Testing Policy Statement.

6. Management of HIV in young people

Management of HIV in young people includes a range of services that provide (a) care, (b) treatment, (c) support, (d) positive prevention for young people living with HIV, and (e) counselling, which is an integral part of all these services.

The aim of services is to help young PLHIV to:

- **Stay healthy and live positively**

  Positive living can help PLHIV to live a full and healthy life. Counselling and support can help them to stay healthy and improve their self-esteem and confidence, with the aim of protecting their own health and avoiding passing the infection to others. Health workers can support the efforts of these people to prevent other infections, take part in physical activity, avoid harmful treatments and maintain good nutrition. They can refer them to other community services for emotional and peer support (e.g. young PLHIV support groups, post-test clubs).

- **Adhere to care and treatment**

  Young PLHIV may need to take medication for a range of infections and illnesses. Adolescents infected through perinatal transmission may have begun antiretroviral therapy (ART) in childhood. Otherwise, as HIV progresses they may require ART. Adherence to all treatments is important. Adherence to ART is important for the health of the individual and to reduce the risk of drug resistance.

- **Understand the benefits of disclosing HIV status to family, sexual partner(s), close friends**

  PLHIV may be hesitant to reveal their HIV status to others for fear of stigma and discrimination. In order to receive the support of family and friends, young PLHIV will need to face the difficult task of telling them of their HIV status. Adolescents who were infected through perinatal transmission may not know that they are HIV-positive, though they have probably suspected. However, there is a risk of disclosing HIV status in an unsupportive setting; women, in particular, may be at risk of domestic violence.

- **Cope with stigma and discrimination towards themselves and their loved ones**

  Health workers have an important role to play in combating stigma and discrimination and assisting young PLHIV to cope with how it can affect them, their families and their loved ones. Unfortunately, health centres are still a place where there is HIV stigma and discrimination against PLHIV. Young PLHIV should be involved in developing and planning of HIV support services. This can lead to improved utilization and ownership of services, as well as reduce the stigma and present a positive role model to healthcare workers and patients.

(a) CARE

Management of HIV is based on medical care and psychosocial care in a healthcare setting. It includes antiretroviral therapy (ART), care and treatment of opportunistic infections (OI) and STIs, and also treatment of other conditions (e.g. cancers, depression).

The ten principles (see Box 10) can be used in managing many diseases, including HIV, and risk conditions. HIV can be a chronic disease, especially for young people who may be living with the virus for many years with no symptoms. ART has also changed HIV to a chronic disease. These principles are described below with regard to their application to caring for young people with HIV.

BOX 9

Young people and HIV stigma and discrimination

HIV-related stigma is when unfavourable attitudes, beliefs, and policies are directed to people who are perceived to have HIV or AIDS, as well as to their loved ones and others (like close associates, social groups, and communities).

HIV-related discrimination results when actions differentiate between people based on stigma (e.g. a confirmed or suspected HIV serostatus). Persons associated in the public mind with HIV or AIDS (e.g. homosexuals, prostitutes, drug addicts, haemophiliacs, family members and associates of HIV-positive people) may also face discrimination.

HIV-related stigma, discrimination and human rights violations are serious barriers to progress in understanding HIV infection, to providing care, support and treatment, and to alleviating the impact of the epidemic.

Discrimination occurs when ill-informed people or institutions treat individuals unfairly or unjustly because of their presumed or actual HIV status. This can be through actions or omissions to act and result in a violation of human rights.

Patterns of prejudice, which include devaluing, discounting, discrediting, and discriminating against these groups of people, play into and strengthen existing social inequalities—especially those of gender, sexuality, and race—which are at the root of HIV-related stigma.

Factors which contribute to HIV-related stigma:

- HIV is a life-threatening disease.
- People are scared of contracting HIV.
- The disease is associated with behaviours (such as sex between men and use of injecting drugs), which are already stigmatized in many societies.
- People living with HIV are often thought of as having been responsible for becoming infected.
- Religious or moral beliefs lead some people to believe that HIV is the result of a moral fault (such as promiscuity or “deviant sex”) that deserves to be punished.

Stigma and discrimination discourage people from getting tested for HIV. They also discourage those who are infected with HIV from obtaining needed services because this may reveal their HIV status.

BOX 10

General principles of good chronic care

- Develop a treatment partnership with your patient.
- Focus on your patient’s concerns and priorities.
- Use the 5 A’s – Assess, Advise, Agree, Assist, Arrange.
- Support the patient’s education and self-management.
- Organize proactive follow-up.
- Involve “expert patients”, peer educators and support staff in your health facility.
- Link the patient to community-based resources and support.
- Use written information – registers, treatment plans, patient calendars, treatment cards – to document, monitor, and remind.
- Work as a clinical team (and hold team meetings). Each team must include a district ART clinician.
- Assure continuity of care.

Source: *Chronic HIV Care with ARV Therapy, Integrated Management of Adult and Adolescent Illness* (IMAI), WHO, 2004.

Good chronic care for young people with HIV

Here are some general principles for good chronic care applied to young people living with HIV.

- The treatment partnership is a treatment plan that is decided between the young person and the health worker. Young PLHIV may respond well to this because it gives them some ownership and control over their treatment and lessens the feeling that they are being told what to do. This involvement of adolescents is important because they can be encouraged during the change from paediatric to adult care.
- By asking about and listening to the young patient, it is possible to respond to the issues that they see as the most important. Each young person may have different concerns which will change over a period of time. Their concerns and priorities may be different from what we expect. Respond to any signs and symptoms that the young patient is experiencing at the moment.
- The 5 A's are a key part of good chronic care. They are a series of steps used in caring for patients: Assess, Advise, Agree, Assist and Arrange. You can respond to a patient's symptoms and problems using the 5 A's (refer participants to Box 11 in the Handout). The Assist and Arrange will be particularly important for young people in order to provide them with links and support to other services.
- Many young people continue to have misconceptions about HIV. Young PLHIV need HIV education and care plans to help them manage to live positively. Young people may especially need support in their self-management. Involvement of PLHIV peer counsellors, family and friends is essential.
- Young patients may not return to clinic appointments. Health workers need to follow up on them (e.g. home visits or going to places where young people gather). However, this needs to be done with tact and while ensuring confidentiality. Find creative ways to encourage young patients to come back.
- It is very important for young PLHIV to be part of the planning and implementing of HIV services in the clinic and community. Their perspective will influence the work of the other professionals and provide a convincing example of positive living to other young clients. Encourage training and support for young PLHIV as peer counsellors to facilitate support groups and youth support services. HIV information presentations by peer educators at schools, post-testing groups, football clubs and girls' clubs can raise awareness and encourage young people to seek testing and counselling. Encouraging self-management can improve their understanding of their care and prepare the adolescent for adult care.
- It is essential to provide links and referrals to other health services, peer support groups and other community-based resources. Ensuing continuity of care to meet immediate and longer-term needs of the young person is vital to maintain support in the community and home. Keeping a resource file of services for young people can help health workers to access local information easily.
- Patients' records need to be kept so that different support services can maintain continuity of care. Pictures, diagrams or words written out for an individual patient can assist young patients in understanding treatment plans and remembering treatments, appointments and information. Written information can be presented in a way that is interesting and attractive to young people.
- Working as a clinical team ensures that the patient receives consistent care and information from all staff at the clinic. Patients may be more comfortable if they see the same carer at each visit and are able to build up a relationship.
- Continuity of care is important in the clinic and through community support services. Young PLHIV may be using the services over many years and continuity of care ensures that the changing needs of the young client and their family can be met.

BOX 11 - part 1

Guide for health workers: using the 5 A's with a young patient living with HIV

The 5 A's are a key part of good chronic care. They are a series of steps used in the IMAI approach to Chronic HIV Care with ARV Therapy to guide health workers at each consultation. Described below are the 5 A's with particular focus on the issues that are important for a young patient living with HIV.

Note: If the patient is a minor, you must know the legal requirements in terms of consent, bearing in mind the best interests of adolescents and their evolving capacities.

ASSESS

- Assess young patient's goals for this consultation: they may be different from yours.
- Assure them of confidentiality.
- Assess the patient's physical and mental status, understanding that HIV may progress more slowly in adolescents than in adults.
- Review current treatments and assess adherence.
- Assess whether sexually active or not (or planning to be sexually active), contraception and condom use.
- Assess young women for pregnancy.
- Assess other risk factors for HIV transmission (e.g. injecting drug user, orphan, sex worker).
- Assess young patient's knowledge, beliefs, concerns, and daily behaviours related to HIV.
- Assess support structure and who knows of their HIV status (partner, family, friends, etc).

ADVISE

- Use plain language and a non-judgmental attitude. Include parents or guardians in discussions, if this is the young person's choice.
- Correct any inaccurate knowledge and complete gaps in the young patient's understanding of his/her condition.
- Advise on being young and living with HIV (relationships, sex, alcohol and drug use, etc.).
- Advise on sexual activity, condom use, contraception. and other aspects of positive prevention
- Discuss couple counselling and advise on benefits of disclosing HIV status to chosen people, in order to develop support structure.
- Advise on peer support from other young people living with HIV.
- Advise on adherence.

If developing a Treatment Plan:

- Discuss the options available to the young patient (risk reduction, positive prevention, prophylaxis and treatment).
- Advise about the simplest regimen possible. Evaluate the patient's confidence and readiness to adopt and adhere to treatment.
- Take adolescent developmental phase into consideration in prescribing ARV therapy (using Tanners Stages).
- Discuss any proposed changes in the Treatment Plan, relating them to the patient's specific concerns.

AGREE

- Agree on where the young person would choose to receive treatment and support.
- Discuss to whom they choose to disclose their HIV status.
- Discuss how they may disclose and the support they may need.
- Agree on the roles that the young person and others will play in their care and treatment.
- Agree on the treatment plan that has been developed.
- Agree on goals that reflect the young patient's priorities and ensure that the negotiated goals are:
  - clear;
  - measurable;
  - realistic;
  - under the young patient's direct control;
  - limited in number.

BOX 11 - part 2

Guide for health workers: using the 5 A's with a young patient living with HIV

ASSIST

- Provide a written or pictorial summary of the plan.
- Provide referrals to youth friendly health services in the community.
- Provide links to support services for youth living with HIV in the community.
- Provide treatments and other medications (prescribe or dispense).
- Provide skills and tools to assist with self-management and adherence, including adherence equipment (e.g., pill box by day of week and self-monitoring tools, such as a calendar or other ways to remind and record the Treatment Plan).
- Address obstacles to adherence (e.g. side-effects, weight gain, medication being a constant reminder of HIV status)
- Help patients to predict possible barriers to implementing the Treatment Plan and to identify strategies to overcome them.
- Assist with patient's physical, mental and social health, including the provision of sychological support as needed. If young patient is depressed, treat depression.
- Assist by strengthening the links with available support:
  - friends and family;
  - peer support groups;
  - community services;
  - treatment supporter or guardian (for certain treatments).

ARRANGE

- What the young person will do during the time between visits.
- Agree on the next appointment date and underline the importance of attending even if they feel well and have no problems.
- Schedule for group counselling or links with young PLHIV support group.
- Record what happened during the visit.

(b) TREATMENT

Treatment includes antiretroviral therapy (ART), prevention, treatment and care of opportunistic infections (OI) and STIs. Treatment also includes management of other chronic conditions (e.g. cancers, depression). This module does not discuss the full range of clinical care but the IMAI booklets provide guidelines. This module will give some information on ART and young people.

There are distinct groups of HIV-infected adolescents who may require ART, but have different needs because of their infection history. For adolescents who were infected around birth and have survived into adolescence, HIV disease may develop as rapid progression or slow progression. In rapid progression, they may have begun ART during childhood and are likely to have had experience with different treatments. These adolescents may face challenges relating disclosure of HIV status, developmental delays, transition of care from paediatric to adult care, and choice of appropriate ART regimens and adherence. Adolescents who were infected around birth with slow progression of HIV disease may present for the first time to ART services during adolescence; their treatment and care needs are similar to those who become infected during adolescence.

ART-related issues

- **Life-long treatment**

  ART is a life-long treatment and this creates a challenge for adherence. To be told you need to take potent drugs all your life can be overwhelming for anyone and for young people this news may be even more distressing. Adherence to ART is essential and will be discussed later.

- **Timing of when to start ART**

  Decisions on when to begin a young patient's treatment can be very difficult. Young people may not need ART for many years. WHO has developed a system of HIV Clinical Staging that gives guidance to health workers on when to begin treatment (see IMAI Guidelines).The young person should be involved in the decision to begin therapy through an agreement that shares responsibility with the health worker.

- **Fixed-dose combination (FDC) drugs**

  ART is multi-drug therapy. Mono-therapy is not recommended because of rapid development of drug resistance. FDC drugs are pills containing 2 or 3 substances in one tablet (e.g. a triple combination with three substances). Many young people prefer them as it means they do not have to take medication during the day. FDCs are easier to distribute and store, assist in improving adherence, and reduce the incidence of treatment failure and drug resistance. FDC drugs are recommended by WHO as first-line treatment in developing countries. Drug doses need to be managed with care for young people using the Tanner scale (see Box 12).

- **First- and second-line treatment**

  National regulating authorities select their first- and second-line treatment regimen which is usually a triple combination. Patients will only change to a second-line treatment regimen if the first-line treatment fails and the patient starts to decline clinically or immunologically (CD4 count falls). Generic drugs are not inferior to brand name drugs. They are subjected to the same rigorous quality assurance as brand name drugs and their active ingredients are exactly the same. The difference is in their cost, generic drugs being much cheaper, which enables drug budgets to go further to treat more people.

- **ARV drugs are potent and cause side-effects**

  ART use highly potent and potentially toxic drugs with a range of side-effects. Some can be experienced on a daily basis and others can be long-term effects on a patient's physical development and future outcomes. These include changes in body shape, fertility, puberty and growth. Young people need an opportunity to discuss and understand these effects. Fortunately, most persons starting ART are able with support to manage the early or minor side-effects and can successfully take the first-line drugs even for several years.

- **Drugs can interact with treatments of other conditions**

  ARV drugs may interact with other treatments (e.g. TB, antidepressants) and may pose problems for the patient on ART. For the individual patient, management of life-threatening opportunistic infections may be a higher priority than ART.

- **Equity and fair distribution**

  WHO advocates a public health approach to ARV drugs. Equity and fair distribution are essential for ARV drug distribution. Nevertheless, it is difficult to put this into practice and there are settings where ARV drugs are still not available.

BOX 12

ART regimens and dosages for young people

This module orients health workers to HIV and young people but does not aim to provide training in prescribing ART.

WHO has developed a clinical training course that uses simplified guidelines to train first-level health workers in chronic HIV care including ART (IMAI Basic ART Clinical Training Course). This enables health workers to provide quality ARV therapy to PLHIV in their communities.

ARV drug doses need to be managed with care for young people. WHO recommends basing the choice of ART regimens and dosages for adolescents on Tanner staging. The Tanner stages are stages of physical development in children, adolescents and adults. The stages define physical measurements of development based on external primary and secondary sex characteristics. The stages are based on observing the development of the genitalia in boys, the development of the breasts in girls and the growth of pubic hair in both sexes.

Adolescents in Tanner stage I, II and III should be begun on paediatric schedule and monitored particularly carefully because they are at a time of growth-spurt hormonal changes. Adolescents in Tanner stage IV or V are considered adult and should receive adult-dose ARV regimens. In choosing ARV regimen for adolescents it is also necessary to consider simplification and long-term adherence, and to consider the use of EFV (efavirenz) and NVP (nevirapine) in adolescent girls who are at risk of pregnancy.

Challenges in maintaining adherence to ART for young PLHIV

Adherence to ART regimens is a struggle for most people but may be especially difficult for young people. Adherence can be difficult because many young people:

- prefer to live in the present rather than plan into the future;
- desire their independence and want to move to adulthood;
- have not disclosed their HIV status to people who could support them, because of feelings of shame or fear of stigma. (Adolescents who had been infected around birth may not know their HIV status, although they may suspect this.)
- are afraid that taking regular medication can identify them as having HIV and expose them to HIV stigma and discrimination.

Some of the factors contributing to non-adherence relate to young people themselves and some to the features of drug regimens. Factors that improve adherence include:

- informing young people of their HIV status if they do not know (as with perinatal transmission);
- providing a support system to assist with clinical care and advice (e.g. management of side-effects, simplifying the dosage, monitoring of missed doses, etc.);
- accessing peer support to help them with finding strategies to assist with adherence and improve self-esteem and reduce the stigma of HIV;
- providing clear information on HIV, the aims and advantages of the regimen, and the importance of adherence. Prescribe the easiest possible ART regimen (e.g. single dose);
- giving the young person greater responsibility and understanding of their treatment by negotiating their care and coming to an agreement. This can be with a partnership or an agreement on treatment and care.

It is important to discuss adherence and adherence-related problems openly and with respect and empathy in every encounter with the young patient, and to seek solutions to any problems. Recently, health workers have moved towards making an agreement with young patients in order to give them a greater sense of personal responsibility in their HIV care.

(c) SUPPORT

Support deals with the emotional, spiritual and material support for young PLHIV, which is often provided by peers, family and community.

Support for young PLHIV

- Support may be connected to ART and care. However, support for young people should start before ART. The majority of young people living with HIV do not have symptoms and may not need ART for many years, but they do need or will need support to help them cope with their HIV status. The support needed will be different for each young person.
- Support is about assisting young PLHIV to cope with the impact of HIV on their lives - on every aspect of life. Like all people, young people can feel overwhelmed and depressed by the prospect of living with HIV. They may not have the experience, relationships, or maturity to help them to cope as adults can. Having the support and positive example of other young PLHIV can be very valuable. Peer counsellors and peer support groups can provide information and practical support in a manner that is credible and acceptable.
- Support from the health services will change with the changing needs of the young PLHIV. It can begin with post-test support, continue over the years when the young PLHIV has no symptoms, and become ongoing support. Support for young people who have acquired HIV through perinatal transmission begins in the paediatric services. When the young person becomes an adolescent or young adult, paediatric care will no longer be appropriate. The transition of care is sometimes a difficult time and comes at a stage in their development when they especially need support to cope with the changes of adolescence. There are not many special services that address their particular needs. Transition of care needs to be planned in advance and introduced gradually.
- HIV has emotional, social and economic impacts on the families who frequently experience the stigma and discrimination associated with HIV. The young PLHIV's family, partners, household, community, work and school may all need support. They can also all be a source of support.
- Support includes all measures that alleviate the impact of HIV on the young PLHIV, their family and their community. As with all chronic diseases, there is usually less money in a household where a PLHIV lives. Young PLHIV may be in need of support strategies to meet their daily needs (e.g. spiritual, nutritional, sexual, financial, legal support and support to ensure their human rights are respected).

Psychosocial issues especially pertinent to young PLHIV

For most people, sexual activity begins during adolescence and, in general, sex is an important part of the lives of young people. Young PLHIV need practical support to deal with their questions, concerns and fears around being HIV-positive, wanting to have friendships and to be loved, and having or wanting to have sexual relations and children. Like all people, PLHIV have the right to have intimate relationships and children.

People who work with young PLHIV say that in general the following questions identify the young people's greatest concerns. Health workers may find it hard to raise and discuss these sensitive

issues and young people themselves may not be able to voice their concerns. The following responses can help health workers to talk with young people about these issues.

- *Will anyone want to have sex with me if they know I am HIV-positive?*

  PLHIV can continue to have sex. However, there is a high risk of HIV transmission if a PLHIV has sex without a condom. Always use a barrier to prevent contact with blood or sexual fluid. Condoms are the most common barrier for men. Female condoms can protect the vagina or anal area during sex. There is no way to know how risky it is for two HIV-positive people to have unprotected sex. Using a condom will reduce the risk. Use condoms correctly and consistently every time you have sex. Although it is not easy, it is important to tell your partner you are HIV-positive before there is any risk of HIV transmission. Counselling and support from other young PLHIV can help you to understand your options for enjoying a healthy sexual life as a PLHIV.

- *Will I be able to have children?*

  Like all people, PLHIV have the right to have children. HIV-positive women and couples have the right to choose for themselves whether they want to have children or not. You need to have access to sexual and reproductive services, including counselling to make you aware of your reproductive choices and the health risks for your unborn child, in order to make informed decisions.

  Couple counselling should be encouraged but an individual's situation may make this impossible and the health worker needs to support the young person's decision.

- *Will I die early?*

  Some young people may not understand the difference between HIV and AIDS. They may think that a positive test result means they will die soon. With more effective drug regimens and earlier detection, it is possible to remain healthy for many years. But the reality is that many young PLHIV will die earlier than they would without HIV.

  Emotional and spiritual support can help alleviate depression, help to prevent suicidal ideas, and help deal with the strong emotions associated with having a chronic and fatal condition. This support can come from many formal and informal individuals and settings. For young people, peer support is especially important. If peer support is not available, the health worker can be active in starting a peer support group for young PLHIV.

- *I am too young to have a chronic disease*

  Adolescence is a special time in peoples' lives. All people have dreams for the future and to learn that you must live with HIV is shocking news at any age. For young people it can be hard to imagine how they are going to live their whole lives with a chronic disease, when they feel that they have only just begun to live. All their desires for relationships, family life and career are overshadowed by the news. The health worker can play an important role in providing the young person with hope, and in helping him/her to develop the perception that life can continue - and be meaningful - even in the presence of HIV infection. Health workers can also provide referral to peer support.

- *I can't tell anyone that I am HIV positive*

  Many people are naturally fearful of telling family, friends and sexual partners that they are HIV-positive. Young people should be encouraged to understand the benefits of telling family and friends their HIV status. They need their support to help them cope with living positively. They can also benefit from sharing their fears and concerns with other young PLHIV. However,

young people will need encouragement and support to tell, and all concerned must be aware that there may be a risk in disclosing HIV status in unsupportive settings.

Through counselling they can be made aware of the benefits of disclosing their HIV status to selected people who can support them to live positively. However, the young person is always the one who ultimately decides whom to tell and when.

- *I am afraid that people will reject me, shun me or be violent towards me*

  Many people with HIV experience stigma and discrimination. Acts of discrimination against people living with HIV can range from inappropriate comments to violence. Information and education about HIV can help moderate the fears and misconceptions of people in the community and reduce the stigma and discrimination. As more people learn their HIV status, being HIV-positive can become less of a stigma. HIV can have a negative impact on education and work opportunities. Young people will need support and advice on how to manage their future opportunities.

  Young PLHIV may have feelings of loneliness and isolation. They may lose friends because they are HIV-positive. They may also be wary of revealing their status to anyone (sex partner, peers, family member, school officials, etc.) due to the possibility that disclosure may ruin their image, plaguing them with the stigma associated with HIV. Although this may be true for anyone, young people have heightened difficulty because, to a certain extent, they base their self-worth on what other people think of them.

  Stigma and discrimination are serious barriers to HIV prevention.

- *Can I still smoke, drink, go out and have fun like my friends?*

  Young PLHIV should be encouraged to live the same life as their friends, but they may need to be more aware of maintaining their good health and avoiding activities that jeopardize their health.

  Health workers should ask for permission before giving young persons information on how to stay healthy. Young people will decide for themselves their limits and the risks they will take. General information on healthy living (nutrition, hygiene, exercise, adequate rest, avoiding smoking, moderate alcohol use, etc.) is important. They will also need practical information on HIV transmission, substance use, negotiating and practising safer sex, and ARV drug adherence.

  Remind young people that substance use can impair judgement, making them more susceptible to pressure to engage in unwanted or unprotected sex. Using substances can also interfere with their medication.

  Young PLHIV will need support on deciding whom (among their friends) to tell and how to tell about their HIV status.

(d) POSITIVE PREVENTION

Positive prevention for young people includes all strategies that increase the self-esteem and confidence of young PLHIV, with the aim of protecting their own health and avoid passing the infection to others.

Improving the self-esteem and confidence of young PLHIV has many benefits at the individual, family and community level. Positive prevention recognizes the rights and needs of PLHIV and can empower them and help them to take charge of their lives and encourage them to take responsibility for preventing HIV transmission. Positive prevention is focused on communication, information and support, safer and healthier sex, harm reduction, PMTCT and STI management. The concept

of positive prevention is expanding and can also include provision of safe drinking water, impregnated bed nets, screening and chemoprophylaxis (e.g. co-trimoxazole and INH) for tuberculosis.

An important part of positive prevention is counselling, with the aim of:

- Supporting positive living (emotional, psychological and physical), which can help PLHIV to live healthily and take responsibly for their health.
- Assisting PLHIV to learn how to enjoy a healthy sexual life, without fear of infecting their loved ones.
- Involving PLHIV and associations of PLHIV in community activities.

Positive prevention requires the meaningful involvement of young PLHIV in the planning and implementing of HIV strategies. Young PLHIV can work with service providers to make strategies relevant and useful to young people. They give a perspective that is unique and provide credibility and relevance to the local context. They also give a face to HIV. When programmes enlist young PLHIV and their organisations (where they exist), they become emissaries to the general community which can lead to increased awareness, decrease in stigma and discrimination, and an increase in the use of services.

(e) COUNSELLING

Counselling of young PLHIV concentrates on the emotional, behavioural, and social issues that relate to living with HIV. Counselling often begins with an HIV test result; however, counselling is an essential part of HIV management and care and is much more than explaining to a young PLHIV his/her test result.

How to modify counselling to respond to the needs of young PLHIV

- **Be prepared for the variety of ways they may respond**

  Young people are faced with a diagnosis of HIV in many different situations. By being aware of the different situations and of what the young person's thoughts and feelings are likely to be, the health worker may be able to prepare for the different responses that may occur.

  Try to "put yourself in their shoes" (i.e. try to understand what the young person may be thinking and feeling). This will help you to respond to them more effectively and with greater sensitivity. Try to encourage trust and comfort. Be supportive of their situation and their decisions. Guide them appropriately, without letting personal opinions and values interfere with the work.

- **Give referrals and links to other support services**

  Be sure to provide them with links to places in the community where they can seek further assistance. In order to do so properly, find places within the community that can be trusted and where young patients will feel comfortable. Many young people need a safe place to go and 'be' without having to feel judged. These links are essential in supporting the young person with positive prevention. Support from other young PLHIV is particularly important to lessen their feeling of being different and isolated.

- **Provide support for the development of skills in HIV risk reduction**

  Young people need support in learning skills to reduce their risk of acquiring or transmitting HIV. This information needs to be clear and practical. Handing over condoms is not enough, health workers need to ensure that the young person knows how to use condoms correctly and

understands the importance of putting one on (male) or inserting one (female) every time before intercourse. Group counselling sessions can be considered with young PLHIV as a method of discussing difficult situations in living with HIV (e.g. disclosure, sexuality, negotiating condom use, living with peers). This takes the focus away from the individual and requires the group to discuss and identify risk-reduction strategies.

If peer support services are not available for young PLHIV in a community, health workers can consider helping establish such a group. Begin with a small group and support the young PLHIV to take the lead in developing the support service.

- **Help them to develop an immediate plan for the moment they leave your clinic**

  The moment they leave your clinic, young people will likely be full of unanswered questions. By developing an immediate plan with them, they will know where to go to access more information until their next appointment with you. Focus on this short-term approach while making sure that they understand the importance of coming in again for the next step in this process.

BOX 13

Successful approaches to working with young people and HIV

- Youth participation in planning and implementation of programmes.
- Comprehensive life skills and sex-and-relationships education in and out of school.
- Peer-led programming to inform and encourage young people to protect their health.
- Youth-friendly health services offering HIV testing and counselling, and services for the diagnosis and treatment of sexually transmitted infections.
- Harm reduction to prevent HIV transmission through injecting drug use along with demand-reduction programmes, and health services directed to other vulnerable groups, such as young sex workers and mobile populations.
- Community-based programmes for young men and education of young women to tackle sexual coercion and other forms of violence.
- Sustained media campaigns using communications channels that young people find credible and acceptable to promote gender equitable norms and HIV prevention education.

Adapted from: WHO (2004), *Steady..Ready..Go!* The Tallories Consultation to review the evidence for policies and programmes to achieve the global goals on young people and HIV/AIDS, and from UNICEF (2002), *Young People and HIV/AIDS: Opportunity in Crisis*.

7. Publications on HIV and young people

1. *HIV Testing Policy Statement*. WHO, 2006. http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf
2. *The WHO Testing and Counselling Toolkit.* http://who.arvkit.net/tc/en/index.jsp
3. *HIV Counselling and Testing for Youth: A Manual for Providers.* Family Health International, www.fhi.org/en/Youth/YouthNet/rhtrainmat/vctmanual.htm
4. *Integrated Management of Adolescent and Adult Illness (IMAI).* Four booklets: *Guidelines on Chronic Care with ARV Therapy, General Principles of Good Chronic Care, Acute Care, Palliative Care*. WHO, 2004.
5. *2006 Report on the Global AIDS Epidemic*. UNAIDS/WHO, Geneva, 2006.
6. *HIV-Related Stigma, Discrimination and Human Rights Violations: Case Studies of Successful Programmes*. UNAIDS, 2005.
7. *Impact of HIV and Sexual Education on the Sexual Behaviour of Young People: A Review Update.* UNAIDS, 1997.
8. *Protecting Young People from HIV and AIDS: The Role of Health Services*. WHO, 2004.
9. *Risk and Protective Factors Affecting Adolescent Reproductive Health in Developing Countries*. WHO, 2004.
10. *Steady..Ready..Go! The Tallories Consultation to review the evidence for policies and programmes to achieve the global goals on young people and HIV/AIDS*. WHO, 2004.
11. *Young People and HIV/AIDS: Opportunity in Crisis*. UNICEF/UNAIDS/WHO, New York, 2002.
12. *Action for Adolescent Health: Towards a Common Agenda. Recommendations from a Joint Study Group*. UNICEF/UNAIDS/WHO, 1995.
13. *National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people*. WHO, 2004.

Websites

UNAIDS: www.unaids.org

UNFPA: www.unfpa.org

UNICEF: www.unicef.org

WHO: www.who.int

8. Definition of terms

ABC: An HIV prevention acronym that was developed to help remember choices to reduce the risk of acquiring HIV infection through sex: **A**bstinence - **B**e faithful – **C**ondoms. Although each of these is an important component of HIV prevention, ABC is not gender sensitive; it reflects behaviour options that are mainly male controlled and does not address a wider prevention concept.

Adherence: The extent to which the patient continues to follow the agreed, prescribed mode of treatment or intervention. In ART, adherence is important to avoid the risk of drug resistance.

Antibodies: Molecules in the blood or other body fluids that tag, destroy or neutralize bacteria, viruses, or other harmful toxins (antigens). An antibody is specific to an antigen.

AIDS (Acquired Immune Deficiency Syndrome): This occurs because HIV has damaged the immune system of an HIV-infected individual.

ART (antiretroviral (ARV) therapy): This includes all the specialized medical and diagnostic services for outpatients to properly manage and monitor their drug treatment which aims to suppress HIV replication and improve HIV-related symptoms.

BCC (behaviour-change-communication): An interactive process with communities to develop tailored messages and approaches using a variety of communication channels. The aims of BCC are to develop positive behaviours; to promote and sustain individual, community and societal behaviour change; and to maintain appropriate behaviours.

Burnout: People who work with patients who have a chronic fatal condition (like cancer and HIV) can suffer from burnout; it is also known as fatigue or compassion fatigue.

CD4 (+) cells (cluster designation 4 (plus) cells): A type of T-cell that is an important part of the immune system involved in protecting against infection. HIV enters and attacks the CD4 cell. Destruction of CD4 cells is the major cause of the immunodeficiency seen in HIV disease. Although CD4 counts fall, the total T cell level remains fairly constant through the course of HIV disease because of a related increase in the CD8 cells. The ratio of CD4 to CD8 cells is therefore an important measure of disease progression.

Discordant couple: Heterosexual or homosexual couples where one partner is infected with HIV and the other is not (or has not been tested).

Discrimination: when there is action or inaction that is based on stigma that results in an infringement (disrespect) of human rights. This is often evident as some form of abuse against an individual or group. Discrimination results when actions treat people differently based on stigma (e.g. a confirmed or suspected HIV serostatus). Persons associated in the public mind with HIV or AIDS (e.g. men who have sex with men, sex workers, drug users, haemophiliacs, and the family members and associates of HIV-positive people or people suspected to live with HIV) may also face discrimination.

Drug resistance is due to the ability of HIV to mutate and reproduce itself in the presence of antiretroviral drugs. Consequences include treatment failure and the need to start second-line treatment with increased direct and indirect health costs for the patient, the spread of resistant strains of HIV, and the need to develop new anti-HIV drugs.

Dual protection: This refers to simultaneous protection against both unwanted pregnancy and sexually transmitted infections. Condoms are the only effective means to prevent both an unintended pregnancy and sexually-transmitted diseases, including HIV.

ELISA (enzyme-linked immuno-sorbent assay) is an HIV test. If the first ELISA test is positive, it is repeated. If the second is also positive, then a Western Blot test is usually carried out. If all three tests are positive, the person is considered HIV-positive.

Gender can be understood as the social construct of masculinity and femininity. Since, in many societies, more value is given to what is considered masculine than feminine, opportunities associated with gender lead to relationships in which more power is given to men than women.

HAART: highly active antiretroviral therapy.

Harm reduction for IDU: This refers to various strategies and approaches for reducing the physical and social harms associated with risk-taking behaviour. Harm reduction includes making use of needle-syringe programmes, condoms, and drug substitution.

HIV (Human Immunodeficiency Virus): The virus that causes AIDS. Infection with HIV is a lifelong infection. A positive HIV test does not mean a person has AIDS; it means that HIV antibodies have been detected in the blood.

Incidence: The number of newly appearing cases of a disease. Incidence rates can relate to the general population or a specific population.

Incubation period: the period from infection with the virus until the appearance of disease symptoms.

Microbicide: An agent (e.g. a chemical or antibiotic) that destroys microbes. Research is being carried out to evaluate the use of rectal and vaginal microbicides to inhibit the transmission of sexually transmitted diseases, including HIV.

Opportunistic infections: Illnesses caused by various organisms, some of which usually do not cause disease in persons with healthy immune systems. People living with advanced HIV infection may suffer opportunistic infections of the lungs, brain, eyes and other organs. Opportunistic illnesses common in people diagnosed with HIV include *Pneumocystis carinii* pneumonia, cryptosporidiosis, histoplasmosis, other parasitic, viral and fungal infections, and some types of cancers.

PLHIV: Person (or People) Living with HIV.

PMTCT (Prevention of Mother-to-Child Transmission of HIV): Prophylactic therapy given to pregnant women who are HIV-positive in order to prevent infection to their infants during pregnancy, at delivery or during breastfeeding.

Prevalence: the number of existing cases of a disease in the general population of a specific area.

Prevalence rate: HIV prevalence is the estimated number of (adult) persons living with HIV at the end of the year divided by the total number in the (adult) population.

Rapid HIV Test: This test uses a drop of blood collected from a fingerstick and the results can be read in 10 to 30 minutes. If a person is HIV-positive with this test, it is considered a *preliminary positive result.* Although the test is extremely accurate, it has to be confirmed by a second rapid HIV test with a positive result.

Seroconversion: The development of antibodies to a particular antigen. When people develop antibodies to HIV, they seroconvert from antibody-negative to antibody-positive. It may take from as little as 1 week to several months (average 6 weeks) after infection with HIV for antibodies to develop. After HIV antibodies appear in the blood, a person should test positive with antibody tests.

Sexually transmitted infections (STI): These are spread by the transfer of organisms from an infected person to another during unprotected sexual contact.

Stigma: HIV-related stigma includes all unfavourable or discriminatory attitudes, beliefs, and policies that are directed towards people who are perceived to be living with HIV, and also towards their families and loved ones, their social groups and their communities.

Susceptibility: A predisposition ("weakness") to a disease or infection. *Biological susceptibility* to HIV refers to the increased physical risk of acquiring HIV. For example, a young girl of 14 years has a higher risk of acquiring HIV than a woman of 30 years (even when exposed to the same situation and viral load) because of her immature genitalia and inadequate mucosal defence system. A person with an STI is also biologically susceptible to HIV.

Vulnerability: The concept of vulnerability accepts that individuals may not have a choice in whether they engage in behaviours that increase their risk of HIV. People who may have limited choices in social, sexual and financial areas of their lives are vulnerable for HIV infection. In many societies these vulnerable people include women, children, sex workers, males who have sex with other males, injectors, migrants, ethnic minorities and poor people. The majority of those who are vulnerable are young people.

Western blot: A laboratory test for specific antibodies to confirm repeatedly positive results in the HIV ELISA test.

Orientation Programme on Adolescent Health for Health-care Providers

Annex 1

Module schedule

Activities that are marked with * are optional activities which are not included in the 180 minutes planned for this module. The facilitators' decision to include the optional activities depends on the available time and whether these activities are covered in other modules in this workshop.

Sessions and activities	Time
Session 1 **Module introduction**	10 min
ACTIVITY 1-1 Module objectives	
ACTIVITY 1-2 Spot checks	
Session 2 **The situation of HIV among young people ***	40 min *
ACTIVITY 2-1 Mini lecture: Basic HIV *	10 min *
ACTIVITY 2-2 Mini lecture: Young people and HIV globally *	10 min *
ACTIVITY 2-3 Mini lecture by guest presenter: Young people and HIV – the national situation *	20 min *
Session 3 **How HIV affects young people**	35 min
ACTIVITY 3-1 Mini lecture and brainstorming: Risk and protective factors	
ACTIVITY 3-2 Mini lecture: Biological susceptibility	
ACTIVITY 3-3 Brainstorming: Risk and protective factors *	20 min *
ACTIVITY 3-4 Brainstorming: Young people, HIV, stigma and discrimination	
ACTIVITY 3-5 Mini lecture: Young people and the natural history of HIV	
Session 4 **HIV prevention and young people**	45 min
ACTIVITY 4-1 Mini lecture: Introduction	
ACTIVITY 4-2 Group exercise: Community mix *	20 min *
ACTIVITY 4-3 Mini lecture: Overview of HIV prevention *	10 min *
ACTIVITY 4-4 Plenary discussion: HIV preventions and the health worker	
ACTIVITY 4-5 Group work: HIV preventions in the clinic and community	
ACTIVITY 4-6 Condom demonstration *	30 min *

Sessions and activities	Time

Session 5
HIV testing and counselling among young people

40 min

ACTIVITY 5-1
Mini lecture: Introduction
ACTIVITY 5-2
Mini lecture: HIV testing and counselling for young people
ACTIVITY 5-3
Mini lecture: Circumstances for HIV testing
ACTIVITY 5-4
Plenary discussion: Feelings around HIV testing and counselling
ACTIVITY 5-5
Group work: Do's and Don'ts in testing and counselling with young people

Session 6
Management of HIV in young people

40 min

ACTIVITY 6-1
Mini lecture: Introduction
ACTIVITY 6-2
Mini lecture: Care and treatment
ACTIVITY 6-3
Mini lecture: Antiretroviral therapy
ACTIVITY 6-4
Mini lecture: Support
ACTIVITY 6-5
Mini lecture: Positive prevention
ACTIVITY 6-6
Mini lecture: Counselling young PLHIV
ACTIVITY 6-7
Group work: Young PLHIV and the health worker

Session 7
Module review

10 min

ACTIVITY 7-1
Review of Spot Checks and Matters Arising Board
ACTIVITY 7-2
Review of objectives and key messages
ACTIVITY 7-3
OPPD
ACTIVITY 7-4
Reminders and closure

180 min **optional 120 min**

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Annex 2

Spot checks

Sessions 1 and 7

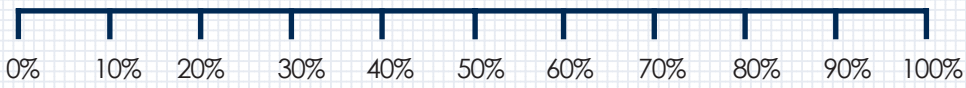
SPOT CHECK 1

Please explain the difference between HIV and AIDS.

SPOT CHECK 2

Globally, what percentage of all new HIV infections per year is among young people?

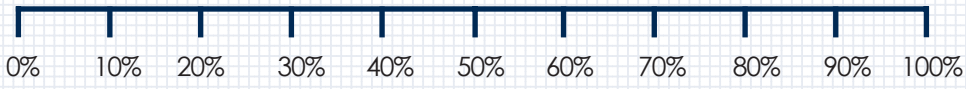
please mark your estimate with a spot anywhere along the line



SPOT CHECK 3

What percentage of young people aged 15-24 years who are living with HIV in sub-Saharan Africa are female?

please mark your estimate with a spot anywhere along the line



SPOT CHECK 4

Why are young people more likely to be exposed to HIV?

please list three reasons

SPOT CHECK 5

Why are girls and young women biologically or culturally/socially vulnerable to HIV infection upon exposure?

please list five reasons

SPOT CHECK 6

How confident do you feel about working with young people on the issues of HIV?

please mark your answer with a spot anywhere along the line

Uncomfortable | Not very confident | Confident | Very confident

SPOT CHECK 7

What can be done to reduce HIV transmission among young people in the clinic and in the community?

Clinic

Community

SPOT CHECK 8

What is important in counselling young people?

please provide three answers

SPOT CHECK 9

A high percentage of drug injectors are young people. Injectors are at high risk of acquiring HIV through use of non-sterile needles.

please name three strategies for harm reduction

SPOT CHECK 10

Read each statement and tick the box that reflects your point of view

	I agree	I disagree
Young people who get HIV have brought it on themselves by their behaviour	○	○
Everyone should have to have an HIV test whether they want to or not	○	○
As a health worker, I should be allowed to refuse to treat a client who is HIV positive	○	○
It is acceptable for boys to have sex before marriage	○	○
It is acceptable for girls to have sex before marriage	○	○
It is wrong for young men to have sex with men	○	○
Our health services should not waste money on treating people with HIV	○	○
Girls and boys need to have information on sexuality and HIV	○	○
If a young person tests HIV negative I do not need to give them counselling	○	○
If a boy of 14 years came for HIV testing I would tell him I could not help him unless he comes back with a parent	○	○
If a young person tests HIV positive, it is my duty to tell their parents or their spouse	○	○
If an unmarried girl asks me for condoms, I would not give them to her and tell her to wait until she is married	○	○

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Annex 3

Brief scenarios

Session 3: ACTIVITY 3-3

The facilitator will identify a scenario to be read aloud by a participant.

As a brainstorming exercise, the participants will give responses to the two questions on the flipchart:

1. What are the risk factors that could facilitate HIV transmission in this scenario?
2. What are the protective factors that may or do occur in this scenario?

You can use your imagination about some of the facts of the scenarios and you can elaborate on the story.

The responses will be written on the flipchart in two lists – **Risk factors** and **Protective factors**.

SCENARIO 1

A girl in a secondary school of a large town has sex with older men in exchange for money or favours.

SCENARIO 2

A young man at university in a medium-sized town is persuaded by his class mates to join them for an evening out. The evening includes viewing an X-rated film, dinner and drinks, and a visit to the town's red light area.

SCENARIO 3

A young man in a big city occasionally injects drugs with his friends. He uses their needles and syringes. He sees no problem in this because he says they are all healthy and he has known these friends all his life.

SCENARIO 4

A young married woman lives in a rural area. Her husband, a factory worker in a big city some 50 km away, returns home periodically. Like many of his co-workers, he occasionally visits a brothel.

SCENARIO 5

A young woman, a migrant worker, is employed as a domestic servant. She is forced into having sex with her employer. When she raises this matter with the madam of the house, she is slapped across her face and is threatened with more violence.

SCENARIO 6

A young man is part of a gang in a big city. He occasionally has anal sex with men, while continuing his relationship with a young woman.

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Annex 4

Scenarios: HIV prevention in the clinic and community

Session 4: ACTIVITY 4-5

In this group work, we will identify practical ways in which health workers can develop strategies to prevent HIV transmission among young people.

You will be divided into 3 groups and assigned a scenario.

You have 10 minutes to discuss the situation within your group and complete the task.

Task

You have recently arrived as the health worker in charge of the municipal health centre in a small town.

After attending a course on HIV and young people organized by your national AIDS programme, you decide to map the situation of young people in your community.

Based on your findings, as described below, how would you respond in order to contribute to HIV prevention among these targeted groups of young people?

Write a list of possible approaches, discuss their advantages and disadvantages. Then choose one approach that can be applied:

1. Within your clinic
2. Within your community.

One participant should summarize the group's discussion and present in plenary the approach that you have considered and the approach that you have chosen. You should present one approach which can be used in the clinic and an approach in the community.

SCENARIO 1

You learn from a reliable NGO that injecting drug use is occurring among some young people in the community. The boys involved are aged 15-18 years, some attend the secondary school and some do not. Some of the boys have girlfriends at the school. Their practices are relatively unknown (or are ignored) among leading members of the community. Nothing is currently being done to address the matter. You are told that the young people want to avoid contact with the authorities for fear of getting into trouble with the law or with adults in the community.

SCENARIO 2

In the course of your work, you realize that some of your STI patients are students from some nearby secondary schools. When you ask, you learn that there is no health education on sexual and reproductive health offered in these schools. You decide to approach the principals of the schools to explore the possibility of working with them to start a collaborative sexual education programme.
The principals respond with extreme resistance. They feel that such a programme will only encourage the young people to engage in premarital sex, which is exactly what they and their staff have been trying to work against. They say they have enough of a problem with teenage girls who had to be expelled from school because they got pregnant. The principals have strong opinions about this and feel they are speaking on behalf of the parents as well.

SCENARIO 3

You discover that there is a red light area in a poor backstreet not far from your health centre. From discussions with the nurses in the health centre, you learn that young women from the brothels are sometimes brought to the centre by an older woman and a tough looking man. The nurses tell you that many of these young women cannot speak the local language. They seem sure that these women have been 'trafficked' from other parts of the country. "There is nothing we can do", one of the nurses says to you, "Powerful people are involved".

Annex 5

Scenarios: Do's and Don'ts in testing and counselling with young people

Session 5: ACTIVITY 5-5

You will be divided into 3 groups and each allocated a scenario.

Task

1. Go over the scenario you have been given and work together in your group to develop the story further, making it a real life situation. Prepare a presentation (with one person telling the rest of the story or presenting it as a short role play).

2. Identify a list of practices that the health worker should always carry out (the Do's) and practices that should never be carried out (the Don'ts) in a situation like this. Consider the practices described in the scenario and the practices in the additional story that you have developed. One person will present the list.

You have 10 minutes to carry out this task.

SCENARIO 1

A young pregnant woman, who appears to be in good health, comes to the weekly antenatal clinic. She is accompanied by an older woman, a kindly neighbour. The neighbour tells the health worker that this is their second visit to the antenatal clinic. At her first visit, in addition to a physical examination, the pregnant woman had blood taken for tests.

The health worker quickly looks at the notes from the previous visit and the laboratory test results. The test indicates that the woman is HIV-positive. “Another one. The third today….”, the health worker mutters.

The neighbour leans forward and asks softly: “What did you say?”

SCENARIO 2

A young boy of 15 comes to the public health centre and asks to be tested for HIV. He appears healthy but anxious. The nurse asks him if he has come with a parent. The boy says no, neither of his parents knows that he is here. The nurse tells him he will have to come back tomorrow with one of his parents, but the boy becomes agitated and says he does not want to tell them, he just wants to be tested. He is sent away from the clinic but he is later seen waiting near the door.

SCENARIO 3

A young woman of 18 years comes to the clinic because she thinks she is pregnant. On discussion, she says she has a regular boyfriend who is the father of the baby and that she is glad to be pregnant. Later, when talking with the health worker, she says she is worried because she has recently learnt that her boyfriend injected drugs when he was younger.

SCENARIO 4

A young man, a university student, is in the consulting room of a private practitioner.

He is looking on anxiously as the doctor carries out a rapid HIV test.

The doctor is engrossed in his task, and the young man is in the grip of his fears and concerns. After several minutes of silence, the doctor scratches his head and says to the young man: “The test result is not clear. You should go to the hospital for another one.” There is a sense of panic in the eyes of the young man. He says, “What do you mean that the test result is not clear?”

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Annex 6

Case studies

Session 6: ACTIVITY 6-7

You have been divided into 3 groups and assigned a case study.

Task

A young person with HIV has approached you (the health worker) with a concern as described in your scenario.

Your task as a group is to discuss your case study and identify this patient's concerns and the important information that you (the health worker) should communicate to him/her in this situation.

You have 10 minutes.

Using the flipchart and pen, write down the patient's concerns and the information he/she needs.

One person in your group will present this to the other participants. Begin the presentation by reading or giving a summary of the case study.

CASE STUDY 1

Sexuality

A 20-year-old young man tested HIV-positive one week ago. He tells you that he has had unprotected intercourse over the last year with five different young men at the college he is attending. In spite of the relatively low HIV prevalence within this community, the boy became infected. After finding out about his infection, he was very upset by the fact that the man who transmitted the virus did not tell him his HIV status. Now, he wants to continue his sexually active lifestyle but does not want to put his future partners at risk. He says that there are many misconceptions and little understanding about HIV in his community, so he is afraid to tell anyone. What options can you, as the health worker, give him to consider in this situation?

CASE STUDY 2

Sexuality

An 18-year-old HIV-positive man says he believes he was infected with HIV after engaging in unprotected sex with a female sex worker. It was his first sexual experience. He says he was pressured into doing it by his peers who said that he would gain experience and enter manhood through his first sexual encounter. Now he is interested in pursuing a relationship with a particular girl. He wants to have sex with her but is afraid because of his HIV status. What can you, as his health worker, suggest to him in this situation?

CASE STUDY 3

Fertility

A young woman of 16 years has been diagnosed as HIV-positive. She recently married a man who frequently travels to neighbouring towns for work. She never had sex prior to her marriage. In her culture, it is expected that she should bear many children for her family. She believes that her husband unknowingly acquired HIV after unprotected intercourse with sex workers in the neighbouring town. The health worker at the antenatal clinic told her that she should not get pregnant but she is distressed because she wants to have children. She comes to you for advice and help. What can you, as the health worker, do for her?

CASE STUDY 4

Living with chronic disease

A 22-year-old man, who is a university student, recently tested HIV-positive. He admits to you that on a few occasions in the past he has injected drugs and shared needles. Now he feels that his life is over and he has given up on everything. He spent several months in his room not wanting to talk to anyone. He does not know anyone who has HIV but he heard of a student who people said had AIDS; he was treated badly and thrown out of the university. He says he has a girlfriend for 6 months and does not know what to tell her. He is in the clinic now for the first time since his positive test result. What can you, as the health worker, suggest to him regarding his situation?