

Responding to the HIV prevention needs of adolescents and young people in Asia: Towards (cost-) effective policies and programmes



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Executive Summary

The major recommendation of this paper is to strongly increase resources available for age- and gender- appropriate HIV prevention and support services for young people engaging in high risk behaviors: injecting drug users, young women and men involved in sex work and young men who have sex with men.

The coverage of comprehensive interventions that specifically reach these young people should be scaled up to reach 50% in 2010 and 80% in 2015.

Despite the huge difference in physical and cognitive development levels within the age group of 10 to 24 year olds (defined as adolescents and young people) the current HIV prevention services for people engaging in high risk behaviors are not age-specific. For the age group of 18 to 24, operations research is needed to study whether the effectiveness of existing programs can be further increased by making them more appropriate. For those under 18, it is proposed that, in principle, interventions should aim at providing alternatives to the behaviors in question and preventing exploitation. For those who have no alternative or do not wish to change their behavior, the paper urges a rights-based approach aimed at reducing harm to the child – i.e. they should not be withheld their right to access prevention services because of their young age.

‘Young people’ or ‘youth’ as a defining ‘target group label’ for prevention, care and support is unhelpful, because it masks enormous differences in HIV risk and vulnerability, which correspond to different needs. It is proposed that young people should instead be conceptually divided into three types and prioritization for HIV prevention programming given accordingly.

Since the predominant vectors of HIV transmission in most Asian countries are one of three main risk behaviors (injecting drug use, sex work and male to male sex), it is proposed that adolescents and young people engaging in high risk behaviors should be the main priority; followed by adolescents and young people who are more vulnerable to start engaging in high risk behaviors.

For this second priority group, young people who are vulnerable to start engaging in high risk behaviors (including young migrants, young people living on the street and out-of-school young people), a wider, less HIV specific approach is needed, focused on improving the safety of their direct environment. This can be done, for example, by providing safe spaces to stay and education or vocational training opportunities. Here, HIV/AIDS related messages may be mainstreamed and integrated into wider social support programs.

Lastly, there is a large majority of people in the age group up to 24 years old who are adolescents and young people at low risk and low levels of vulnerability to HIV infection. Many of these are in the younger age groups. It is proposed that HIV prevention information and skills for them should be considered only after the first groups have been sufficiently covered, or if prevention information and skills can be integrated at low or no cost – for example as part of broader adolescent reproductive health programs. To the large majority of young people, who are living in very low HIV prevalence areas, do not have risk behaviours, live in relatively stable families, work and / or attend school, HIV/AIDS related awareness messages can be integrated into school curricula at low or no cost; community-integrated responses (i.e. Youth union activities, scouts, youth clubs) or via the mass media could be considered as part of a wider package of ‘adolescent health and development’.

Majority of adolescents in Sri Lanka belong to this category.

In order to effectively reach out to the most at risk young people and reduce stigma and discrimination which are barriers to their accessing of health and other services, it is proposed that reform – or at least a temporary ‘freeze’ of the implementation of laws prohibiting or criminalizing the above-mentioned behaviors is called for, in order to enable health workers and NGOs/CBOs to expand their reach and coverage of these groups.

Recommendations

Overall Recommendation:

Strongly increase resources available for age- and gender specific HIV prevention based on a hierarchy of risk and vulnerability to HIV: Governments need to prioritize programmes that provide comprehensive HIV prevention for young people engaging in high risk behaviors: injecting drug users, young women and men involved in sex work and young men who have sex with men. Coverage of interventions (currently hovering between 2 and 38% for different groups in different countries) should be scaled up to reach 50% in 2010 and 80% in 2015.

Supporting Recommendations:

- 1. Develop age-appropriate HIV prevention strategies and interventions:** Despite the huge difference in physical and cognitive development levels within the age group of 10 to 24 year olds, the current HIV prevention services for people engaging in high risk behaviors are not age-specific. For those under 18 years old, interventions should, in principle, aim at providing alternatives to the behaviors in question, and at preventing abuse and exploitation. For those who have no alternative or do not wish to change their behavior, however, the paper urges a rights-based approach aimed at reducing harm to the child – i.e. they should not be withheld their right to access prevention services because of their young age. For the 18-24 age group operations research is needed to study the extent to which the effectiveness of these services can be further increased by making them more appropriate for this age group.
- 2. Categorize adolescents and young people by their HIV risk and vulnerability -** not all adolescents and young people are at same risk and vulnerability to HIV infection: for effective HIV prevention amongst young people, better definition of sub-populations within 10-24 year olds based on their HIV risk and vulnerability is necessary. Using a definition of ‘young people’ or ‘youth’ as a ‘target group label’ for HIV prevention is ineffective, since it masks enormous differences in HIV risk and vulnerability among young people, which correspond to different needs. Young people should instead be conceptually divided into three types:
 - **“Most-at-risk adolescents and young people”:** defined as those already engaging in high risk behaviors
 - **“Especially vulnerable adolescents and young people”:** defined as those who are more vulnerable to start engaging in high risk behaviors.
 - **“Low risk adolescents and young people”:** the majority of adolescents and young people in South Asia whose behaviors and situation place them at little or no risk of HIV infection
- 3. Prioritize HIV-specific resources and attention for those most at risk.** It is recommended that since the greatest proportion of HIV infection in most Asian countries – especially in low-level and concentrated epidemics, but even in generalized epidemics – are caused by three main risk behaviors (injecting drug use, sex work and male to male sex), ‘most-at-risk adolescents and young people’ should be the main priority for resource allocation.

4. For the second level of priority, the especially vulnerable adolescents and young people (those who are vulnerable to start engaging in high risk behaviors), a wider, less HIV-specific approach is needed, focused on improving their direct environment, especially by providing safe spaces to stay, educational and vocational training opportunities. Here, HIV/AIDS related information, vulnerability-reduction skills and access to basic services could generally be integrated into wider social support programs. (For example, rather than HIV-specific interventions for adolescents and young people living on the street, integrate appropriate prevention information and skills into the broader outreach, protection and care services for these adolescents and young people).
5. To the third type of adolescents and young people – the large majority of whom are living in environments where specific risk behaviors are very minimal and where HIV prevalence is very low or negligible – it is recommended that no significant HIV prevention resources should be allocated in low-level and concentrated HIV epidemics, and a limited share of resources in generalized epidemic areas. Age and gender specific HIV/AIDS related information should be integrated into school curricula at low or no cost; community-integrated responses (i.e. Youth union activities, scouts, youth clubs) or via the mass media. These should be placed within a context of broader adolescent health and development, rather than specific to HIV/AIDS, STIs or reproductive health.
6. In order to effectively reach out to adolescents and young people most at risk of HIV infection, and reduce stigma and discrimination, which are barriers to accessing health services, reform – or at least a temporary ‘freeze’ of the implementation of laws prohibiting or criminalizing the above mentioned behaviors is called for, in order to enable service providers to expand their reach and coverage of these groups.

It is recommended that each country develops specific policies for adolescents, young people and HIV, following the example set by Pakistan and taking the principles and recommendations of this paper into consideration. Such a policy should include country-specific epidemiological evidence showing the role adolescents and young people play in the epidemic, and be jointly developed by all stakeholders, including at least the Ministry of Health, Ministry of Education, Ministry of Social Welfare, Ministry of Youth and Ministry of the Interior and Justice.

Introduction

CHAPTER

1

The current paper was commissioned by UNICEF and its partners (UNFPA, UNESCO, UNAIDS) to provide advice to the AIDS Commission in Asia on policy options on how to respond to HIV/AIDS among young people, in response to a 'Policy Options Workshop' which was held in Bangkok on 4-6 January 2007. It is part of a series of thematic policy papers filling perceived gaps in what we know about policies and programs related to HIV/AIDS. Other papers are or have been written for the Commission; topics include orphans and vulnerable children, gender and HIV/AIDS, cost-effectiveness and resource allocation, country-level responses, compulsory licensing, and epidemiological modeling of the epidemic in Asia.

This paper aims to provide guidance to policy makers on how to respond to the HIV prevention needs of young people in Asia. In particular, it aims to set priorities for action, aimed at preventing major HIV epidemics from occurring or limiting the scope or impact of current HIV epidemics in the region.

The paper will start by briefly providing the latest information about the HIV epidemics in Asia in Section Two. It will look specifically for information related to HIV prevalence and risk behaviors among young people, and discuss - based on the latest evidence - what the 'drivers' of the epidemic are.

A short discussion follows about the concepts of risk, vulnerability, young people, adolescents - clarifying who or what we mean when we talk about these commonly used concepts. 'Young people' are defined in this paper as people aged 10-24 years - later a subdivision will be proposed in those under 18 and those legally 'adults'. This means this paper covers a significant part of the total population of many countries. The paper will discuss the use of this term and propose a refinement of how we define 'young people' in the context of HIV/AIDS (Section 2.3).

In Section Three an overview of policy responses for young people related to HIV is presented.

Based on these sections, a simple framework is proposed on how to respond to HIV/AIDS among young people, dividing them in young people most at risk (Section Four), young people especially vulnerable to HIV (Section Five) and young people at no or low risk (Section Six).

Reviewing HIV Epidemics in Asia

CHAPTER

2

2.1 Number of people living with HIV, HIV prevalence and AIDS mortality

UNAIDS estimates that in 2006, 8.6 million people were living with HIV in Asia (range: 6.0 – 13.0 million). Due to its large population, this translates to an average adult HIV prevalence of 0.4% (range: 0.3-0.6), well below levels seen in Sub-Saharan Africa (6.1%) or the Caribbean (1.6%). However, this low overall prevalence hides high prevalence levels in certain sub-populations or in states / provinces in some countries in the region.

Globally, UNAIDS estimates that half of all new HIV infections occur in the 15-24 age group. Approximately 630,000 people died from AIDS-related illnesses in Asia in 2006 (range: 430,000 – 900,000) (UNAIDS 2006).

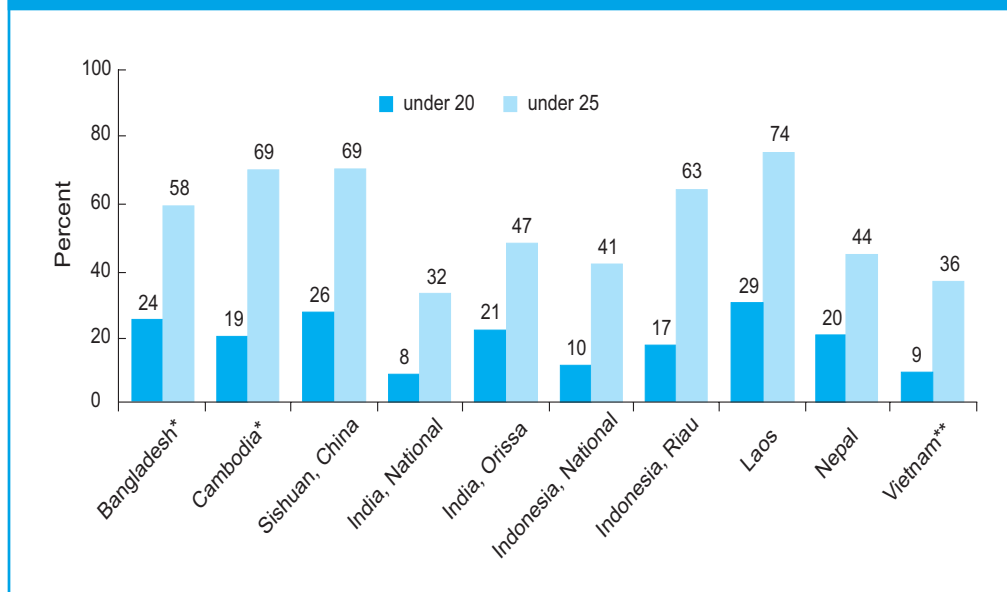
2.2 What drives HIV epidemics in the region?

According to the MAP reports, a number of factors determine whether HIV will spread once introduced into a population: the frequency of unprotected sex, the type of unprotected sex (i.e. oral, vaginal or anal), the frequency of (unsterilized) needle sharing among injecting drug users, the proportion of the population engaging in these unsafe injecting or unsafe sexual behaviors, the number, type and 'mix' of sex partners, and the levels of other sexually transmitted infections in the population. These factors influence HIV transmission individually and in combination. As a result HIV epidemics consist of multiple, overlapping epidemics around injecting drug use, male to male sex (where the main risk factor is anal sex) and sex work, evolving on different time scales, which makes them inherently unpredictable. The mere presence of high levels of risk behavior does not guarantee immediate epidemic growth, even though the potential for growth exists. This raises concerns for countries such as Bangladesh, East Timor and Pakistan, where behavioral surveillance has shown high levels of risk, especially among sex workers and men who have sex with men, and yet so far HIV prevalence remains low (MAP reports).

Obviously, in order for an epidemic to expand a significant part of those infected with HIV must pass the virus on to one or more persons. This is why HIV is unlikely to spread among 'general young person population' who do not engage in the above mentioned behaviors regularly – they have little or no penetrative sex, not enough STI or not enough needle sharing for the HIV epidemic to start spreading, considering the low transmission efficiency of HIV. The efficiency of the mode of transmission is an important factor affecting the rate of HIV spread. It is estimated that insertive penile-vaginal intercourse between an infected and an uninfected person has a transmission risk of 5 in 10,000 per sex act if the woman is infected, and 10 in 10,000 per sex act if the man is infected. For anal intercourse, it is 6.5 in 10,000 if the receptive partner is infected and 50 in 10,000 if the insertive partner is infected¹. In most Asian countries, up to 95% of HIV cases are directly linked to male to male sex, sex work or injecting drug use.

¹ European Study Group on Heterosexual Transmission of HIV (1992). "Comparison of female to male and male to female transmission of HIV in 563 stable couples". *BMJ*. **304** (6830): 809–813. [PubMed](#) and Varghese, B., Maher, J. E., Peterman, T. A., Branson, B. M. and Steketee, R. W. (2002). "Reducing the risk of sexual HIV transmission: quantifying the per-act risk for HIV on the basis of choice of partner, sex act, and condom use". *Sex. Transm. Dis.* **29** (1): 38–43. [PubMed](#)

Percent of female sex workers who are under 25 and under 20 in various ASIAN countries (WHO)



Injecting drug use

Sharing contaminated needles and syringes is a very effective mode of HIV transmission (a transmission rate of 69 in 10,000 occurrences of exposure to an infected source – or nearly 7% per injection act²), and HIV prevalence among injecting drug users can therefore grow very rapidly, especially since drug users often inject at least 3 times a day. For example, in Manipur, India, prevalence grew from a few percent to over 80 percent in only three to four years; rapid increases have also been witnessed in Kathmandu (Nepal) and Yangon (Myanmar) (UNAIDS 2003 and UNESCAP 2006). Indonesia recently found that 48% of injecting drug users in Jakarta are infected with HIV, Viet Nam has found 25.5% prevalence amongst drug users in 2005, and Malaysia has identified that the HIV epidemic there is driven by injecting drug use, with 74.3% of people with HIV being injecting drug users (ASEAN 2007). In many countries, injecting drug users are young; according to UNICEF, 80% of people admitted to drug treatment centers in Thailand in 1999-2000 were under 25 years old.

Sex work

Although vaginal sex is not a very effective mode of transmission (see first paragraph of this section), if condom use is low, STI rates high and the average number of clients of sex workers high, significant numbers of infections can occur in the context of the sex industry. Strongly growing prevalence in sex workers in Cambodia and Thailand was seen in the 1990s. It should be realized that despite the per-act probability of transmission being very low (only 0.1% per sex act), many sex workers have up to 10 partners per day. Besides, if a sex worker has an untreated STI, the transmission probability may be 7 to 10 times higher. Significant numbers of sex workers are under 25 and under 20 years old (see figure above).

Male to male sex

Receptive anal sex is 5-10 times more efficient in transmitting HIV than vaginal sex. As a result of this, as well as relatively high partner turnover and other factors, men who have sex with men have been disproportionately affected by HIV in many countries

² Kaplan, E. H. and Heimer, R. (1995). "HIV incidence among New Haven needle exchange participants: updated estimates from syringe tracking and testing data". *J. Acquir. Immune Defic. Syndr. Hum. Retrovirol.* **10** (2): 175-176. PubMed.

around the world. Bangkok saw a rapid increase in HIV prevalence among men who have sex with men who visit entertainment venues. Prevalence rose from 17 to 28% in only two years time; the rise in the youngest (15-22 year old) age group was steepest, from 12.9% in 2003 to 22.3% in 2005 (Van Griensven et al 2006). Epidemics have also been reported in other Asian cities, including Phnom Penh, Hanoi, Beijing, Mumbai and Yangon (UNAIDS 2007, forthcoming). Due to cultural taboos, anal transmission is often ignored in general population campaigns for HIV prevention, despite the high prevalence of anal sex between men as well as between men and women in countries in the region (see Verma and Collumbien 2001). The prevalence of male same-sex behavior in the population at large varies from 2-3% to up to 9-10% in some younger populations in Asia (UNAIDS 2007). If these men reach HIV prevalence of 15-20% percent, numbers which have already been surpassed in some major urban centers, it can contribute anywhere from 0.1% to 0.5% to total adult HIV prevalence, which may be from 5% to 25% of the total number of people with HIV in a country. In countries where overall adult prevalence is below 3%, this can be a substantial proportion of all HIV infections (De Lind van Wijngaarden et al 2007, forthcoming).

In summary, available evidence suggests that epidemics in the Asia-Pacific region are driven by three behaviors:

1. Unsafe injecting drug use
2. Unsafe sexual intercourse in the context of sex work
3. Unsafe sexual intercourse in male to male sex

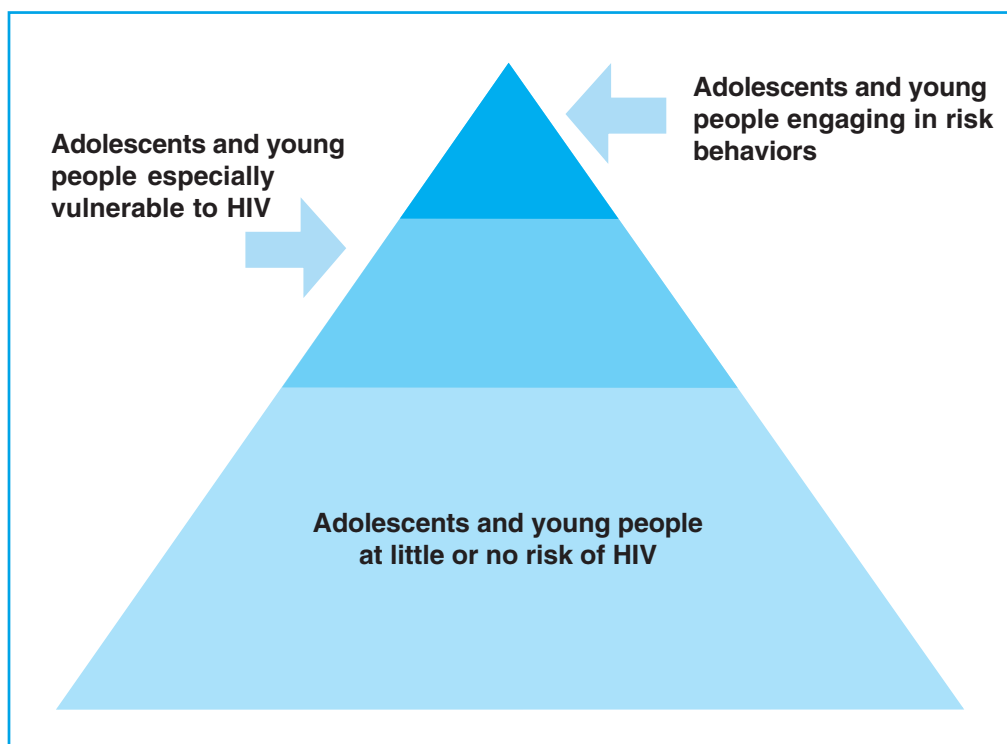
The extent to which these behaviors happen 'safely' or 'unsafely' is partly determined by structural factors, including levels of poverty, levels of education, gender disparities and legislative issues – this goes particularly for sex work and injecting drug use.

2.3 Young people and HIV/AIDS: refining our strategic focus based on principles of epidemiology

Since this paper deals with a huge category of people – young people aged 10-24 years old, who make up anywhere between 30 and 50% of the population in Asian countries, or a total of around 600 million people in the Asian region – it makes sense to make a division in different 'types' of young people, taking their risk behavior and/or the likelihood to engage in risk behavior (vulnerability) into consideration. Their risk / vulnerability profile should correspond with different prevention strategies and policy actions.

It is proposed to conceptually divide young people (10-24) in three types:

1. The first type is young people who are already engaging in one or more of the high risk behaviors outlined above – i.e. engaging in commercial sex, engaging in injecting drug use or engaging in male to male sex. A further division within this group is made:
 - a. Those younger than 18;
 - b. Those who are technically adults – i.e. those older than 18 but younger than 24.
2. The second type is those who are more likely to start engaging in the high risk behaviors listed above, due to several contextual factors discussed below – both those who are underage and those over the age of consent.
3. The third type is young people who are at low or no risk to HIV, living in stable families and working or going to school – a large majority in most countries – again, both underage and 'adult' youth are included here.



Most specific HIV programming efforts, both in terms of prevention as well as care and support, should be focused on the first type – young people already engaging in high risk behavior, who are most likely to become infected with HIV and to pass the virus on to others. They have the highest need for care and support services as well. From the epidemiological perspective, prevention funds spent on the third (low-risk) group are not necessary, especially if resources are scarce, because only few infections can be prevented in this group. Of course, funding for HIV prevention at the country level is not based only on epidemiological considerations; other issues may play a role.

The figure above - a 'pyramid of risk and vulnerability' – shows that a minority of young people is disproportionately affected by HIV.

Responses should also be carefully tailored to the age and gender of young people – the needs of a 10 year old are different those of a 24 year old, and the needs of young women are different from those of young men.

An Overview of Policy-level Responses

CHAPTER

3

Specific policy documents related to HIV and young people are rare. The topic of young people is usually discussed in policy documents and strategies to enhance the wellbeing and development of young people in general (often developed by Ministries of Youth or Education), whereas the topic of HIV/AIDS (also in general) is discussed in National Strategic Plans and policies usually developed by the Ministry of Health or a multisectoral HIV/AIDS body. This section reviews some of these documents and then looks at international policy commitments.

3.1 Examples of country-level policy documents

Pakistan is the only example found in this review of a country that has developed a specific HIV prevention strategy for young people. It was developed by the National AIDS Control Programme (NACP), Ministry of Health, with assistance from UNICEF Pakistan. Since Pakistan recently ‘graduated’ from a low-prevalence country to a concentrated epidemic (with prevalence levels of 5% among people practicing high-risk behavior(s)), the strategy sensibly suggests a focus on young people with high risk behavior, rather than the current approach of raising awareness about HIV in the ‘general’ young person population through the mass media.

In line with the suggestions of this paper, the Pakistan strategy includes a distinction of young people in ‘high risk’ (i.e. already engaging in one or more risk behaviors), ‘vulnerable’ (i.e. due to their situation more likely to start engaging in one or more risk behaviors – for example street children or young migrants) and ‘low/no risk’ – which is the largest group of them all, and consists of young people who are part of stable families, and though some of them might be sexually active or experiment with alcohol or drugs, they are unlikely to be linked to the concentrated networks of HIV transmission in Pakistan.

In order to make prevention work with young sex workers (male and female), young drug users and men who have sex with men possible, the strategy calls for different sectors to join prevention activities, notably the Ministry of Justice and Internal Affairs and the Ministry of Youth. Since many of the behaviors that carry a high risk of HIV transmission are illegal in Pakistan, working with the law enforcement sector to find pragmatic methodologies for outreach, care and support for these groups makes sense – decriminalization would remove an important first barrier for young people engaging in these behaviors to access health care and social support services. The strategy also identifies unemployment and poverty as important vulnerability-enhancing factors, and calls for better vocational training and other educational opportunities for young people.

The consultation process leading to the formulation of the young people prevention strategy combined with the insight that not all young people are equally vulnerable and at risk has led to an adaptation of the National Strategic Framework of Pakistan – Area 3 (focusing on young people).

In **India**, a National Youth Policy was developed in 2003. The policy defined ‘youth’ very broadly, i.e. as aged between 13 and 35. The policy sets 9 objectives, one of which is related to access to health information and services, which includes those related to

HIV/AIDS. It also mentions HIV/AIDS as one of the issues that should be mainstreamed in school curricula. Under the Health chapter, there is a section on HIV/AIDS which deals with the establishment of 'adolescent clinics in large hospitals'. Remarkably, rather than focusing on the main drivers of the epidemic, the policy prioritizes rural and tribal youth for HIV/AIDS prevention, but also out-of-school youth and adolescents, 'particularly females, youth with disabilities and youth in vulnerable situations such as those who are trafficked, orphaned and live on the streets' (UNFPA 2006).

Nepal's National HIV/AIDS Action Plan and Budget 2005-6 acknowledges the importance of addressing the needs of 'vulnerable groups who have not previously been acknowledged as priorities' and 'the value and strength of civil society organizations as implementing partners in reaching the most-at-risk and vulnerable populations.' Targeted interventions should be 'comprehensive' and include 'peer-led information, education and communication, STI service or referrals, VCT service or referrals, condom distribution and community sensitization'. The Action Plan identifies the following groups that should be covered by this approach: 'Sex workers, men who have sex with men, injecting drug users, mobile populations and families, uniformed services and young people.' It should be noted that by including 'young people' in this list – which are about half of Nepal's population – the Plan distracts from the need to focus on the four groups listed before, and risks diluting scarce prevention funds towards low-risk young people. Programmatic elements focusing on young people that the Strategy proposes include awareness raising through IEC campaigns, lifeskills education including integration of HIV/AIDS into formal education curricula and teacher training, and for out-of-school youth peer education and IEC. Youth friendly information and health services, including condom promotion, VCT and STI services are also part of the action plan (MOH/Govt of Nepal 2005).

The strategy does not mention the fact that many (if not most) sex workers, IDU, migrants and men who have sex with men are themselves young people, and whether and how strategies for young people and those outlined for the other groups should be related.

In 2006, in Nepal a National Adolescent Strategy on Reproductive Health was developed. The document outlines strategies including mainstreaming of reproductive health education (which includes HIV/AIDS) into school curricula, 'community-based dissemination' of adolescent reproductive health information, dissemination of STI prevention messages in all available and appropriate channels, and 'multisectoral advocacy for creation of a supportive environment for adolescents to practice safe behavior' and 'mobilization of adolescents and their gatekeepers against risk taking behaviors' (quoted from UNFPA 2006). Again, the focus on 'national adolescents' as a group should be considered non-strategic since it covers up differing levels of risk and vulnerability among Nepali youth.

Lao PDR's National Strategic and Action Plan on HIV/AIDS/STI 2006-2010 aims to maintain HIV prevalence in high-risk populations (defined in the usual way) below 1%. In order to do so, it aims to scale up coverage of behavior change interventions, condom promotion, STI services, VCT and awareness raising, across different populations, including sex workers and clients, to 90% in target provinces.

Apart from sections on sex work and mobility, the strategy contains a section on young people. It notes that 54% of Lao PDR's population is under 20 years old, and that socio-economic development has led to changes in the lifestyle and sexual behavior of young people, including high alcohol and rising recreational drug use. It sets a target of reaching 40% of all out of school youth in selected provinces with awareness raising and 4% with a broader package including IEC, VCT and STI services. The strategy sets

a nationwide target of 30% 'reached with RH/HIV/AIDS/STI education and drug awareness' for Grade 5 and secondary school youth.

The strategy also includes ambitious and surprisingly frank sections on sex workers, men who have sex with men and drug users – many of whom are young people, something the strategy does not explicitly mention (NCCA 2005).

The strategy is sensible in making an implicit distinction (and prioritization) of high risk people, 'vulnerable youth' (defined as 'out of school youth') and other youth (presumably low risk and in schools) with coverage targets of 90%, 40% and 30%, respectively.

The **Chinese** 'Action Plan (2006-2010) for Reducing and Preventing the Spread of HIV/AIDS' sets ambitious targets for reaching knowledge levels of 'HIV prevention and treatment and blood donation' of 85% of school students by 2007 and 95% by 2010; for out of school young people targets are set at 65% in 2007 and 75% in 2008. Separately, the Government sets 'effective intervention measurement' targets for 'the floating population and people engaging in high risk behaviors' of 70% by 2007 and 90% in 2010; it includes increased needle exchange and condom use of 'people with high risk behavior', which mentions IDU but does not mention sex workers or men who have sex with men explicitly.

It should be noted that unlike Lao PDR coverage targets were set not based on immediate epidemiological need, but on what the Chinese consider as doable and realistic; it is easier to reach adolescents and young people through schools than those out of school or who are engaging in high risk behaviors. As such, the coverage targets in schools are set higher than those for out of school. It is interesting how the Chinese strategy, despite being ambitious in terms of the targets it set to reach hundreds of millions of people with information within the coming 3 years, is not very efficient from the epidemiological point of view; it will spend a huge effort educating people who are extremely unlikely to be exposed to HIV and while it addresses injecting drug use and unsafe blood donation and transfusion practices, it ignores two behaviors that are already significantly contributing to the spread of HIV in China: unsafe sex in the context of sex work and male to male sex.

The 'National Strategy on HIV/AIDS Prevention and Control until 2010 with a vision to 2020 of the Socialist Republic of **Vietnam**' is even more ambitious than the Chinese plan in setting a 100% coverage target for 'people's knowledge about prevention of HIV transmission' in urban areas by 2010, and 80% for people living in rural and mountainous areas. Furthermore, 100% of people with risk behaviors will be covered by comprehensive harm reduction intervention measures; 100% safe injections and condom use 'when having risky sex'.

Whereas the policy speaks of 'drugs and prostitution prevention' in one clause, in another it seems to acknowledge the need to work 'with high-risk behavior groups' in behavior change, education and communication activities. Integration of HIV prevention into school curricula is also mentioned as a main objective. In contrast to China, sex workers are explicitly mentioned in the strategy as a 'community' to be engaged – so are injecting drug users. However, like in China, and despite the recent finding of 9.4% HIV prevalence among this group in Hanoi, men who have sex with men are absent from the strategy.

In Vietnam, the legal framework related to children affected by HIV/AIDS was reviewed in 2005. One of its recommendations was to increase the legal upper age of childhood from 16 to 18 years old, in line with international practice. It also calls on the Government to stop mandatory counseling and testing and to stop the practice of

confinement of under-18 year old drug users and sex workers in adult rehabilitation centers (MOLISA/UNICEF 2005).

In **Cambodia**, UNAIDS supported the National AIDS Authority to conduct an assessment and audit of policies on HIV/AIDS. It was reported that as of January 2007, a total of ten Ministries had developed some kind of policy document on HIV/AIDS; eight sectoral strategies for HIV/AIDS and 26 policy documents were identified. No other country in the region has such a well developed policy framework. The report says that ‘the high level of policy development in relation to NSP II commitments and Universal Access indicators suggests that the major focus of work needs to be not so much in policy development but more in implementation.’

The Cambodian ‘Law on the Prevention and Control of HIV/AIDS’ is an overarching legal framework, which was found to be one of the key instruments for creating legislation for an enabling environment for HIV/AIDS programs. It includes three types of provisions: those dealing with public health policy, those dealing with social sector policy and those dealing with program commitments. Despite this plethora of policies – many of them developed long after programs started to be implemented – some important gaps remain, especially the fact that there is no policy on harm reduction in relation to law enforcement (at a time when injecting drug use, previously unheard of in Cambodia, appears to be making inroads), and no specific Government policy statement on men having sex with men and HIV/AIDS/STI (at a time when HIV prevalence among Phnom

TABLE:1 Cambodian non-health related policy development related to young people

Line Ministry	Policy document
Ministry of Social Affairs, Veterans and Youth Rehabilitation	<ul style="list-style-type: none"> • Policy on Alternate Care for Children (04/2006) • Minimum Standards for Substitute Care (draft) • National Orphans and Vulnerable Children Action Plan (being drafted)
Ministry of Education, Youth and Sports	<ul style="list-style-type: none"> • School Health policy (08/2006) • Life Skills Education policy (draft) • Youth Policy (draft)
Ministry of Labor and Vocational Training	<ul style="list-style-type: none"> • Law (parkas) on creating HIV/AIDS committees in enterprises and establishments and Managing HIV/AIDS in the work place (09/2006) • Missing: public work place policies for HIV/AIDS
Ministry of Public Works and Transport	<ul style="list-style-type: none"> • Policy on HIV/AIDS and Prevention in the Public Works and Transport Sectors (08/2006) • Prakas on education of HIV/AIDS, safe migration and labour rights for Cambodian workers abroad (08/2006)
National Center for Drug Control	<ul style="list-style-type: none"> • Whole range of guidelines for needle and syringe programs, substitution therapy and treatment are under development • Missing: law enforcement and drugs guidelines
Ministry of Women's Affairs	<ul style="list-style-type: none"> • Policy on women and girls and STI/HIV/AIDS • Role of MWA versus other ministries unclear
Ministry of National Defence	<ul style="list-style-type: none"> • Sectoral strategy exists • Implementation plan under development
Ministry of the Interior	<ul style="list-style-type: none"> • No policies in place

Source: NAA 2007

Penh MSM exceeds 8%, according to a recent survey (NCHADS/FHI 2007)). In the Education sector, a School Health policy was recently completed (August 2006) and a Youth Policy and Lifeskills Education Policy exist in draft form.

3.2 International policy documents / declarations

Several international declarations have been adopted by most member states of the United Nations over the past decade. These include:

1. UN Convention on the Rights of the Child:
 - a. The convention affirms 'the right of the child to the enjoyment of the highest attainable standard of health', the right to education and to be free from all forms of exploitation
 - b. The CRC General Comment No. 3 compels Governments who signed the CRC to give children/adolescents (10/17 years old) access to 'adequate information related to HIV/AIDS prevention and care.'
2. Millennium Development Goal on HIV/AIDS³:
By 2015 halt and begin to reverse the spread of HIV/AIDS (using the prevalence of HIV among pregnant 15-24 year old women as indicator)
3. The UN General Assembly Special Session on Children:
Develop and implement national health policies and programmes for adolescents, including goals and indicators, to promote their physical and mental health.
4. The UN General Assembly Special Session on HIV/AIDS:
 - a. By 2005, ensure that at least 90% (and by 2010 that 95%) of young people have access to the information they need to reduce their vulnerability to HIV;
 - b. By 2005, ensure that at least 90% (and by 2010 that 95%) of young people have access to the skills they need to reduce their vulnerability to HIV;
 - c. By 2005, ensure that at least 90% (and by 2010 that 95%) of young people have access to the services they need to reduce their vulnerability to HIV;
 - d. By 2003, develop or strengthen strategies, policies and programmes which reduce the vulnerability of children and young people;
 - e. By 2005 HIV prevalence among young people (15-24 years) reduced by 25% in the most affected countries, and by 2010 reduce prevalence by 25% globally.
5. The Kathmandu High Level Regional HIV/AIDS Declaration (2003) affirmed existing commitments (MDG and UNGASS) and called to 'break the silence and denial', and urged more leadership in responses with 'the most vulnerable groups and young people'.
6. The SAARC HIV/AIDS Regional Strategy & implementation plan 2006-2010:
 - a. The strategy mentions 'a large youth and other vulnerable population' in the SAARC region as one of seven issues to be addressed;
 - b. Encourages member countries to engage civil society, including youth and media leaders.
7. Operational Work Plan of the Third Asean Work Programme on HIV and AIDS 2006-2010 (AWP III)
Objective 8: 'Youth reducing vulnerability to HIV transmission' – groups identified

³ <http://www.un.org/millenniumgoals/>

include “young people out of schools, young sex workers, young men who have sex with men, young drug users, orphans and other vulnerable children”.

In conclusion, it can be seen that none of the countries, with the exception of Pakistan, have policies to respond to the age and gender specific HIV prevention needs of young people, let alone make a distinction between different levels of vulnerability and risk among young people. Policies that exist either address HIV prevention needs of adults or of the general population, or address youth without giving specific guidance for fulfilling the HIV prevention, care and support needs for those engaging in high risk behaviors or those especially vulnerable. With the exception of Pakistan and Lao PDR, none of the other countries reviewed in this section has made an explicit division of young people into subgroups based on their HIV risk or vulnerability – Vietnam and China do make a division too, but ignore male to male sex as a main epidemic driver and focus for programming. If coverage of prevention services for young people at high risk is to be increased or if their quality is to be improved, countries should consider developing such a specific HIV prevention policy document for young people. Such a policy document should be jointly authored and adopted by different stakeholders including the Ministry of Health, Ministry of Education, Ministry of Youth and Sports, Ministry of Social Welfare and the Ministry of the Interior.

Many National Strategic Frameworks for HIV reviewed for this paper did make mention of most at risk populations and young people separately (including those of Nepal, Vietnam, China and Lao PDR), but they fail to recognize that significant numbers of people at high risk are themselves young people.

This raises several difficult questions for policy makers, who often have difficulty formally accepting the existence of (adult) sex work, injecting drug use and male to male sex in their country – and now have to deal with the fact that some young people (often defined by law as ‘children’) are engaged in these behaviors, and are endangering their health by it.

Responding to the HIV Prevention Needs of Most at Risk Adolescents and Young People (the top of the pyramid)

General principles for policy and programming

The age of consent⁴ for sex differs across countries – for example, it is 13 in Japan, 14 in China, 15 in Thailand and Pakistan (in Pakistan the person has to be married for the sex to be legal), 16 in India, Malaysia, Nepal and Cambodia, 17 in Indonesia, and 18 in Vietnam and the Philippines⁵; some countries have different ages of consent for boys and girls, most have an age of consent of 18 for marriage; Thailand specifies a higher age of consent for sex in the context of sex work, which is 18. These rules, while aimed at the prevention of sexual exploitation of children and therefore largely beneficial, may also raise barriers for sexually active young people to access health services; health care providers may worry whether they, by providing services to adolescents will be regarded as endorsing the involvement of under-age young people in sex work, male to male sex or drug use. This means there can be a conflict between child rights on the one hand, and the right of adolescents to access essential health care on the other.

Apart from the age of consent issue, the behaviors of most-at-risk adolescents are usually illegal by law for both adults and children (prostitution and injecting drug use in most countries, male to male sex in many). All programmatic approaches for most at risk adolescents and young people outlined below would become easier to implement if legal frameworks either did not criminalize the behaviors that are targeted for change, or at least if existing laws and regulations are temporarily suspended for the sake of the ongoing public health work, as happened for long spells during the successful responses to reduce HIV transmission among sex workers and their clients in Thailand, Cambodia and parts of India.

For young people who are younger than 18 who are engaging in high risk behavior, providing prevention and health services can be ethically challenging. The key word here is ‘pragmatism’, or acknowledging that there is a difference in ‘the ideal world’ where there is no underage sex work, drug use or male to male sex, and reality, where these behaviors exist among those who are under 18. Whereas policy-wise and legally the existence of under-age sex (work) and drug use is banned and deemed undesirable, in practice these occur in all countries in the world. The negative health and other consequences for adolescents and young people engaging in these behaviors should be minimized, even if (or perhaps especially if) they can not be persuaded to quit the behavior that puts them at risk, or if there is no viable alternative that can be offered to them. A strict law enforcement approach, arresting those involved in these risk behaviors, would drive the persons involved underground and make them inaccessible

⁴ While the phrase age of consent typically does not appear in legal statutes, when used with reference to criminal law the age of consent is the minimum age at which a person is considered to be capable of legally giving informed consent to any contract or behaviour regulated by law with another person. This article refers specifically to those laws regulating sexual acts. This should not be confused with the age of majority, age of criminal responsibility, or the marriageable age (Source: Wikipedia).

⁵ See http://upload.wikimedia.org/wikipedia/commons/e/ef/Age_of_Consent.png

for provision of health care and social protection. This would have the effect of making adolescents and young people more vulnerable to exploitation, crime and worsened health; the key to success is to work *with* these young people in situations of acute risk to find solutions, as well as with gatekeepers who may control their lives and may also be a route through which outreach could be possible, while at the same time promoting policies and programs that prevent new generations of young people from entering in such risky situations.

Key principles for responses for most at risk adolescents and young people aged under 18:

1. From a rights perspective, all children have the right to be free from sexual or other forms of exploitation, and they have the right to good health (which is compromised in case they use drugs or expose themselves to STI or HIV). As a matter of principle, therefore, children should not be engaged in risk behaviors for HIV; policy frameworks for HIV prevention among young people should make a distinction in those who are legally 'children' (i.e. under 18) and deserve social service assistance and 'rehabilitation', and those who are legally 'adults' and deserve access to prevention and care services.
2. At the field level, however, a certain level of pragmatism is necessary for those who are younger than 18. Those who are engaged in male to male sex or sex work and who are not coerced or exploited should have access to age- and gender appropriate STI care, VCT, prevention information and condoms and lubricants *if they can not be persuaded or assisted to quit or delay these behaviors*. For drug users, principles of harm reduction apply, similar as those that apply to adults.
3. Any response – be it in policy or programming – should include consultation of children involved and their care givers, if they have any; any intervention should have the best interest of the child in mind.
4. There is a need for the development and implementation of adolescent friendly/age-specific policies that ensure their rights to better health and social protection, and that their basic rights as children are not impeding their access to such services.

For young people aged over 18, similar programs as those for adults should be considered – however, young people may have additional or different needs, and it is important that these are acknowledged and integrated in programming for them based on operations research. When designing operational research, it is important to ensure that the needs of young people are assessed and compared to the needs of older people at high risk.

Key principles for responses for most at risk young people over 18 years old:

1. Interventions should be developed with strong involvement of the target audience, ensuring that they are age- and gender specific. Tailor-made responses for young men who have sex with men, or young injecting drug users, or young sex workers may end up being quite different than those for adults
2. Interventions should be based on evidence. Community-led baseline assessments can help assure this. The needs of an 18 year old sex worker who just started working may be very different to those of a 53 year old sex worker who is close to retirement; an 18 year old MSM who starts becoming sexually active is more at risk than a more experienced and self confident older MSM.
3. Interventions should be broad, covering issues outside HIV and STI transmission, and include protection of human rights and tackling stigma and discrimination, and including vocational training and access to education and skills that may help them find employment and reduce poverty. This means different sectors should be involved in them – the health sector, social welfare, education, youth and justice / interior sectors are key.
4. Interventions should occur at different levels: policy level, health service level, individual outreach level, and include social support, condom promotion, STI care and VCT, at the least.

Programmatic responses

Programmatic responses for young men who have sex with men

In many Asian countries, there is a marked MSM entertainment infrastructure in large cities (Thailand, Indonesia, Malaysia, parts of China and southern Vietnam), and this is where MSM find sex partners and where sexual transmission originates. This infrastructure is insufficiently covered by traditional intervention programs based on peer education, promotion of sexual health services, and outreach that includes promotion of clinical services (VCT, STI, ARV); in addition, these intervention programs are not age-specific. Reasons for this poor coverage include the large number of establishments to be covered, the lack of active community-based organizations, and the presence of MSM-negative official policies, which impede the implementation of crucial interventions and activities (De Lind van Wijngaarden et al 2007, forthcoming). Young people, who are often not allowed to frequent these premises until they are 18 (or in Thailand 21), often depend on non-formal entertainment spaces – including parks, bus stops and (especially in cities) the internet to find friends and sex partners; this means their awareness of HIV and access to condoms and lubricants is often lower than that of adults.

Herbst et al (2005) conducted a meta-analysis examining the efficacy of HIV prevention interventions designed to reduce sexual risk behavior of men who have sex with men (MSM) (presumably adult). Interventions were associated with a significant decrease in unprotected anal intercourse (odds ratio [OR] = 0.77, 95% confidence interval [CI]: 0.65-0.92) and number of sexual partners (OR = 0.85, 95% CI: 0.61-0.94) and with a significant increase in condom use during anal intercourse (OR = 1.61, 95% CI: 1.16-2.22). Interventions successful in reducing risky sexual behavior were based on theoretic models, included interpersonal skills training, incorporated several delivery methods, and were delivered over multiple sessions spanning a minimum of 3 weeks. Behavioral interventions provide an efficacious means of HIV prevention for MSM. The authors conclude that to the extent that proven HIV prevention interventions for MSM can be successfully replicated in community settings and adapted and tailored to different situations, the effectiveness of current HIV prevention efforts can be increased.

For young MSM, programmatic responses should focus on:

1. Reaching young MSM before they become sexually active – a study in Thailand showed that MSM become sexually active at the age of 14.9 years old, which is earlier than their heterosexual peers, and that they face higher levels of sexual abuse than their peers (Van Griensven et al, 2005). Young MSM should have access to information and education through age specific IEC materials, either in print or on the internet, and where possible the link between male homosexuality and HIV risk should be integrated in sex education / reproductive health programs for young people in general, be they delivered through schools, health facilities or via youth clubs / unions.
2. Avoiding exploitation and abuse. Exploitation of adolescent boys by adults – either through the internet or by other means – should be acknowledged and dealt with. Especially young transgendered men often face sexual abuse at a very young age, and stigma and discrimination for this group is often stronger than for more hidden men. Improving self-esteem and general life skills is key to help reduce abuse.
3. Using innovative channels to provide sexual health information and education – including reducing fear and myths about homosexuality, since this information is usually not provided as part of mainstream adolescent health education in schools. Interventions that use the internet may be able to reach out to MSM effectively by providing peer outreach in chat boxes and information and counseling through web boards; telephone hotlines may also be possible methodologies; however, these types of interventions have never been thoroughly evaluated for effectiveness in Asian contexts.

4. Establishing self-help groups. At an age where group conformity is often more important than later in life, adolescent boys who are discovering that they prefer men to women often face issues of lack of self confidence and even self-hatred, fear for disclosure, fear for negative repercussions of their sexuality from parents and their community, and a strong sense of loneliness. Self-help groups, linking them with other boys with similar issues, either through the internet or through existing organizations, may be effective to resolve some of these mental health issues which are known to reduce the likelihood of adopting safer sex behaviors.
5. Developing and adapting IEC and messages about HIV in relation to anal sex, and related to safer sex. These may need to be adapted to include language popular with teenagers – sometimes MSM also use different terminology in a ‘sub-cultural language’; the ‘level’ of information provided may also need to be lowered for young MSM, as they have less basic knowledge and less experience than their older peers.
6. Reducing harm, including violence, rape, HIV and other STI, for young MSM; this means that even if he is under 18 years old young MSM should not be refused access to prevention services and health care.

Programmatic responses for young sex workers

UNAIDS stresses the importance to establish clear policy frameworks for sex work, which will make setting up programmatic responses much easier. Within such a framework, a focus on young sex workers should be included, since in many countries most sex workers are young. Policy-makers should take into account the complexity of the sex work system and address the various needs of the diverse groups of sex workers within it.

First and foremost, a policy framework must establish its legal stance on sex work, be it prohibition, regulation or decriminalization. It is also important that a stance be taken explicitly supporting international conventions governing exploitation of children, and that the age at which sex work may occur is determined. Many (male and female) sex workers start working when they are younger than 18 – either due to individual circumstances or due to trafficking and exploitation. This section deals with young sex workers – up to 24.

For young sex workers, programmatic elements should focus on:

1. Avoiding sexual exploitation and promoting child rights for those under 18. Children should not have to earn a living in the sex industry. They deserve an education and a safe and healthy lifestyle. Young people in sex work (not only those under 18) should be screened for the extent they control their own lives, including the decision to enter the sex trade, their say in the selection of their customers, the type of services that they provide and the income they generate.
2. Rehabilitating sex workers who want to quit. If sex workers are under 18, in principle the law enforcement and social welfare sectors should take over; sex workers over 18 should be given the option, since relapse is common among those who are forced to quit. So-called ‘rehabilitation’ of young people that have been in sex work should focus on providing appropriate education and / or vocational training, where the child is based in her/his family or community or (as a measure of last resort) in institutions. They should have access to counseling and social support, health care, and all efforts should be made to avoid stigma and discrimination by upholding standards of confidentiality.
3. Reducing harm, including violence, rape, HIV and other STI, for young people who do not want to quit sex work. Even if a sex worker is under 18, is not exploited or forced by an adult manager or pimp but still refuses to quit, he or she should not be refused access to prevention services and health care.
4. Reducing demand for underage sex workers. Criminalizing customers seeking services from underage sex workers may be more effective than focusing on curbing

the supply of young sex workers, especially in countries where trafficking of young women and girls is common or where entry into the sex trade by 'dutiful daughters' to earn money for a poor family is implicitly appreciated or encouraged by segments of the population.

5. Establishing self-help groups for young sex workers. This is appropriate if young sex workers who are part of groups that consist of older sex workers feel discouraged to speak out.
6. Adapting IEC and messages for behavior change. These may need to be adapted to include language popular with teenagers; also the 'level' of information provided may need to be lowered for young sex workers, as they have less basic knowledge and less experience than their older peers.

Programmatic responses for young injecting drug users

According to UNODC, 'compelling evidence' suggests that addiction should be seen as a chronic relapsing medical condition, and should not be considered to be a crime. Many of those who develop addiction disorders suffer multiple relapses following treatments and are thought to retain a continuing vulnerability to relapse for years, or perhaps a lifetime. In considering addiction a chronic condition, it is no longer surprising that incarcerations or brief stabilizations – the most common response to the problem of injecting drug use in most Asian countries – are not effective, with relapse rates of over 70%.

Based on these findings, policies and programs should first of all accept drug addiction as a social and health problem, and guide health officials in tackling the problem of drug abuse by combinations of continuing outpatient therapy, medications and monitoring, with the goal of retaining drug abusers in that treatment/monitoring regimen to maximize and maintain the full benefits of treatment. In other words, the issue of HIV prevention through the consumption of injection drugs should be tackled by health authorities and not by law enforcement officials, who still have a role to play in tackling supply and production of illegal drugs (UNODC 2003).

For young people, programmatic elements should be similar to those provided to adults (but they should be age appropriate), and include:

1. Preventing drug abuse among those who have not started. These programs could be delivered through schools and mass media. More 'targeted' prevention programs

BOX 1: The Sonagachi Project, India

In India, the basic approach of the STI/HIV Intervention Project, better known as the Sonagachi Project, in Kolkata, India, has been to create an enabling environment based on the 'three Rs': 'respect' for sex work and those engaged in it; 'reliance' on those involved in sex work to run the programme; and 'recognition' of their professional and human rights. From the first, sex workers were dynamically involved in all aspects of the project and were viewed holistically rather than simply in terms of their sexual behavior or reproductive tracts. It was felt that the most effective way to respond to the sex workers' needs and interests was to have a clear and full understanding of the range of issues that determine the quality of their lives. It was also recognized early on that the root causes of sex workers' vulnerability needed to be addressed simultaneously with their STI/HIV health needs. Activities such as literacy, vocational, legal and human rights training and services were undertaken to build sex workers' capacity and self-esteem. Support services for sex workers' children were also established. A cooperative society provides economic and social assistance to sex workers through savings and loans, social marketing of condoms and child-related programmes. Steps were taken against discriminatory practices (violence, police harassment, violation of human rights, etc.) through advocacy and lobbying at the local and national levels. As a result of this approach, sex workers are able to discuss their health and welfare issues with public officials and at national conferences. (Taken from UNAIDS 2002).

should be focused on children in families where one or both of the parents is a drug user, since parental use appears to be a predictor for use by the children (this is partly 'nurture', but there appears a genetic reason as well).

2. Reaching out to young drug users using their community networks. This can reach drug users who don't participate in conventional service systems, especially very young drug users; in Asia 'conventional services' for drug users are rare anyway. It is likely that peers, who are often used in community outreach, are likely to be trusted by young drug users, especially if they are slightly older 'brothers' or 'sisters'.
3. Provision of substitution treatment (with methadone or other substitution drugs). Most young drug users cannot stop using without it. Treatment with substitution drugs prevents HIV transmission because it helps users reduce drug- and sex-related risk behaviors. It has major positive effects on a user's life, often bringing more stability, which may enable young drug addicts to start rebuilding their lives, going back to school or finding employment.
4. Provide access to sterile syringes for those who are not (yet) ready to quit. This will reduce sharing of needles and syringes between young drug users who may have no access to new ones (drug users in general, and young drug users in particular may be refused needles if they try to buy them at pharmacies). It will also enable service providers to establish contacts with young drug users which may lead them to other health services, including treatment or VCT and rehabilitation services.
5. Integrate the above mentioned elements into services provided within the Criminal Justice System, since many young drug users are in jail, prison or Government youth institutions because of their drug use; in such settings disproportionately high rates of HIV infection, STDs, and hepatitis have been found.
6. Include strategies to prevent sexual transmission in the drug use reduction program, because high-risk drug use and unsafe sexual behaviors are often linked (see Bangkok example below)
7. Promoting of age- and gender specific counseling and testing services for drug users.
8. Establishing access to antiretrovirals for young drug users living with HIV/AIDS (considering the high HIV prevalence among drug users, there will be considerable numbers)

Source: CDC Atlanta and UNODC 2003

BOX 2: Bangkok Metropolitan Administration project with IDU

In Bangkok, Thailand, a community-based outreach program was implemented with Injecting Drug Users in 2004. Outreach objectives were to reduce sexual and injecting HIV risk, to increase uptake of voluntary counseling and testing and to promote treatment with methadone. Seven Methadone clinics were involved; five of them with professional outreach staff and two working with peer-trained educators. 30 clinic staff and 17 IDU peer educators were trained – the latter for a period of four months. Outreach objectives included promotion of risk reduction, provision of HIV risk reduction information and materials, demonstration of syringe cleaning and correct condom use, discussion of a personal risk-reduction plan and follow-up, promotion of methadone treatment and referrals to BMA methadone clinics, promotion of VCT and referrals to VCT services at BMA methadone clinics. Since about a third of the participants was HIV positive, the provision of referrals for HIV care, TB screening and treatment, and other health services was also important. 785 IDUs were contacted between January 2004 and May 2006, or about 21% of Bangkok's estimated number of 3700 IDUs; 737 of them adopted 'personal risk reduction plans'. At enrollment, 31% reported to have shared injecting equipment in the past month, and 68% did not use condoms in sex with a regular partner and 46% did not use condoms with a casual partner during the past month. About half of those referred for VCT, methadone treatment or TB screening accessed the health service; for ART treatment the access rate was lower. After three outreach contacts (N=251), safe needle use behavior was significantly improved; however, condom use practice with both regular and casual partners remained low (Yongwanitchit et al, 2006).

Responding to the HIV Prevention Needs of Especially Vulnerable Adolescents and Young People (layer 2 of the pyramid)

General principles for policy and programming

Adolescents and young people in this category are considered to be more likely than the broader young population to start engaging in one or more of the three main epidemic-driving behaviors listed in Section Two. This can be due to a number of contextual factors listed below, which differ in importance across countries:

- a. Societal change, including changing norms and values about sex among young people, especially in cities (globalization, increasing importance of money as a marker of status, rather than other individual characteristics or culturally determined gender-linked 'virtues' like virginity);
- b. Lack of education opportunities for young people;
- c. Poverty and / or lack of employment opportunities and increasing disparities between rich and poor;
- d. The fact that employment for children is often illegal may lead to 'underground' employment for young people for example as domestic servants, which can hamper their access to health and other services and may facilitate exploitation, also sexually, by their employers⁶;
- e. Lack of entertainment opportunities, which could lead to boredom and facilitate addiction among young people (drugs, alcohol);
- f. Disparity between genders or ethnic groups;
- g. Lack of access to prevention information and sexual health services;
- h. Mobility – migration (i.e. being away from the family / community);
- i. Ethnic or political conflict, being a refugee, being in a post-conflict situation.

Young people in this category are often living outside parental or care-giver supervision, for example those who live on the streets, migrants (for study or work purposes), orphans, in institutions; and also includes young people who are living in marginalized families – children of sex workers, drug users, poverty stricken families, etcetera. Responding to the prevention needs of these young people needs to move beyond awareness raising and provision of basic HIV prevention messages and include access to shelter, nutrition and general health improvement, strengthening skills for income generation and general lifeskills and improve opportunities to study and work. Interventions for this group therefore need to be broad and integrate HIV prevention and health care seeking behavior into interventions that respond to other – usually much more acute – needs they have.

Marriage

According to UNFPA, most countries have declared 18 as the minimum legal age of marriage. In Vietnam, 53% of girls are married at the age of 22; 33% are married before age 20. While the practice of child marriage has decreased globally over the last 30 years, it remains common in rural areas and among the poorest of the poor.

⁶ UNICEF estimates that there are up to 5 million underage (under 14) domestic workers in South Asia alone.

Impoverished parents often believe that child marriage will protect their daughters. In fact, however, it results in lost development opportunities, limited life options and often in poor health. Child marriage is a health issue as well as a human rights violation. Because it takes place almost exclusively within the context of poverty and gender inequality, it also has social, cultural and economic dimensions.

Married adolescents have been neglected from the global adolescent reproductive health and HIV/AIDS agenda because of the incorrect assumption that their married status ensures them a safe passage to adulthood and is protective of HIV. In fact young married girls and women must be considered vulnerable to HIV due to the possible risk behaviors of their husbands; policy reform and awareness campaigns to prevent child marriage is therefore also a sensible HIV vulnerability prevention strategy.

Education

Education and being in school are seen as important protective factors against HIV infection for young people, especially girls. According to UNESCO, in most Asian countries, net enrollment in primary schools is high (about 86% in South and West Asia and 94% in East Asia); however, at the age of adolescence many people drop out and do not enroll in secondary schools. In Cambodia, for instance, only 22% of girls and 30% of boys were enrolled in secondary schools as of 2004; for India these percentages were 47% and 59% and for Indonesia 57% for both girls and boys⁷.

Therefore the promotion of the principle of Education For All, ensuring that schools are inclusive, actively counteract drop-out and work to enroll young people who are out of school is a sensible vulnerability reducing strategy, especially for adolescents.

Additional programming principles for reducing vulnerability of adolescents and young people:

1. Promoting open discussion and analysis of societal change in schools and media – helping young people to make sense of the changes happening around them – ensure that the contents and messages of learning and teaching ‘connect’ with the lives of modern young people;
2. Promoting enrollment in the education system and creating linkages between education institutions and employers, reducing the likelihood of young unemployment and ensuring the curriculum is relevant to the future work place
3. Combating poverty by social, micro-credit, employment and other types of support programs
4. Promoting sports and other healthy forms of entertainment for young people, enabling them to make a choice to avoid more risky pastimes
5. Promoting social norms that promote equality between the genders and a healthy sexual lifestyle. This includes de-stigmatizing sex workers and men who have sex with men, and discussing the pitfalls of early marriage.
6. Strengthening the social support networks of young people who are without parental supervision (especially orphans, young people living on the street and young migrants), preferably through community-led initiatives rather than by increasing Government institutions
7. Providing a legal framework that does not criminalize people engaging in marginalized risk behaviors (drug use, male to male sex, sex work)

Programmatic responses

Programmatic responses in this category aim to reduce vulnerability to HIV/AIDS by focusing on strengthening skills to resist peer pressure, enhance self esteem and improve communication and negotiation skills. Programs can also provide shelter and nutritional support (for example for street children), education (including vocational training) and other types of support aimed at reducing poverty or dependence.

⁷ See <http://unesdoc.unesco.org/images/0014/001489/148975E.pdf>

A key strategy more directly related to HIV vulnerability prevention involves making health and counseling services more accessible to vulnerable young people. The above mentioned WHO paper also reviews evidence for interventions to increase young people's use of health services in developing countries. The studies reviewed (12 in Africa and 3 in Asia – Mongolia, China and Bangladesh) provided evidence of increased use of health services by young people for those types of interventions that included training for service providers, making improvements to clinic facilities and implementing linking activities in the community, with or without the involvement of other sectors (WHO 2006:151). It should be noted that strong health care services – especially STI and VCT care – are an essential component of responses for 'type one' young people (engaging in risk behaviors) as well.

WHO concluded that interventions through health services are essential and effective, if implemented based on an evidence-based package of services to prevent the spread of HIV and if operating under 'youth friendly' principles, in collaboration with the community in which the health service is located. Evidence is sufficient to support widespread implementation of interventions to increase young people's access and use of health services.

The WHO report also includes a chapter on 'community interventions', which looked at four types of interventions: first, those targeting young people, delivered through existing organizations or centres that served young people; second, programs that targeted young people but were not affiliated with existing organizations or centers; third, interventions that were aimed at the community as a whole, not specifically young people, delivered through 'traditional kinship networks' and fourth were interventions targeting the community as a whole but delivered through events. The review included 22 evaluations; programs from Indonesia, Nepal, India, Thailand and Sri Lanka were included.

It appears that interventions in type one (i.e. aimed at young people, and delivered through existing organizations or services) had a higher success rate than the interventions of the other types. The authors suggest that there is sufficient evidence to support widespread implementation of interventions to prevent HIV that are delivered within the framework of existing youth-service organizations or youth centers, however, these efforts should be closely monitored and evaluated.

Other programs that will help reduce HIV vulnerability include vocational training for unemployed young people, poverty reduction programs, income generation and saving schemes – all of which go beyond the scope of this paper.

BOX 3: FPAN, Nepal

Family Planning Association of Nepal (FPAN) implemented a health service intervention for adolescents, with technical support from UNFPA. Three different settings of service providers comprising NGO, government and private sector were selected in each district for creating a youth friendly services model. Young people's participation and consultation at all levels was a key component of the project. Nearly 14,000 young people aged 10-24 were reached by services in the two districts over a 13-month period. Baseline and end-line surveys were conducted, with the following results:

Selected indicators	baseline	endline
Knowledge on STIs	65%	93%
Knowledge on HIV/AIDS	74%	99.7%
Knowledge on transmission of HIV/AIDS	31%	72%
Know about existing Youth Friendly Services (YFS) in the districts	NA	97%
Sought services offered by the YFSC	NA	94%
Condom use among those who had sex	27%	77%

(Source: FPAN/UNFPA 2006:9)

Key lessons learned included the importance of involvement of a wide range of stakeholders, and the importance to embed 'serious' communication in entertainment and sports activities for young people, to sustain their interest. Also, the need for comprehensiveness was stressed.

Responding to the HIV Prevention Needs of Adolescents and Young People at Little or Low Risk (the base of the pyramid)

General principles for policy and programming

Adolescents and young people in this category are often termed “general population young people” – they live in environments where risk behaviours are very minimal and where HIV prevalence is low or very low; may live in relatively stable families, go to school or have safe jobs (especially for those over 18). They may be married and have a family. In general there is limited or no penetrative sex during adolescents, and where there is, it is typically limited within a small network. They may use cigarettes or alcohol occasionally, and even experiment with using drugs, but as a rule they do not inject drugs, let alone share injecting equipment. Considering the low transmission efficiency of HIV discussed in Section 2.2 as well as the fact that occasional sex happens within their own group and is not linked to the concentrated networks of sex work-, male to male- or injecting drug use related HIV transmission that exist in Asian countries, the chance for them to become infected with HIV is extremely small. Or for the few who may become infected by occasional involvement in injecting drug use or visiting sex workers (they would be part of the higher part of the pyramid), the chance of them transmitting the infection to others is small. Of course, they should be aware of the disease as part of awareness of other health dangers, like malaria, traffic accidents, diabetes, addiction; they should be taught about the way HIV is and is not transmitted. This may help them protect themselves, it may help them teach their children, and it will also help reduce fear and stigma of people living with HIV/AIDS.

Only limited specific HIV prevention funds should be made available for the following, integrated into a broader adolescent health and development framework:

1. Ensuring that young people have basic life skills and correct age and gender appropriate information about HIV/AIDS transmission and prevention as part of general adolescent health and development education in schools; information should become more sexually explicit with higher age, based on country level data on average sexual debut;
2. Ensuring that most young people will have received sex education and HIV and pregnancy prevention education before their sexual debut (in a culturally appropriate manner);
3. Ensuring that information about HIV/AIDS transmission and prevention is available in health centers or libraries, written in a language and tone appropriate for young people;
4. Ensuring that HIV prevention information is provided to young people through community initiatives, including existing structures (youth unions, youth clubs, etc);
5. Promoting compassionate and non-stigmatizing attitudes about minorities of all kinds among young people, as part of the entire curriculum;
6. Mobilizing mass media to sustain awareness of HIV/AIDS, especially during special events.

Programmatic responses

Responses in schools can reach young people of all three epidemiological levels in the pyramid of risk – in most countries, young men who have sex with men, young people engaging in sex work and injecting drug users attend (or have attended) schools, at least for a few years. It should be considered to integrate basic messages about these behaviors into the school curriculum, especially non-stigmatizing messages related to homosexuality (including anal sex) and messages preventing drug abuse that are not stigmatizing towards drug users. School-based responses are especially effective for providing general knowledge and awareness of reproductive health and HIV/AIDS, information which can complement more specific interventions dealing with the three driving behaviors of the epidemic outlined in section 5.1.

Kirby *et al.* (2005) studied 83 evaluations of HIV education programs based on written curriculums that were implemented among groups of young people in schools, clinics or community settings. 18 of these studies were in developing countries; in Asia, only one study, from Thailand was included in the study. The review found that there are significant and mostly positive effects of these programs on one or more of six aspects of sexual behavior: initiation of sex, frequency of sex, number of sexual partners, condom use, contraceptive use in general, and composite measures of sexual risk-taking, for example:

- Of the 52 studies that measured impact on sexual initiation, 22 (42 percent) found that the programs significantly delayed the initiation of sex among one or more groups for at least six months, 29 (55 percent) found no significant impact.
- Number of Sexual Partners. Of 34 studies measuring this factor, 12 (35 percent) found a decrease in the number of sexual partners, while 21 (62 percent) found no significant impact.
- Condom Use. Of the 54 studies measuring program impact on condom use, almost half (48 percent) showed increased condom use; none found decreased condom use.
- Sexual Risk Taking. Some studies (28) developed composite measures of sexual activity and condom use (e.g., frequency of sex without condoms). Half of them found significantly reduced sexual risk-taking. None of them found increased sexual risk-taking.

Overall, these results strongly indicate that these programs were far more likely to have a positive impact on behavior than a negative impact. Two-thirds (65 percent) of the studies found a significant positive impact on one or more of these sexual behaviors or outcomes, while only seven percent found a significant negative impact. One-third (33 percent) of the programs had a positive impact on two or more behaviors or outcomes. Findings for all the studies were similar in both developing and developed countries and the programs were effective with both low and middle-income young people, in both rural and urban areas, with girls and boys, with different age groups, and in school, clinic, and community settings (Kirby *et al.*, 2005).

School based responses should be the main way of reaching the huge group of young people who are at no or low risk for HIV/AIDS with basic information about the transmission and prevention of HIV/AIDS and STI. No specific HIV prevention funds may need to be allocated to this, as HIV and reproductive health education can be included as one of many more health / hygiene and development related learning objectives. There is a sufficiently strong evidence base to support widespread implementation of school-based interventions as long as they incorporate certain characteristics; these efforts should be led by adults rather than be peer-based.

It would be helpful to strengthen the evidence base for this recommendation for the Asian region, since Kirby's evidence stems mostly from non-Asian settings; anecdotal evidence from Asian countries suggests that many teachers have culturally inspired inhibitions against talking or teaching about sex in front of their students; students have also reported discomfort with this situation (UNESCO, personal communication).

Mass media responses have also been found to help young people become aware of HIV as a health issue. The above mentioned WHO report included a review of mass media interventions (through radio, radio with supporting media, or radio and television with supporting media). 15 programmes were included in the review, of which 1 was in Asia (China). Only studies that compared 'intervention groups' and 'control groups' were included. The data support the effectiveness of mass media interventions to increase knowledge of HIV transmission (including the Chinese study on a radio program for adolescents), to improve self efficacy in condom use (this was also found in the Chinese study), to influence social norms, to increase the amount of interpersonal communication, to increase condom use and to boost awareness of health providers. Fewer significant effects were found for improving self-efficacy in terms of abstinence, delaying the age of sexual debut or decreasing the number of sexual partners. It was found that programmes including television broadcasting had to be implemented with most care, but also yielded the best results if following certain basic principles (Bertrand et al, in WHO 2006).

An interesting finding of four of the reviewed studies was a so-called 'dose-response relationship', indicating that more exposure leads to more of the positive outcome, and less exposure leads to less of the positive outcome.

Mass media responses may be able to reach low- or no-risk young people, especially in rural areas, with basic information about HIV transmission and prevention. The authors conclude that mass media have the potential to reach millions of people with life-saving messages that can increase knowledge and awareness about HIV and can also, when conducted carefully, help change behavior. Large-scale campaigns should be closely linked and coordinated with other intervention types (such as those that are school- or clinic-based) to maximize their effect (WHO 2006).

Concluding Discussion and Recommendations

CHAPTER

7

Available literature and research clearly identifies the behaviors which are resulting in high rates of HIV transmission in the Asian region, and can be seen as the 'drivers' of HIV epidemics in the Asian region, contributing a huge proportion (over 90% in concentrated epidemics) of HIV cases: commercial sex, drug injecting, male-male sex, and combinations of these behaviors. Three common elements must be present to ensure HIV prevention successes: addressing specific behaviors and providing services to reduce these behaviors; providing access to information and services on a scale large enough to make an impact; and ensuring that the social, political and security environment supports the provision of appropriate HIV prevention services to those most at risk, allowing adoption of safer behavior.

Higher coverage of quality services to reduce HIV risks associated with injecting drugs, commercial sex and sex between men would turn the epidemic around in Asia (MAP reports). UNAIDS conducted a study on minimum coverage needs for different types of programs and populations, divided by epidemic type (low level, concentrated and generalized⁸). See the table above for suggested coverage targets by 2010. The key message from this table is the need to reach 80% coverage for injecting drug users, sex workers and men who have sex with men in all epidemic types. However, in 2005 it was estimated that only 3% of injecting drug users in South and Southeast Asia⁹ and 8% in China had access to comprehensive prevention and care services. 20% of sex workers were covered in South and Southeast Asia and 38% in China. The poorest coverage data were found for men who have sex with men: 2% in South and Southeast Asia and 8% in China. Compared to 2003, coverage of IDU and sex workers had dramatically improved (starting from a very low base), whereas the coverage of MSM had remained stable.

In terms of vulnerable groups, coverage of prisoners with comprehensive prevention and care programs was 31% for South and Southeast Asia – the number for China was not known. For young people living on the street, coverage was 10% for China and 26% for South and Southeast Asia (Stover and Fahnstock 2006).

The major recommendation of this paper is therefore to strongly increase resources available for age- and gender- appropriate HIV prevention and support services for young people engaging in high risk behaviors.

The coverage of comprehensive interventions that specifically reach these young people should be scaled up to reach 50% in 2010 and 80% in 2015.

Despite the huge difference in physical and cognitive development levels within the age group of 10 to 24 year olds (defined as adolescents and young people) the current HIV prevention services for people engaging in high risk behaviors are not age-specific. For the age group of 18 to 24, operations research is needed to study whether the effectiveness of existing programs can be further increased by making them more

⁸ The 'successful' countries in Asia - i.e. Type 4 in the MAP reports - are not included as a separate type in this division.

⁹ The following countries were included: Bangladesh, Bhutan, Cambodia, India, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka, Thailand and Viet Nam

appropriate. For those under 18, it is proposed that, in principle, interventions should aim at providing alternatives to the behaviors in question and preventing exploitation. For those who have no alternative or do not wish to change their behavior, the paper urges a rights-based approach aimed at reducing harm to the child - i.e. they should not be withheld their right to access prevention services because of their young age.

This review has argued that 'young people' or 'youth' as a defining 'target group label' for prevention, care and support is unhelpful, because it masks enormous differences in HIV risk and vulnerability, which correspond to different needs. It is proposed that young people should instead be conceptually divided into three types and prioritization for HIV prevention programming given accordingly.

Since the predominant vectors of HIV transmission in most Asian countries are one of three main risk behaviors (injecting drug use, sex work and male to male sex), it is proposed that adolescents and young people engaging in high risk behaviors should be the main priority; followed by adolescents and young people who are more vulnerable to start engaging in high risk behaviors.

For this second priority group, young people who are vulnerable to start engaging in high risk behaviors (including young migrants, young people living on the street and out-of-school young people), a wider, less HIV specific approach is needed, focused on improving the safety of their direct environment. This can be done, for example, by

TABLE:2	Feasible and necessary coverage goals for prevention services in 2010 as percentages of those needing the service that should have access to it by epidemic type		
	Low level	Concentrated	Generalized
Vulnerable Populations			
AIDS education for primary and secondary students	30%	45%	100%
Programs focused on out-of-school youth (6-15)	10%	20%	50%
Programs focused on sex workers and clients	80%	80%	80%
Programs focused on men who have sex with men	80%	80%	80%
Harm reduction programs for injecting drug users	80%	80%	80%
Prevention for people living with HIV	80%	80%	80%
Workplace prevention	0%	3%	50%
General populations			
Percent of adults reached through community mobilization	0%	0%	70%
Number of mass media campaigns per year	2	4	5
Percent of adult population accessing VCT each year	0.1%	1%	5%
% of casual sex acts covered with condoms	80%	80%	80%
% of married people with casual partners using condoms in marital sex	30%	30%	30%
Medical services			
% of need for post-exposure prophylaxis that is met	100%	100%	100%
Safe blood (proportion of units screened for HIV)	100%	100%	100%
Safe medical injections	77%	92%	99%
Universal precautions	77%	92%	99%
Treatment for sexually transmitted infections	60%	75%	100%
PMTCT (coverage among women attending antenatal care)	80%	80%	80%

Source: UNAIDS as quoted in Stover & Fahnestock 2006

providing safe spaces to stay and education or vocational training opportunities. Here, HIV/AIDS related messages may be mainstreamed and integrated into wider social support programs.

Lastly, there is a large majority of people in the age group up to 24 years old who are adolescents and young people at low risk and low levels of vulnerability to HIV infection. Many of these are in the younger age groups. It is proposed that HIV prevention information and skills for them should be considered only after the first groups have been sufficiently covered, or if prevention information and skills can be integrated at low or no cost - for example as part of broader adolescent reproductive health programs. To this large majority of adolescents and young people, who do not have risk practices, may live environments where there is little or no HIV, may live in relatively stable families, work and / or attend school, HIV/AIDS related awareness messages can be integrated into school curricula at low or no cost; community-integrated responses (i.e. Youth union activities, scouts, youth clubs) or via the mass media could be considered as part of a wider package of 'adolescent health and development'.

In order to effectively reach out to the most at risk adolescents and young people and reduce stigma and discrimination, which are barriers to their accessing of health and other services, it is proposed that reform - or at least a temporary 'freeze' of the implementation of laws prohibiting or criminalizing the above-mentioned behaviors is called for, in order to enable health workers and NGOs/CBOs to expand their reach and coverage of these groups.

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