Programme Guidance Notes

HIV prevention among most at risk and especially vulnerable adolescents and young people in South Asia
Produced by the United Nations Children’s Fund Regional Office South Asia (UNICEF ROSA) in partnership with the United Nations Office on Drugs and Crime, UNFPA, the World Health Organisation and Family Health International.

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# Programme Guidance Notes

HIV prevention among most at risk and especially vulnerable adolescents and young people in South Asia

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<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>ANPUD</td>
<td>Asian Network of People who Use Drugs</td>
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<tr>
<td>APNSW</td>
<td>Asia Pacific Network of Sex Workers</td>
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<tr>
<td>BBS</td>
<td>Biological and Behavioural Survey</td>
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<tr>
<td>CEE/CIS</td>
<td>Central Eastern Europe/Commonwealth of Independent States</td>
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<td>CND</td>
<td>Commission on Narcotic Drugs</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>DIC</td>
<td>Drop-in Centre</td>
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<td>ECOSOC</td>
<td>Economic and Social Council</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FSW</td>
<td>Female Sex Workers</td>
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<td>HAP</td>
<td>HAP (Now known as UNAIDS)</td>
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<td>HATI</td>
<td>HIV/AIDS Targeted Intervention</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HQ</td>
<td>Headquarters</td>
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<td>IDU</td>
<td>Injecting Drug Users</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>ISS</td>
<td>Information, Skills and Services</td>
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<td>MARPs</td>
<td>Most at risk populations</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
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<td>MSM</td>
<td>Males who have sex with Males</td>
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<td>MTCT</td>
<td>Mother to Child Transmission</td>
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<td>NACO</td>
<td>National AIDS Control Organisation</td>
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<td>NACP</td>
<td>National AIDS Control Programme</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NSE</td>
<td>Needle and Syringe Exchange</td>
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<td>NSP</td>
<td>National Strategic Plan</td>
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<td>OST</td>
<td>Opiate Substitution Therapy</td>
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<td>PCB</td>
<td>Programme Coordinating Board</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>ROSA</td>
<td>Regional Office for South Asia</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>UNAIDS</td>
<td>United Nations Joint Programme on AIDS</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<td>UNODC</td>
<td>United Nations Office for Drug and Crime</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>UNRTF</td>
<td>United Nations Regional Task Force</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WAPN+</td>
<td>Women of Asia Pacific Network of Positive people</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Introduction

Guidance for country programmes

This document provides guidance to countries in South Asia on how to:

- design and deliver HIV prevention programmes that reach adolescents and young people practicing unsafe behaviours that increase their risk of HIV and other Sexually Transmitted Infections (STIs)
- design and deliver related programmes that may impact on the behaviour of adolescents and young people to reduce their risk of HIV and STIs
- best reach adolescents and young people who are in situations that make them especially vulnerable to higher risks of HIV or other STIs.

Not all adolescents and young people in South Asia are at risk of HIV or STIs. But some practice or are exposed to unsafe behaviours that increase their risk. These risks can be substantially mitigated by the provision of appropriate and timely information, skills and services (ISS).

The Programme Guidance Note will assist programme planners to understand the key issues, challenges and recommended strategies for reaching adolescents and young people with targeted, effective, rights-based and youth-friendly HIV prevention interventions by:

- defining unsafe behaviours
- explaining why these behaviours increase the risk of HIV or STIs for young people
- describing the contexts in which young people may practice or be exposed to unsafe behaviours
- identifying young people who may not be practicing unsafe behaviours yet, but may do so based on certain vulnerable circumstances in their lives
- giving practical advice on how most at risk and especially vulnerable adolescents and young people can be reached with appropriate ISS.

Working with and for young people

Consultation with adolescents and young people during programme development and implementation is important and has been shown to be beneficial in targeting programmes. Consultation and inclusion is the most effective way of ensuring that interventions are appropriate to and will benefit young people.

One role of programme planners, implementing organisations and donor agencies is to listen to and appropriately engage young people in all activities, not to design and implement programmes in isolation without consulting and involving young people.
**Context**

The Programme Guidance Note builds on the principals of the *Guidance Brief on HIV Interventions for Most At risk Young People* developed by the Inter-Agency Task Team on HIV and Young People, expanded to include practical recommendations for implementing interventions and best practices for reaching most at risk and especially vulnerable adolescents and young people.

The Guidance Note has been developed in thorough consultation with UN agencies (United Nations Children’s Fund [UNICEF], United Nations Office for Drug and Crime [UNODC], United Nations Population Fund [UNFPA], United Nations Educational, Scientific and Cultural Organisation [UNESCO], World Health Organisation [WHO], United Nations Joint Programme on AIDS [UNAIDS] and United Nations Regional Task Force [UNRTF] on Injecting Drug Users), development agencies (Family Health International [FHI]) and civil society organisations (Seven Sisters, Asia Pacific Network of Sex Workers [APNSW], Asian Network of People who Use Drugs [ANPUD], and Women of Asia Pacific Network of Positive people [WAPN+]) including young people from these groups where possible.

The principals of the Guidance Note are based on the aims of significant international declarations on HIV/AIDS; for example, the 2008 United Nations General Assembly’s Special Session (UNGASS) on HIV. The 2008 UNGASS meeting called upon all regions, regardless of their epidemic settings, to take action to:

- make prevention the foundation of all international, national, and regional responses to HIV/AIDS;
- target interventions based on evidence and current HIV/AIDS related responses; and
- prioritize HIV interventions with most at risk populations, including adolescents and young people.

The meeting stressed that all countries must aim for an HIV-free future generation by implementing ISS that are comprehensive, targeted to the needs of the communities by consulting with them, based on existing evidence on who is most at risk and how they are currently being reached, and use an approach strongly based on human/child/gender rights. It also highlighted the need to promote responsible sexual behaviour among young people (including the correct and consistent use of condoms); create youth-specific HIV education/information; utilise mass media to effectively reach young people; and set up youth-friendly health services as some of the key interventions for HIV prevention among young people.

Since 2006, several high-level meetings, and their resulting reports and resolutions, have provided direction to the HIV response over the next few years. They advocate for better results in HIV prevention through well-resourced and country-specific programmes that create major changes in people’s behaviours, attitudes and beliefs, as well as change to or relaxation of laws that criminalise or penalize specific practices. They reaffirm the importance of a comprehensive HIV/AIDS response that includes partnerships with those who are most at risk and vulnerable, better HIV surveillance methods, improved monitoring and evaluation of HIV and related programmes, and better resource tracking and financial needs analysis, all of which will assist countries to design appropriate and effective responses.

The meetings and resolutions have resulted in a range of guidelines to assist HIV prevention work with most at risk populations. However, they have not addressed the unique needs of most at risk and vulnerable adolescents and young people, and the challenges in developing targeted and effective strategies to develop appropriate information channels and services. The Programme Guidance Note fills this gap by taking the global commitments to targeted, intensified HIV prevention for most at risk populations and applying them to adolescents and young people considered to be most at risk and vulnerable to HIV/STI in South Asia.
**The United Nations**

**Age definitions**

<table>
<thead>
<tr>
<th>Children</th>
<th>0 up to under 18 years (17 years)</th>
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<tr>
<td>Adolescents</td>
<td>10 to 19 years (WHO)</td>
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<tr>
<td>Youth</td>
<td>15 to 24 years</td>
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<tr>
<td>Young people</td>
<td>10 to 24 years</td>
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Regardless of these age definitions, the adolescent years are a transition time when young people move from reliance to independence; when they experience physical changes; and when they mature sexually and socially. The exact age groups will differ from country to country, but it is the inexperience and experimentation that surrounds the adolescent and youth years that continues to mean that young people have special needs.

**Why focus on adolescents and young people?**

- The United Nations Convention on the Rights of the Child (CRC), ratified by 194 countries, states that any person below the age of 18 years is defined as a ‘child’. All children have a right to practical and appropriate ISS that provide protection from all forms of harmful behaviours and practices.
- Many young people in South Asia who are aged below 18 years are often unaware of or denied their CRC rights because of various social, economic and policy-related factors.\(^4\)
- Of the 40 million people living with HIV/AIDS worldwide, one third are 15-24 years old and roughly half were infected during their youth.
- In 2008, 40 per cent – almost half – of all new HIV infections worldwide occurred among young people.\(^5\) Throughout the world, almost 3,500 young people aged 15 to 24 are infected with HIV each day. In South Asia, HIV prevalence is higher in specific sub-populations of young people.\(^6\)
- South Asia has high populations of young people:
  - Nearly two-fifths (39.4 per cent) of Nepal’s population is under 15 years and 19.4 per cent is between 15-24 years old. One-third (32.5 per cent) of the population is between 10-24 years old
  - 44 per cent of Afghanistan’s population is under 14 years old and 65 per cent is under 25 years old
  - Nearly 62 per cent of Maldivians are below 25 years old.
- The adolescent years are a time for great curiosity and exploration. Peer relationships and identity are being formed, and the body and brain go through immense and sometimes confronting changes. Interest and experimentation with drugs and sex can be a part of this time, making young adolescents vulnerable to the risks of STIs and HIV.\(^7\)
- Adolescents who engage in risk behaviour are more at risk than adults because they are still developing mentally and physically. They may not have the necessary negotiating skills or decision-making power in their relationships with adults and so they are more vulnerable to abuse and exploitation.

**Focusing on adolescents and young people is critical in order for HIV prevention programmes to reach their international targets of stopping new infections in young people**
• Adolescents face difficulties accessing health care services or information. Without timely information about and the necessary skills to deal with risk behaviours like having sex without condoms, or sharing syringes and needles to inject drugs, they are exposed to greater risk of STIs and HIV.⁸

• Most international treaties and commitments ask for HIV data for young people in the 15-24 year old age group (youth) recognising that many are married, many are sexually active and some experiment with drugs and other behaviours that might put them at risk. Data for young people below 15 years of age is limited and often not collected (or not reported) because it is not culturally acceptable for unmarried young people to be sexually active or use drugs. What data is available does suggest that small percentages of young people under 15 are involved in risky behaviours for HIV. However in some settings young people are overrepresented and accessing them is difficult. In some countries in South Asia, adolescents as young as 10-13 years of age are reported to be involved in risk behaviours for HIV/STI, meaning they too need appropriate information and services.⁹

**In South Asia**

The majority of young people in South Asia are not at risk for HIV. In South Asia:

- 80-90 per cent are considered ‘at little or no risk’ for HIV
- 5-15 per cent are considered ‘especially vulnerable’ to taking up risk behaviours for HIV
- 1-5 per cent are considered at ‘high risk’ for HIV because of their behaviours.

Even though the percentage of most at risk adolescents and young people is currently low in South Asia, it may grow significantly without targeted HIV-related programmes and resources which prioritise young people.

**Figure 1: Concentration of HIV epidemic in South Asia**¹⁰

- 80 per cent to 90 per cent
  - Adolescents and young people at little or no risk for HIV/STI
- 5 per cent to 15 per cent
  - Adolescents and young people especially vulnerable to HIV/STI
- 1 per cent to 5 per cent
  - Adolescents and young people most at risk for HIV/STI

95% of new infections in young people are in most at risk populations (who make up 5% of young people)

Focusing HIV related programmes and resources on those most at risk does not mean that programmes and resources for young people at little or no risk would be reduced. Adolescents and young people at little risk (who are mostly in schools or protected environments and therefore may include children with economic, educational and family structure advantages) also need ISS to ensure they understand the risk behaviours for HIV/STI.
Most at risk adolescents and young people
Adolescents and young people are 10-24 years old male, female and transgender of any sexual identity who are already practicing or exposed to unsafe behaviours that increase their risk (the likelihood or chance) of HIV or other STIs.

Figure 2: Unsafe behaviours with higher risk of HIV/STIs

**Having sex without condoms**

Having vaginal, oral or anal sex without condoms increases the risk of HIV and STI transmission through the exchange of sexual fluids and/or blood.

HIV transmission is at high risk for anal sex. Anal sex without condoms and lubricants significantly increases the risk of HIV or STI transmission since the anal area is more delicate and therefore more likely to tear and bleed, allowing HIV and other viruses to enter the bloodstream.\(^{11}\)

A person receiving unprotected anal sex from an HIV-positive sexual partner is 5-10 times more at risk of getting HIV infection, whether it happens in heterosexual, homosexual or transgender contexts.\(^{12}\)

Lack of treatment for other STIs can increase the chance of HIV transmission because having an STI can cause inflammations and cell changes which create pathways for HIV.

**Sharing used needles and syringes to inject drugs**

Sharing needles and syringes to inject drugs that have been used by a person with HIV allows HIV to enter the person’s bloodstream directly.

This does not mean all young people who inject drugs are at risk. Young people at risk are those who:

- Share needles and syringes for injecting
- Share equipment used for drug injection:
  - share or use unclean water, cookers or cotton
  - use used syringe plungers to stir drug solutions
  - squirt the drug solution from a previously blood contaminated syringe into the drug mixing ‘cooker’ or ‘spoon’ and draw it into another syringe
  - rinse a used, blood-contaminated syringe in water that other users also use to rinse their own syringes or dissolve drugs.
Multiple risk behaviours

Some adolescents and young people engage in multiple risk behaviours for HIV: having sex without condoms and sharing used needles and syringes to inject drugs.

Research suggests that the majority of young people injecting drugs are sexually active, partner change rates are relatively high, with a high degree of sexual mixing between injectors and non-injectors. Condom use is especially uncommon among drug users with regular sexual partners. Negotiating condom use can be a difficult matter for girls, transgender people and young boys.

Providing sex in exchange for money is often associated with drug use. In sex work, it is difficult to negotiate the use of condoms by clients, and sometimes people are willing to pay more for sex without a condom. Many factors may increase the opportunities for young sex workers to engage in multiple risk behaviours: gender; cultural contexts; lack of access to condoms and lubricants; and lack of access to information about healthy lifestyles, safe behaviour, HIV prevention and related services that are appropriate to their age, level of maturity and education.

Using any kind of drug may affect a person’s awareness of and decisions about practicing safe behaviour, including injecting behaviour and safe sex practices: condoms might not be used or are used infrequently or incorrectly; injecting equipment may not be cleaned properly or at all.

Young people who inject drugs often use other substances as well. The use of alcohol and amphetamines can decrease inhibitions, increase sexual desire and decrease planning and rationale thought about the consequences of behaviour. Much research suggests that people are less likely to use a condom when drunk.

Factors

- Age and level of maturity
- Gender power relations in social/cultural settings
- Level of poverty
- Level of education
- Availability of alternative opportunities such as employment, school and recreational activities like sports
- Presence or absence of caring and supportive families and/or communities
- Whether behaviour is practiced in an illegal context i.e. when males having sex with males (MSM) is not legal
- Access to appropriate information and services for HIV/STI prevention, sexual health, reproduction, drug treatment and harm reduction
- What kind of child or youth friendly protection related policies and programmes exist
- The school and home environments including social circle and friends/peers
- A person’s own individual strengths or abilities to cope with these factors; for example, peer pressure to engage in risk behaviour.
Issues that place young people at risk

**Limited awareness:** Young people often have limited education, awareness and knowledge of HIV, sex and drug use. This includes knowing about the options for safe sex and the proper use of condoms, and the options for safer injecting practices and reducing risk behaviour. Information is often not written for or directed to young people.

Young people who inject drugs have probably not experienced the complexity and severity of health problems that older people who have injected drugs for longer have experienced, like abscesses or gangrene. It may be difficult for young people to understand the need for prevention efforts when the risks to health are seen as distant or remote.

**Limited access to services:** It’s common for young people to be unaware of how to access appropriate health, social, legal and welfare services, or they may not know of the existence of these services. Some services are geographically inaccessible. Some countries have waiting lists for health services and hospitals that discourage young people from seeking and receiving help. Young people often perceive services to be ‘unfriendly’.

**Lack of confidentiality at services:** Young people may feel ashamed, fear stigmatisation, or fear lack of privacy and confidentiality when considering using treatment services. They may avoid using services for fear that this will make their problems visible. The desire to keep behaviours such as drug use discrete results from the strong stigma associated with drug use (and with HIV/AIDS).

**Fear of being caught/penalized/imprisoned:** Young people are afraid they might be caught, penalized or imprisoned, inhibiting their approach to services for information and help.

**Peer influence:** Young people are curious and can be easily influenced by peer pressure. They often use or abuse drugs within their peer groups and can be guided by peers who consider drug use to be the norm.

**Poverty and financial insecurity:** Young people often suffer from financial insecurity because of irregular sources of income, unemployment and a lack of skills they can use on the labour market, particularly if they have dropped out of school early. Lack of money may force young people into high risk situations, such as selling sex or selling drugs for money. It may also prevent young people from seeking health care, as they may not be able to afford the care or medication they need.
At risk contexts

Sex work

- Sex workers are female, male and transgender young people who receive money, goods or gifts in exchange for sexual services either regularly or occasionally.

- Evidence from South Asia suggests that some young people younger than 18 years are also engaging in sex work for a variety of reasons, including poverty and forced sexual trafficking.14

- Not all young sex workers and their clients or sexual partners are at risk of HIV/STI. When young people have sex without a condom there is risk if anyone — the young sex worker or their client or their sexual partner — is HIV-positive or has another STI.

- In many cultures, heterosexual sex for boys is regarded as part of the process of becoming an ‘adult’. So young boys may visit female sex workers for that purpose, but without the information or skills to negotiate the use of condoms, or access to smaller sized condoms.

- Some young sex workers may engage in multiple risk behaviours. They may be using drugs, sharing needles and syringes to inject drugs, and having sex without condoms.

- Sex workers who have regular non-commercial male or female sex partners may pass HIV on to their partner/spouse if they do not use condoms. In cases of female sex partners/spouses, pregnancy may occur, with HIV passing on to newborn infants through Mother-to-Child Transmission (MTCT) if Prevention of Mother to Child Transmission (PMTCT) and maternal health services are not available or accessible to them.

- Male and transgender sex workers often face multiple layers of stigma – related to sex between men, sex work, gender identity and HIV – and are highly marginalized. Stigma can create moralistic approaches to sex work that are driven by the aim to reduce or eliminate sex work, rather than by meeting sex workers’ sexual and reproductive health, and HIV/STI needs.

- Sex work occurs in different settings (independent contractors, hotel or street work, managed brothels) but young people may define sex work and types of sexual-economic exchange differently. While some settings may promote condom use, many neither promote safe sex nor protect sex workers from violence and abuse by clients, law enforcement officers and gangs.

“In countries without laws to protect sex workers, drug users and men who have sex with men, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment and fewer deaths. Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us.”

Ban Ki-Moon
Secretary General - United Nations
August, 2008

Source: UNAIDS Action Framework: Universal Access for Men who have sex with Men and Transgender People, 2009
Sex between males and sex between males and young transgender people

- Homophobia, stigma and discrimination toward sexual minorities, and the illegality of male to male sex in some parts of South Asia, means that young males and transgender people may not seek out services and information to help them be safe from HIV and STIs, or violence, abuse, rape and the exploitation they have to endure from older male sexual partners.\(^\text{15}\)

- Young males who have sex with males (MSM) may not have access to condoms or lubricants, adequate information about their use or the skills to negotiate condom use because of their young age.

- Some young MSM also have female sexual partners/wives who may be at risk through intimate partner transmission.\(^\text{16}\) If the female sexual partner/wife becomes HIV-positive and is pregnant or has a young baby, the baby may be at risk through mother to child transmission (MTCT).

- Male to male sex can occur in all-male settings like the army, monasteries or prisons. Young migrants living in single-sex housing are another example in South Asia. Males who engage in this behaviour often describe it as a form of play or ‘sexual relief’ and will rarely describe it as homosexual behaviour or themselves as homosexual.

- Male to male sex can be part of growing up: boys may explore their emerging sexuality by playing ‘games’ with each other. These games can involve mutual masturbation, but sometimes may also include oral and anal sex where safe practices are not often known or practiced.

- In male to male sex where exchange plays a role, sometimes especially poor and young boys have sex with men in exchange for money, drugs if they are using or injecting, or certain other favours like housing or shelter.

- Young MSM may be blinded by feelings of love and trust for an older sex partner, or they may suffer from low self-esteem or even self-hatred, and therefore will be unable to insist on condom use.

- Adolescent boys who have sex with older men are regarded as ‘virgins’, reducing the likelihood of these older partners using or consenting to use condoms.
Sharing injecting equipment, used needles and syringes to inject drugs\textsuperscript{17}

- The unsafe behaviours of young injecting drug users are what increase their risks for HIV. Unsafe behaviour can be injection related or sexual risk behaviours.
- This form of transmission is rapidly increasing worldwide, with rates expanding from 5 per cent to 50 per cent in one year.\textsuperscript{18}
- It has been established that young people share injection equipment in the same way as older drug users.
- If a young person begins drug use early, they face many problems that make it difficult to break the addiction because:
  - at younger ages the individual is less likely to understand the consequences of his or her drug use
  - early drug use is often connected to poly substance use
  - the longer a person uses drugs, the more severe will be the long-term health related consequences
  - early onset will often mean school drop-out and this in turn means few future career or job opportunities
  - inability to find employment can lead young people to remain on the streets and in the drug-using scene
  - young girls and young boys, who quite likely have been unable to stay in school, may end up in sex work to get money for drugs or to be paid with drugs.

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\caption{Mean age of initiation into drug use and injecting drug use in India by region}
\end{figure}

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\includegraphics[width=\textwidth]{figure4.png}
\caption{Age distribution and age of initiation into drug use in Nepal}
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Source: UNODC ROSA. Injecting Drug Use and HIV/AIDS in India - An Emerging Concern UNODC. 2008

Injecting drug use health risks

Injecting drugs have a number of consequences on young people’s health. While preventing HIV is a priority for IDUs, it is important for providers and young people themselves to be aware of the range of other health risks they face:

- Hepatitis C: a very transmissible blood borne virus that is very transmissible through sharing drug injecting equipment or any equipment that may contain traces of blood, such as toothbrushes. High rates exist among people who inject drugs: in many locations over 60 per cent of people who inject drugs are Hepatitis C positive. There is no vaccination for Hepatitis C and the management of this illness is complicated.

- Hepatitis B: acute and chronic forms are common among young people who inject drugs. Hepatitis B is a blood borne virus (transmitted through sharing needles and syringes, and through MTCT), and is also sexually transmitted; using condoms and clean injecting equipment are important prevention methods. There is a commonly available test for Hepatitis B and a vaccine exists but may not be widely available to at risk and vulnerable adolescents.

- Overdose: caused by a higher dose of drug than the body can take, this is often fatal. Mixing drugs into ‘cocktails’ can lead to overdosing

- Physical damage: Ulcers and abscesses are common problems caused by repeated injections, which can result in scarring and marks on the skin. Loss of access to superficial veins means that deeper veins are used for injecting drugs and this can cause tissue damage.
Especially vulnerable adolescents and young people
Adolescents and young people who are not yet engaged in high risk behaviour for HIV or STI but who live in particular situations or social structures that make them susceptible to, or unable to protect themselves from, significant harm or exploitation. They therefore become especially vulnerable to engage in unsafe behaviours linked to HIV.

To be vulnerable means to be prone to physical or emotional injury that may persuade or tempt a person to engage in behaviours that would usually be avoided. In the context of HIV, vulnerability refers to those factors/situations/circumstances, and the interactions between them, that may lead adolescents and young people to take up risk behaviours for HIV/STI (such as having sex without condoms and/or sharing needles and syringes to inject drugs)\(^\text{19}\) (Figure 8).

The more vulnerability factors there are in an adolescent or young person’s life, the higher the chances of taking up risk behaviours for HIV and/or STIs. For instance, a young person who lives on the street, who has no adult or parental care or supervision, and who cannot afford to go to school is often exposed to social sanctions and policing which will result in a short or long stay of care in an institution, where further abuse may take place. Living on the street affords little or no protection for young people, increasing their likelihood of sexual exploitation and exposure to drug use and injecting drug use practices.\(^\text{20}\)
The personal and immediate social life of the individual

The young person
- lives or works on the street with no parental or family/community supervision/protection
- works in forced child labour
- has friends or peers who are engaged in and pressure them to engage in early sex, sex without condoms and/or drug use
- is incarcerated
- is out of school
- is performing poorly in school and is socially withdrawn
- has an unstable family life.

Availability of comprehensive programmes

Comprehensive programmes which cover information and services in health, social protection, education, employment and reproductive health/HIV/STI.

Are they available?
Are they accessible?
Are they appropriate?
Are they comprehensive?
Are they affordable?
What is the coverage level?
Who is covered?
How are they used?
Who uses these services?
Which services are used?
How often do young people use them?

Broader structural and environmental factors

These factors create vulnerability and assessing them can help identify where and how policies and programmes can intervene.

- **Availability of drugs**: ease in buying and finding drugs including low costs such as in Afghanistan and Maldives.
- **Low levels of education**: most of South Asia.
- **Gender inequalities** in access to post primary education, income distribution, property ownership, interpersonal relationships and negotiation: most of South Asia.
- ** Trafficking of girls**: in Nepal, India and Bangladesh.
- **Poverty**: most of South Asia.
- **Sexual abuse and exploitation** within and outside the home: systematic data unavailable because of cultural taboos but anecdotal evidence emerging.
- **Social and economic pressures** on adolescents and young people to sell or exchange sex for money, goods and drugs: this is influenced by various other factors like poverty, gender inequality, group membership and drug use.
- **Social exclusion**: based on caste, religion, sexual orientation and physical status/disability.
- **Conflicts, natural disasters and displacements** increase vulnerability for girls including for sexual abuse, and places boys in vulnerable situations, such as recruitment as child soldiers, among other risks: conflicts in Afghanistan, Pakistan; natural disasters in Bangladesh, India and Nepal; and displacements in Bhutan, Nepal and Pakistan.
- **Volatile political contexts, economic inequalities, barriers in laws, policies, and cultural norms**: that may hinder HIV prevention programming.
Adolescents and young people especially vulnerable to HIV in South Asia

Vulnerability varies from country to country based on economic, cultural, political and social contexts. Some examples are:

- Siblings, friends and peers of those who inject drugs and/or have unsafe sex
- Living in conflict/post conflict situations.
- Living in institutional care; for example, juvenile, correctional, or prison settings.
- Living and/or working on the streets or in slums.
- Work in forced or underpaid labour; for example, factory worker or domestic help.
- Migrant/mobile/displaced.
- Minority or socially marginalized communities.
- Dropped out of school at an early age.
- Children of parents who use drugs and/or sell sex
- Sexually or physically abused either in or outside their homes.
- Orphaned and without any adult supervision and care, or community support.
- Drug users but not yet injecting drugs.
- Early marriage: in South Asia, girls are often married early and mostly to older men.
Comprehensive HIV prevention programmes for adolescents and young people
Recommended actions

The following nine action points are designed to help you build appropriate programmes. Use them as a starting point, refer to our resources and further reading section, and consult with young people about the best approach.

1. Before you start

Ask yourself as many questions as you can to help you understand the young people you want to reach.

**Who do you want to reach?**
Identify the age range, gender, social status (are they mainly street youth or students?), education and income of your target communities.

**What behaviours do you want to address?**
Identify sexual practices that may be unsafe or are conducted in high risk environments:

- Is sex being sold?
- Is sex work seen as something short term or a regular profession?
- Does the young person identify as a sex worker?
- How often are condoms used?
- Are water-based lubricants used during anal sex?

Identify unsafe injecting drug use:

- To what extent are drugs injected?
- Why get high? What's the benefit? What's the effect?
- How many, if at all, visits to a health centre?

Use the STEPS one the next page for planning, development, implementation and evaluation.
**STEPS:** Reaching most at risk and especially vulnerable young people with HIV prevention programmes

**STEP 1**

Collect or gather data about the current HIV situation. For example:

- Is there an HIV prevention strategy in the NSP? Does it include most at risk young people (10-24)? What data is available on who is at risk, what risk behaviours they are engaged in, and where these behaviours are taking place?

- If data is insufficient then gather data, possibly including a mapping exercise

- Identify what policies and laws currently exist for sex work, male to male sex, sexual minorities, drug use, child rights and gender rights

**STEP 2**

Find out the current HIV related responses and gaps.

Through data collection activity get information like:

- **Programmes:** What currently exist for young people most at risk and especially vulnerable? Are they youth friendly and appropriate to age, gender, context? Who is providing them?

- Who are the beneficiaries? What is the coverage and how are they reached? How are the target communities involved in design and delivery?

- **Barriers:** What are the barriers (e.g. policy, legal, social) in implementation coverage and access?

- **Gap Analysis:** What gaps exist in data, resources, programme design and delivery?

**STEP 3**

Design or adopt your programme

- Enlist support from local authorities, communities and families, and support at the policy and legislative levels

- Be prepared to conduct evidence-informed advocacy at all levels at all times

- Use creative, innovative and interesting approaches

- Don’t just focus on HIV issues but make it comprehensive and flexible to fit young people’s needs

- Treat the target communities with respect and dignity

- Tailor the programme based on your consultation with the target communities

- Make sure Monitoring and Evaluation of progress, effectiveness and achievements are conducted regularly

**PARTNERSHIPS**

Continue and strengthen partnership with national HIV and/or PLHIV networks. They have good links to MARPs networks which can assist in reaching communities of adolescents & young people

**PARTNERSHIPS**

Contact and partner with the National HIV and/or PLHIV networks

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Involve the target communities of young people in this process and engage the appropriate staff and technical expertise.

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Involve the target communities of young people in this process and engage the appropriate staff and technical expertise.
2. Work in partnership with young people

Remember that due to stigma and the fear of being detected or punished, young injecting drug users, sex workers, MSM, transgender people and young clients of sex workers will usually not come forward to look for information or help. You need to reach out to and locate young people through outreach programmes.

**Locate** young people through national People Living with HIV (PLHIV) or other HIV networks as a good starting point; partnerships with child protection agencies or NGOs working with vulnerable populations; and using local knowledge of the streets, bars and entertainment venues where at risk and vulnerable young people are located.

**Ask** young people for ideas for effective outreach: for example transgender people have suggested holding community beauty pageants or beauty-related activities.

**Involve** young people in programme planning, by asking the following questions:
- What kind of information and services are most useful?
- What’s your priority for information and services; for example, sex workers may need more information and support around negotiating condom use
- Would you prefer to go to drop-in centres (DICs)? Where would you want those centres located?
- Would you prefer outreach activities? Explore venues where outreach could take place: bars, streets, railway stations, crack houses, brothels, markets or slums, for example.

**Understand** young peoples’ strengths and capacities and how they can be best utilised by
- ensuring information, education, services and activities will be utilised by young people through working in partnership and thoroughly understanding the needs of your target audience; make all your communications and services user-friendly and youth-friendly.
- playing an important role through carrying out activities in drop-in centres and doing outreach work
- continuing with Monitoring and Evaluation of the programme.
BASIC FACTS: Outreach

- Education and services need to be taken out to young people in their own social settings rather than waiting for young people to seek out services. For various reasons, at risk and vulnerable young people are not likely to seek help on their own, so outreach is a major tool to use when working with and for at risk and vulnerable young people.

- Outreach usually occurs directly in places where target communities spend time: streets, bars and entertainment venues.

- Outreach aims to make contact with young people who are not reached by existing health or information services. It’s an important channel for reaching out-of-school and street youth. Experience shows that it is not difficult to do and a good way to reach those living in vulnerable conditions.

- Outreach is most often staffed by peer educators who listen and observe young people, rather than give instructions or push them into services or behaviours they are not comfortable with or don’t want. Good outreach should already know what services are being taken to what groups. Young people shouldn’t feel judged and forced to change behaviours; rather they should be given the opportunity to learn about reducing unsafe behaviours in a respectful, trustful way.

- Some outreach initiatives focus on information and others on direct services, such as food and shelter, to target communities. Ideally both young people’s immediate and longer term needs should be considered.

- In settings with legal restrictions on service provision or where social stigma is particularly high, information provision may be the only effective way to immediate intervention.

- Peer outreach is a more specific form of outreach, using peers to reach out to the target community. It is also usually a less expensive form.

- Although peers may not have educational or social welfare qualifications, they have skills, life experience and commitment and can develop good relationships with other young people.

Source: HIV prevention among young injecting drug users. UNODC, 2004
3. Secure funding support and access to technical expertise

Find out what resources you have available. Consider the following.

- Where could you get funding?
- What educational materials already exist in this field?
- What kind of partnerships could you form with other organisations?
- Which donors may be interested in HIV and most at risk young people? Who is supportive of harm reduction or young women’s projects? If your activity is linked to other organisations, they may already have donors who they work with that you could approach.
- Be clear in explaining what the problem is that you are trying to address and what your project is proposing.
- Don’t ask for too much money in proportion to what you are trying to achieve.
- Be aware that funding is often not sufficient to develop, maintain and sustain an activity or initiative; professionals may not agree to work for no or low pay.
- If necessary, look for cooperation in the private sector or with other countries or international organisations.
- Look for cost-effective ways to develop and maintain activities and initiatives, such as using appropriate voluntary workers. Build any cost-savings into your application for funds.
- Look for competitions or other opportunities to get funding for your activity or initiative.

4. Rights-based approach

There are a number of important documents that give young people rights — significantly the Convention on the Rights of the Child (CRC) available at www.unicef.org. A rights-based approach may be useful to implement in order to ensure protection of young people’s rights when developing programmes.

A rights-based approach (RBA) recognises that all young people are entitled to care and services and ensures your programme does not discriminate based on behaviours. A RBA recognises that although some young people make risky choices they are still entitled to their rights to be treated fairly and without discrimination, to access information and services, and to protection. Under a RBA, young injecting drug users, MSM and sex workers are still entitled to prevention services, testing, and condoms and clean needles that can protect them. A RBA ensures there is no blame or denial of support in programmes, just because the young person has engaged in risky behaviour.

Treat each person as an individual

Rather than using a generic strategy, try to address the unique needs of all individuals in your target communities by tailoring your programme, communications and response to meet individual needs.

It’s not a ‘one size fits all’ situation. Everyone has a unique personality, and a different set of strengths, limitations, capacities, requirements, life experiences, and reasons for their life circumstances and behaviour. For example, when working with sex work communities, be aware of the specific needs of male and transgender people. Sex worker communities have reported that there is too much focus on female sex workers and not enough on male and transgender people sex workers.
Don’t be narrowly focused on separate health goals or categories

- Aim to address as many needs and problems as possible without being too prescriptive.
- Most at risk communities highlight the importance of first addressing the day-to-day survival issues and challenges in their lives rather than jumping directly to discussions and resources on HIV. Addressing immediate needs such as food, clothing and shelter builds strength and capacity for future HIV and STI work.
- Sex workers have expressed the need for a break from the focus on HIV. Instead, they want activities they like to do, which may in the future generate interest in wanting to discuss or learn about HIV and STIs.

Target sexual partners

Consider opportunities for your activities and initiatives to reach out to the sexual partners of your target communities, who may be at increased risk of HIV/STIs due to the risk behaviour of their partners. This may be the sexual partners of:

- males who have sex with males/transgender people
- young people who inject drugs
- adolescents who buy sex
- young male/female/transgender sex workers.

Young village girls in Nepal © FHI YouthNet
**BASIC FACTS: Mapping**

Gathering data about most at risk and especially vulnerable adolescents and young people

**What is mapping?**

Mapping of most at risk young people is one method that had been well used to identify where young people practice their risk behaviours, estimate their numbers, better understand the environment that influences at risk behaviours, quantify behaviours, and identify the need and number for services and commodities.

Mapping requires a partnership with young people and providers working in a specific environment or area. The locations generally used for mapping – usually known as hot spots – are areas identified as problem areas for high risk settings; for example, bars and streets in a specific neighbourhood, well known hot spots for sex trade and drug sales, and sea ports. Mapping with target communities can help establish ownership and authenticity, improving the likelihood that interventions will be effective in reaching young people.

**Methods**

Methods include location-led designs and assessments, followed by other national surveillance data like Second Generation Surveillance (SGS). Technical expertise will be required. Thorough qualitative approaches (such as ethnographic interviews, key informant interviews, focus groups, etc) can also be used to supplement quantitative approaches. Make sure that the interviews and questions used are appropriate and comprehensible.

**Issues to consider**

**Follow ethical guidelines**

As with any data collection exercise, ensure that ethical guidelines are followed by all members of the assessment team for informed consent, voluntary participation, confidentiality, anonymity and absence of harm.

There are guidelines on the ethics of collecting data on children and adolescents. Consideration should be given to any risks faced by participates compared to the benefits to the group. There can be legal issues related to gathering data from young people under 18 but there are no hard and fast rules. The concept of ‘mature minor’ applies to someone who may live alone on the street and make decisions for themselves as they have no parents. In some countries young people aged 14 can be tried as adults under the law, so it makes sense that such young people can also be involved in research about their own experiences related to what may be considered as ‘adult behaviours’. A common sense approach should be employed when working with young people at risk of HIV.

**Combine relevant expertise**

Enlisting the help of target communities to carry out mapping activities – in partnership with technical experts on various research and assessment methods – is a highly recommended strategy. Ask young people, groups delivering services and older MARPs where and how to find target communities, what strategies to use, etc.

**Use available resources**

- Drug treatment services; hospitals and emergency rooms
- Local authorities on AIDS and health as well as universities
- Local researchers in the field can help you with information or references
- Newspapers and magazines sometimes have articles on HIV/AIDS and other important issues
- NGO’s and other groups already working with the target group or with other groups in the area; self help groups

**Be practical**

It may not be easy to gather all the information. Do not let the lack of information stop you from starting your programme or activity, but keep in mind that the more you know, the more chances you will have of reaching your target group. Remember that you can always collect more information once you have started.
5. Get the appropriate staff onboard

Be clear about who is appropriate to work on HIV prevention

- Young current or past drug users or injecting drug users have the advantage of experience, increased credibility among peers, and can speak the same language.

- In peer education approaches, non-users may not have the particular advantages of current or ex drug users but they can be trained professionals with knowledge of HIV, AIDS, STIs and other related areas. This can stimulate discussions about drug using experiences. However it is very important to see what the target group wants in terms of peers and to attempt for your peer outreach/education worker to share the characteristics of the group which you need to outreach: for example, a young woman who has never had sex will find it difficult to understand the issues of a young sex worker.

- For highly technical tasks — conducting assessments, size estimations and specialized interviews — the appropriate technical experts can work in partnership with young people.

- Make sure staff have appropriate characteristics. For example, they should:
  - be open, free of prejudices and stereotypes, and have a non-judgmental position toward drug use, sex work, sexual minorities and male-male sexuality
  - be caring, understanding and sensitive
  - have respect for the target community
  - respect confidentiality
  - have an appropriate level of knowledge of safe injecting, safe sexual behaviour, HIV, AIDS and STIs, and sexual and reproductive health or be able to refer them to appropriate services
  - use everyday rather than technical language, and be familiar with some of the terms and language of the target group
  - be able to work with young people as well as for young people: respecting opinions, listening and including, and pitching to an appropriate level to ensure young people have every opportunity to assist in the development and implementation of programmes
  - be available to work a wide range of hours, including outside standard working hours, as appropriate for the programme.

Provide necessary and appropriate training

- All staff should have basic training so that they are knowledgeable about risk behaviour and risk reduction (both injecting and sexual risks) related to HIV transmission.

- Staff should know the aims of their interventions and be clear about their role and what is expected of them.

- Peer educators need training and skills for outreach work, even if they have previous experience with the target community.

- Staff training should specifically emphasize the reduction or elimination of prejudices and stigma, examining attitudes towards the target community, risk behaviours, HIV, legislative policies, etc.

- Confidentiality, respect for young people and the credibility that must be given to young people’s input should be an important part of all training.

Provide technical support and capacity building opportunities

Keep track of what additional skills are required and explore ways of meeting those needs:

- Hire appropriate experts to conduct workshops on specific skills/topics.
- Provide or look for opportunities for staff to attend workshops and training programmes.
6. Develop effective communications in partnership

- Research what communications are the most effective for young people in your target community, including new technologies like instant messaging (IM), text messaging (SMS), social networking sites, like Facebook. Talk to young people about where they get their information, how often they access it, and in what forms i.e. do they read comics, usually use text messages to communicate, like the movies or go to places where you can put up posters or messages on the walls.

- Avoid using too much text and too many words and long sentences in your printed information. Remember that young people involved in high risk behaviours for HIV often have low education levels and therefore low literacy. Keep communications simple and visual, using pictures and graphs. Explore alternatives to printed information: purely visual comics or posters, screen savers, IM and text, games and quizzes delivered electronically.

- Use some of the same terms used by the young people you are speaking with, i.e. the names of drugs. Avoid jargon, technical language and complicated concepts young people might not be familiar with.

- Tap into local traditions and techniques when preparing IEC material. Colours are very important and have certain symbolic values in South Asian cultures: for example, in many villages, coloured rice is used to make Mandala designs that could be utilised in IEC material.  

- Be sensitive to what is culturally appropriate and test out the IEC materials with most at risk or vulnerable young people. The risk behaviours for most at risk young people require explicit information so caution is needed in sharing the materials and ensuring that they are not misinterpreted or understood to be targeting mainstream young people. Information for young MSM will not be the same as you send to school based mainstream programmes. It is important in each programme and activity to be aware of the different needs of groups and the sensitivities around those issues.

- Use technology when appropriate. Use of technology is high among some young people in South Asia, including ownership of mobile phones in at risk or vulnerable populations. SMS and IM can be used as reminders and to target information to specific groups or individuals. SMS and IM are also a good way to maintain privacy and confidentiality, when used appropriately, because young people usually have some control over how and when they receive messages.

Use creative, innovative, and interesting strategies

To engage young people and help them enjoy and learn from programme activities, sound communication, teaching and learning practice should be used. This will sometimes involve taking the time to create with young people or at least checking ideas with them. Messages and commodities can be disseminated and young people reached through many channels.

- Local sports: football, cricket, hockey.
- Films: Bollywood movies are very popular in South Asia.
- Local beauty pageants: favoured by Transgender community.
- Local theatre, street drama or street concerts.
- TV serials: very popular among young women in South Asia.
- Radio programmes aimed at young people.
- Local food drives, clothes drives, soup kitchen, street fairs.
- National celebrities or local leaders/role models favoured by your target community.
- Think outside the box and consider non traditional ways to reach the hard to reach young people: messages on toilet walls, street art, social networking sites (Facebook) and text messaging.
7. Focus on creating an enabling and protective environment

Make young people feel safe to use your programme or service by creating a trusted and secure environment where confidentiality is upheld and young people are respected.

- Ensure young people are listened to and that their concerns are acted upon, enabling them to gain confidence and better access information and services.
- Don’t force young people to discuss their issues or participate in activities: these must be voluntary. Sometimes young people will only want a specific service and their right not to seek additional help should also be respected. For many reasons young people will chose NOT to participate and many will not want to be advocates.
- Because some behaviours may be illegal in some countries (for example male to male sex or sex work), many young people fear being arrested or handed over to the authorities if they go to service centres for help or information. It is crucial to dispel these fears and create welcoming and safe spaces. You can do this by:
  - creating appropriate and clear advocacy messages about what your programme offers
  - using peer networks as channels of communication
  - using media (radio, television, outdoor media such as billboards) discreetly to emphasise key messages about access and confidentiality
  - increasing community support by involving the local community: organise a local sports event, drama show, film night, or food and clothing drive.

Empower the target communities as partners in advocacy against stigma and discrimination

While some young people will not want to out themselves because of the stigma and their desire to remain private some young people may be ready to take an active role and work with and for the HIV prevention cause. Again, be sure you protect people’s confidentiality and don’t put them at risk through their advocacy efforts.

- Train and support representatives of your target communities of young people as public speakers, educators and counsellors.
- Provide opportunities to deliver personal testimonials in participatory educational settings, conferences, etc.
- Facilitate participation at local, national, regional and global events by young people; for funding, use existing budgets or identify potential sponsors.
- Be sensitive to needs and financial constraints when inviting young people to meetings. For instance, many young people may not have credit cards required by hotels for booking rooms. Staff must ensure alternatives, such as booking the hotel through the organisation.
- Enlist the support and participation of young people in collecting relevant evidence and information that can contribute to changing unfriendly policies or laws that lead to stigmatising or criminalising the behaviours of adolescent and young at risk and vulnerable communities.

Ensure your staff are also protected

For example, outreach workers have reported that without proper identification they have been arrested or detained by authorities who have raided areas where they work with most at risk communities. ID badges with the name, address and relevant contact information of your organisation will help protect them from being harassed unnecessarily. Seek to have positive and protective relationships with local police so that peer educator sex workers will not be arrested for carrying condoms or police will not hang around near clean needle collection points.
Use evidence to influence unfriendly and criminalising policies that deny rights

Young people (and those legally underage) may not reach out for help and information fearing arrest or penalisation. This can drive them underground, making them hard to reach.

Policy makers and legislators need to be convinced through hard data and evidence that young and underage adolescents are practicing unsafe behaviours. Only then will they move toward reforming relevant policies and laws.

Continue and strengthen advocacy at all levels

- Remember and be prepared to advocate at all levels (for example, community, parents and families, policy and legislature) and at all phases and stages of your programme.
- Engage in debate and discussions in the community on your programme, achievements, challenges with policy makers decision makers and the gate keepers of opinion: Church leaders, older women, traditional healers;
- Educate relevant media about the needs for most at risk young people for HIV and provide them with case studies that present the issues and the facts and get them on board.

Enlist the support of authorities and community members

- Look at your aims and consider who can help you and who can create resistance. For example, police and law enforcement officials could be a barrier to reaching young people. Contact these authorities and talk to them about your project and explore the possibilities of gaining their support.
- Involve families and relatives or community members wherever and whenever possible, keeping in mind that families often need help themselves to deal with young drug users.

Basic facts: Getting the evidence

- Undertake the necessary research to gather the data and evidence. A number of countries in South Asia have done so including Pakistan, India and Bhutan.
- Include young people as partners or as sources to access other young people to ensure the real target groups are reached.
- Work with government and larger partners to advocate national surveillance that accesses the group aged 15-24 and encourage the disaggregated reporting of this data.
- Use existing national PLHIV networks or NGOs as starting points to reach the target communities.
- Conduct mapping and relevant exercises to create the evidence. Pakistan has developed an excellent document to help with such mapping.
- Create spokesperson roles for young people, both those who are at risk or PLHIV, and those young people who are respected, popular and can advocate for the rights and needs of their young “friends”.
- Use the media (print, TV, radio) for wider dissemination of findings.

What kind of evidence can you gather?

- Who is doing what? (patterns of risk behaviours)
- Access, coverage, and use of services by them
- What are their needs and how are they being met?
- How are they being treated by authorities, families, communities? Are their basic rights being violated?
- What do young people themselves want in terms of policy and law reforms and modifications?
8. Develop partnerships and linkages with other services

Form partnerships with other organisations working with key populations

Relevant organisations can help to:

- identify relevant interventions for target communities
- expand the range of services the project can offer
- build the capacity of staff and volunteers
- empower target communities to bring them at the forefront
- locate potential donors and resources.

Create linkages with other services and programmes

Outreach is an essential strategy in providing ISS in the community of young people. It can also play a key role in referring and linking the target community to static centres and health facilities for services such as safe abortion, pregnancy testing, male health needs and practical matters such as appropriate sized condoms for adolescent male sex workers.\(^{31}\)

9. Monitor and evaluate programme progress and gaps\(^{32}\)

Why should monitoring and evaluation be done?

Evaluation is important to help you know if your project is going the way you had intended or if it needs adaptations. It should allow you to learn from experience and plan for future activities. It may also help you gain more support and funding from the community and other organisations. Evaluations can be carried out by:

- external consultants or through internal agency reports
- supervisory meetings
- conversations with youth involved
- surveys and assessments
- outreach workers feedback: outreach workers can keep logs to record their experience and feedback.

Monitoring helps you keep track of how your programme is doing through specific, measurable criteria like:

- number of syringes exchanged
- condoms distributed
- number of young people you are targeting who came in contact with the project
- number of people trained (outreach workers)
- brochures printed and distributed.

It is a good idea to monitor drug/injecting drug use and sex behaviours and attitudes

This may be difficult to do, but it will provide a lot of information for your programme. Also, it is important to monitor how your target communities of young people are perceived by the larger community to ascertain if the programme is managing to change any stigmatising or negative images.
**Important elements for comprehensive packages of prevention interventions**

**Key components**

A minimum intervention package for most at risk young people for HIV has been defined as:

- information on HIV/STI, sexual and reproductive health including safe abortion
- voluntary counselling and testing services for PMTCT, STI and HIV, and pregnancy
- condom promotion/distribution including lubricants
- needle/syringe exchange programmes with access to clean needles and syringes
- harm reduction services
- outreach services with referrals to a variety of health and protection service options
- life skills training
- psychosocial/mental health care/counselling services which should include family counselling, treatment and care.

These key components should be part of any comprehensive package of prevention and interventions, designed and adapted to fit the particular culture, differing needs and diverse contexts of the target communities of most at risk or vulnerable young people.

All these components are more effective when conducted through outreach programmes with referral to service providers trained and skilled in working with the target communities. Service providers must be receptive and non-judgemental. The content must be appropriate to age, gender and contexts. The components should be based on Key Principles.

**Adolescents and young people have needs for HIV prevention information, skills and services.** But due to their lack of experience in accessing and negotiating use of services – and in some cases legal barriers to using them including ethical issues in providing services to legal minors – the information and services may need to be delivered in a different manner appropriate to their age, maturity, gender and context.

It does not mean that a parallel programme of service delivery for young at risk people needs be developed. Rather, it is recommended that existing services be tailored and modified to meet the social, biological, medical and psychological needs of adolescents and young people, and be delivered in a youth friendly way. This process involves ensuring that some important elements are in place: components, principles and criteria.

**Key principles**

**A youth friendly approach**

Youth Friendly Services (YFS) are services that attempt to meet the specific needs of adolescents and young people as well as adult populations and all those who use them. The idea is about encouraging services to consider special or additional factors that will create a welcoming environment for young people, accommodate special needs, decrease embarrassment, increase confidentiality and provide information that young people may not be able to access. Because the rights of young people are not a priority, often their needs are ignored or factors that would increase accessibility to the young are not considered, like opening hours, fees, privacy and consent.

Youth Friendly Service principals should of course extend to at risk and especially vulnerable adolescents and young people. Efforts to make specialist VCT, HIV treatment and care and STI services youth friendly are also required.
Key principles

Criteria for YFS
Criteria for Youth Friendly Services have been developed in a number of countries in South Asia based on the work of WHO, UNFPA and other partners. Youth Friendly Services (and indeed all quality services) should consider a number of key elements:

- Providing a range of accessible, appropriate, and affordable services for adolescents and young people – including those most at risk for HIV
- Skills and technical expertise of health staff, including counselling for young people on sensitive issues of reproductive health, contraception, drug use, pregnancy and HIV
- Hygienic, safe and private facility with necessary technical commodities available
- Information and referral opportunities for young people
- Procedural issues that respect privacy, confidentiality and voluntary participation, and treat each young person with dignity, respect and without discrimination
- Allowing young people the choice to make free and informed choices in matters related to their health and sexuality, and providing opportunities for participation and involvement in decisions affecting them

A one-stop shop
A youth-friendly approach to health services means that a service centre attempts to be a one-stop shop where an adolescent or young person can go to one place and find a full range of appropriate health services.

Ideally the most comprehensive services will provide a place for young people to hang out and be involved in activities they like, interact with other young people, get basic necessities like clothes and food, and feel a sense of friendship and belonging.

A one-stop shop can provide a safe space for young people most at risk.

Practical and non-judgemental approaches
- Focus on promoting safe behaviours and providing the necessary tools (i.e. condoms, lubricants, clean needles and syringes) rather than focusing on what they do (i.e. sex work, male to male sex, injecting drugs) and making judgements about their behaviour
- Avoid moralising and promoting specific views. Consider alternative perspectives and provide best options based on engagement with every individual’s health and social welfare needs.
- For those under 18, focus on providing a protective environment and linkages with child protection programmes (if these are appropriate) while remembering to provide them with information, skills and services to remain safe.

Figure 8: Ethical considerations for working with young people

Anonymity
Confidentiality
Voluntary participation
Non judgmental attitude
Peer approach
A focus on behavioural change and prevention of HIV transmission

Since multiple behaviours together contribute to increase risk, behaviours can be targeted through many levels to achieve the best results. Key behavioural change strategies for consideration include:

- increasing knowledge about how to protect oneself from HIV infection
- promoting access to and use of condoms and, especially for MSMs and transgender people, water based lubricants
- providing suggestions for alternative and non-penetrative sexual acts
- encouraging access and use of services, for example methadone maintenance, HIV counselling and testing for HIV, diagnosis and treatment of STI, use of antenatal and reproductive health services
- promoting positive attitudes to condom use which will encourage safer sexual practices
- delaying onset of intercourse if possible
- assisting young people to get appropriate skills for other form of employment or education if they wish to change their work
- improving enrolment in treatment programmes for STIs or HIV
- promoting harm reduction strategies including providing clean needles and syringes to reduce sharing
- focus on the importance of adherence to ARV drugs.

The right combination of strategies depends on who you are trying to reach and the needs of your target community. Following a comprehensive framework – in terms of combination HIV prevention and the use of multilevel behavioural strategies – requires that each strategy be assessed only in terms of what it is trying to achieve. Failure to show that a specific strategy reduces HIV infection does not make it useless in a comprehensive programme. Comprehensive packages should be adjusted to fit the specific needs of young people.
Working with young people at risk

Injecting drug users

When you work with Injecting Drug Users, ensure that the services you deliver are part of a comprehensive package using the following key elements:

- **Harm reduction** through the provision of information on the risks associated with sharing injecting equipment, needle and syringe exchange (NSE), opiate substitution therapy (OST), other drug dependence treatment and basic health services
- **Targeted information**, education and communication (IEC) for IDUs and their sexual partners
- **Condom and lubricant programmes** for IDUs and their sexual partners
- Prevention and treatment of sexually transmitted infections (**STIs**)
- **HIV** testing and counselling (T&C)
- Antiretroviral therapy (**ART**)
- Vaccination, diagnosis and treatment of viral **hepatitis**
- Prevention, diagnosis and treatment of **tuberculosis** (TB)
- **Pregnancy testing** and counselling, and safe abortion services where appropriate (link to reproductive health services).
- Creation of **enabling and supportive environments** through:
  - Provision of training to health care providers, outreach workers and law enforcement personnel
  - Advocate for the removal of stigmatising and coercive tactics.
  - Creating safe places and spaces to access information and services in physical environments (such as drop-in centres and clinics) or virtual environments (such as telephone hotlines, websites and internet chat rooms).

For people who may exchange drugs or money to buy drugs for sex, promoting non penetrative sex is a recommended strategy as per the revised UNAIDS Guidance on Sex Work based on the revised recommendations of the Programme Coordinating Board (PCB).
Sex workers

- Reach out to young sex workers using their own friendships and networks. Use outreach to ensure 100% condom delivery.
- Work with entertainment establishment owners to encourage the promotion and provision of condoms in establishments where sex work may occur. Seek to partner on outreach programmes with establishment owners.
- Keep in mind that poverty is a key reason why young people sell sex; some young people may regard sex work as a viable source of income and migration to areas known for sex work as necessary for increasing their chances of work.
- Assist and empower young people by providing livelihood training, education and other skills in consultation.
- Provide access to counselling, testing, reproductive health and social support, and basic health care services through creative, innovative means such as the media (TV, radio, print, outdoor media), technology (text messages), and community educational initiatives in areas known for sex work.
- Create linkages to other services such as maternal and neonatal health and PMTCT services for female sex workers; involve their male partners.
- Work with sex workers and relevant authorities to reduce harm including violence, rape, HIV and STIs.
- For those under 18, make sure they have access to information, services and condoms/lubricants to promote safe behaviours or if they wish, assist them in quitting sex work by providing necessary skills, reintegration with families if and where possible, and psychosocial counselling as part of child protection.
- Support the young sex worker to reach clients with appropriate information and referrals to services if required, and focus on promoting responsible client behaviour and the practice of safe sex.
- Encourage self-help groups to reach out to young sex workers. This is appropriate if young sex workers feel uncomfortable to speak out when they are with older more experienced workers. This will work better in some settings than in others.
- Make IEC materials appropriate to the needs and contexts. One example is the ‘Smart Girl’ materials from Cambodia: which promote young women who protect themselves from disease as smart and looking after their health.
- Focus resources for programming on the locations where most young sex workers, their clients and their sexual partners can be reached.
Young male and young transgender sex workers

- Build the knowledge base and capacity of male sex workers and their clients on correct and consistent condom use and non-penetrative safer sex to prevent STIs, HIV and unwanted pregnancies (the latter is often a concern for male sex workers with their female clients and partners).
- Provide primary health care and rights-based sexual and reproductive health and HIV services, through outreach work and mobile clinics. Special services that should be considered for male sex workers include access to condoms and lubrication, diagnosis and treatment of rectal and oral STIs, and counselling and medical support for transgenders who take hormones or seek sex reassignment surgery.
- Address stigma and discrimination, including thorough advocacy on the rights of sex workers, legal reform, working with the perpetrators of discrimination and violence, psycho-social support and legal options.
- Ensure sex workers’ participation in developing, implementing and monitoring sexual and reproductive health and HIV programmes.
- Lack of financial resources may be a barrier to reaching male sex workers, but stigma is often the greater obstacle. Sensitizing project staff (from the project coordinator to the receptionists at the clinics) on the rights and needs of male and transgender sex workers usually needs to be the first step to implementing effective and rights-based programmes. Staff should also have the skills and facilities to take accurate medical histories, conduct rectal examinations and throat swabs, and give specialized advice and counselling.

MSM and young transgender people

- Address health issues related to anal sex, including diagnosis and treatment of rectal STIs, and promoting use of lubricants with condoms. There is increasing anecdotal evidence that MSM use female condoms during anal sex, and these should be made available to them, where possible. Other rectal health issues – such as anal fissures, warts and rectal bleeding – also need to be addressed. Moreover, counselling, information and education materials need to appeal to, and meet the needs of, MSM.
- Address homophobia, stigma and discrimination, and criminalization of same-sex behaviour which forces men underground and hinders their access to sexual and reproductive health and HIV information, services and support. This marginalized position in society – not just their engagement in higher-risk behaviour – puts MSM at increased risk of HIV and STIs. Along with service provision, programmes should also address stigma and discrimination, in health care settings and elsewhere; provide psycho-social support; and challenge the legal barriers that increase the vulnerability of MSM.

Specific actions for transgender people

- Provide access to appropriate information, counselling and support on transgender issues.
- Provide access to drugs, gender reassignment procedures and support, where necessary.
- Support their ability to change their names and gender identity on official documents and the legal right to live as another gender, free from stigma and discrimination.
- Strengthen their understanding of the effects of HIV antiretroviral medicines and HIV related infection treatments for transgender people taking gender reassignment drugs.
- Create linkages to psychosocial counselling, legal options and child protection programmes to address violence, rape, abuse and exploitation related challenges they may face.
The most important components of your programmes

**Outreach:** This method is one of the most important in working with young people. It aims to reach those who are not reached by conventional services by locating, travelling to make contact with at risk and vulnerable groups.

**Information and communications:** Young people need to know the facts about HIV and AIDS, and about risk behaviour. Information should be easy for the target group to understand, attractively presented and brief.

**Needle and Syringe Exchange Programmes (NSEP):** Concrete services like NSEP are important for young people who inject drugs. The idea is to distribute clean injecting equipment to reduce sharing. Location and operation hours are important to consider. This, like other services (e.g. condom distribution), is also used as an entry point to offer counselling and treatment options.

**Condom distribution:** Access to and use of condoms and lubricants is important for sexually active youth. It can promote safe sexual activity by overcoming barriers such as availability and financial issues, as well as providing information about proper and regular condom use.

**Youth friendly services:** When trust has been established with the group through outreach, young people may feel comfortable coming to a drop-in centre where you are stationed. Such a place must be a safe and comfortable place, located in an accessible area. Services could include counselling, life skills and vocational training, hygiene, referrals, NSEP, information, recreation and more.

**HIV testing and counselling:** Voluntary HIV testing is an important aspect of prevention and should be encouraged. Counselling before and after the test is vital to help a young person understand the meaning of the result and its consequences.

**Drug treatment services:** When a trusting relationship exists, young people who inject drugs can be referred to drug treatment services that will assist them to deal with their drug use, with the hopeful outcome of reducing or stopping drug use.

**Life skills and vocational training:** As part of a comprehensive programme, it can be beneficial for youth to learn skills to implement the safer behaviour they learn about as well as improve their functioning in other areas. Vocational training helps them to gain the necessary skills for meaningful employment and livelihood opportunities.

**Confidentiality and respect:** Anonymity, confidentiality and sensitivity are important. Using active listening skills, clear and accessible language, and being accessibly located are also important for young people.
Challenges in working with most at risk adolescents and young people
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<tr>
<th>Challenges</th>
<th>Examples</th>
<th>Approaches and solutions</th>
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<tbody>
<tr>
<td>Moral issues</td>
<td>Giving young people easy access to condoms</td>
<td>Distribute free condoms at community levels through peer outreach and local initiatives. Use ‘social marketing’ and public-private partnerships to adapt commercial marketing methods to social goals to make needed products available and affordable. Make local pharmacists more youth-friendly by using branded services and putting up signs outside pharmacies to indicate that the shop caters to young people.</td>
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<td></td>
<td>Giving condoms to unmarried young people or adolescents considered to be too young to have sex (legal age for sex will differ across countries)</td>
<td>Seek opportunities for young people to access condoms through a variety of sources so that those who are sexually active can access what they need to protect themselves. Remove restrictions on young people’s access to condoms: don’t request proof of ID, don’t ask about their age, have condoms freely available in condom café’s health services or have youth friendly vendors who ask no questions of young people. Be practical: if underage young people are having sex despite the biological risks and cultural/social restrictions, it is more practical to keep them safe from any STIs or HIV instead of trying to moralise about sex or force abstinence.</td>
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<td>Talking to young people about sex and drugs</td>
<td>Promote safer practices among target communities who are already engaging in these behaviours through strategies like peer outreach. Create advocacy messages and develop community awareness campaigns at locations known for high risk behaviours using creative, attractive, and culturally appropriate and acceptable methods. Be realistic: create and communicate messages at the community level stressing that if parents/families/teachers/older sexual partners are not talking to young people about (safe) sex or the risks of drugs, somebody else might be who may not be giving the right information. Show evidence of the benefits of talking to young people about sex, drugs and other behaviours they are curious about. Show that talking about these issues does not increase experimentation. Disseminate such evidence through channels like local newspaper articles, community awareness campaigns, and outreach work with families/communities with whom young people live or interact regularly.</td>
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The **most obvious challenge** in South Asia is ‘selling’ the idea to national governments, policy makers and communities about HIV prevention programming for most at risk communities and in particular young people.

Since the HIV epidemic is low in the region, it is not a major priority for a number of governments, even if it is stated as a top priority in most National HIV Strategic Plans. Moreover, there is a culture of denial that underage young people could or do engage in risk behaviours. Hence one of the key challenges relates to advocating sufficiently, rigorously and continually to bring HIV prevention programming for young people to the attention of government decision makers and programmers.

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<td>Moral issues</td>
<td>Providing services to underage young people</td>
<td>If local authorities are approachable, contact them and talk to them about your programme: why it is needed, what its benefits are, etc. Get a sense of the cooperation level of authorities. Don’t assume that local agencies will not co-operate; however look for the most approachable people to help open doors. Use local authorities’ expertise and local knowledge to collect evidence of risk behaviours among young people and those underage. Remember that local authorities like the police may know more about locations, challenges and risk practices in the area, so tap into their skills and seek assistance. Think HUMAN RIGHTS, Think CRC. If underage young people are engaging in risk behaviours, linking them to services is a far more rights-based approach than leaving them unsafe, uninformed, and unskilled. According to the CRC, which all countries in South Asia, are signatories to, young people are entitled to access to health services. Develop procedures that avoid asking someone’s age as a criteria for service. Focus on winning the trust of the young person and let him/her open up and disclose personal information. Prioritise issues like confidentiality and anonymity. Sensitise staff and community on the need to link young people regardless of age, gender, caste and other factors to services and safe spaces. Create methods to attract young people so they venture out of curiosity. Remember that if curiosity can encourage young people to experiment with risky behaviours the same curiosity may lead them into your programme.</td>
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| Stigma and Discrimination that limits access to services or programmes | Sensitising and changing negative attitudes and discriminatory actions | Communicate examples of negative and discriminatory attitudes regarding gender, sexuality, sexual orientation, rights for young people to access services, etc.  
Work with decision makers and gate keepers (community and religious leaders) Ministry of Women's Affairs, parent advocate groups, etc. to sensitise them about gender inequalities, sexuality and sexual identities, risk behaviours, and why they need information and services.  
Within a safe context, encourage representatives from target communities to come out and speak about their issues, problems, and what kind of help and treatment they expect and desire from their communities and families.  
Strengthen community development work with families and community leaders to enable young people to live in/ or return to their home or communities without discrimination and harassment.  
Address gender inequality by involving young boys and men in dialogues about gender, relationships and sexual health to empower them as advocates for young women’s rights. |
| Harmony among organisations and UN agencies working with most at risk young people (10-24 yrs old) | Getting everyone to speak the same language when working with young people and conceptualizing programmes for young people | Find out who is doing what and for whom. Examine areas where you can work together, share expertise and pool resources.  
Propose and collectively create a feedback mechanism so that everyone speaks the same language, uses commonly agreed terminologies and knows what is going on.  
Engage the target communities in the process and where appropriate have target audiences employed as advisers or peers advocates on most at risk young people’s activity. |
| Resources | Getting the funds | Examine what educational and other technical materials (such as research studies, manuals, guidelines, etc.) already exist.  
Explore potential donors for funding – approach them early so that you have time to present your ideas and explain your needs, current resources and limitations.  
See if you can link with other organisations that already have donors they work with.  
Don’t ask for too much money – be realistic and aim for a balance between your needs and what donors can give. |
| | Making your programme less donor driven and having a greater say in how your programme is carried out | Empower the target communities to be able to speak out about their concerns to the donors.  
Create a feedback mechanism to allow the issues and problems of target communities to make it to the donors. |
Good programme practices
for most at risk adolescents
and young people
India: Bringing in young people from the margins

Project: Expanding Access to Information and Services for Key Populations
Implementing organization: Family Planning Association of India (FPAI)
Location: Kohima Town, Nagaland

What are the issues?

India’s HIV epidemic shows high variations across states and regions – with adult HIV prevalence rates in a six states survey in 2007 varying from 0.07 per cent in Uttar Pradesh to 1.13 per cent in Manipur. One thing, however, is consistent across this huge country: vulnerable populations – such as sex workers, injecting drug users and men who have sex with men – are disproportionately affected. In Nagaland, for example, 5 per cent of men who have sex with men tested positive.

How did the project tackle these?

Building on this knowledge – and its previous work with sex workers, injecting drug users and men who have sex with men – FPAI developed a project that aims to reduce high risk behaviour among key populations in four locations. It tries to achieve this by:

- increasing access to sexual and reproductive health information and services through outreach work by peer educators, drop-in centres and static clinics
- addressing stigma and discrimination through facilitating interaction among members of the key populations and the community, and sensitization training for the police, health care providers and community leaders
- providing vocational training that aims to empower key populations

One of the project locations is Kohima, where the Association is predominantly targeting injecting drug users. As this is such a difficult group to reach, staff and peer educators were recruited from among the target population. This has been very successful – almost 60 per cent of the project’s clients accessed sexual and reproductive health services for the first time.

‘Though I initially came for the health services, I also started to attend counselling sessions. These gave me confidence to change my life and FPAI staff referred me to Kripa Foundation. Now I am staying clean.’

During their outreach work, peer educators distribute ‘access cards’ and refer clients to the drop-in centre, where they can access free services, such as voluntary counselling and testing, condoms and lubricants, hepatitis B testing and vaccinations, diagnosis and treatment for STIs, family planning and general health consultations. Staff at the centre were trained to provide non-stigmatising services and treat clients with respect and warmth.

Staff and peer educators were recruited from the injecting drug user population, and were able to reach people who had never accessed sexual and reproductive health and HIV services in their lives.

‘Staff at the centre always warmly accept me as I am and teach me about HIV and AIDS, hepatitis, sexual and reproductive health issues and STIs.’

A partnership with the Kripa Foundation (India’s largest non-governmental organization working on drug dependency and HIV) allows the project to offer a much more comprehensive range of services to its clients and refer them for rehabilitation if requested.
Maldives: Opening the eyes of communities

**Project:** WAKE UP Campaign  
**Implementing partners:** National Narcotics Control Bureau, UNICEF, Journey (NGO), Dhiraagu (Media)  
**Location:** Male and other atolls

Wake Up is a national campaign in the Maldives aimed at preventing drug abuse and promoting recovery from drug addiction.

Drug use and abuse is increasing in the Maldives and adolescents and young people are increasingly exposed to the risk of drug experimentation. The most popular drug in the Maldives – heroin or brown sugar – is one of the most highly addictive and destructive drugs in the world. Every family member of a drug user is affected by drugs, either directly or indirectly. It’s in the interest of each and every Maldivian to take action to protect young people and prevent HIV transmission, through this education campaign. The Maldivian community is a small community and when one person suffers, everyone ends up suffering.

Wake Up is spearheaded by the National Narcotics Control Bureau (NNCB), the NGO Journey, and UNICEF and sponsored by Dhiraagu. The concepts behind the Wake Up campaign were conceived by a group of 20 Maldivian youth aged between 15–22 years old.

Wake Up emphasizes the importance of community support and acceptance for young people with drug addiction/problems to help break the cycle and promote recovery. The public – particularly parents and teachers – are encouraged to speak openly about drugs and the consequences of drug abuse.

Wake Up messages are sent through billboards, posters (see this page), brochures, TV and radio with the help of partners such as Dhiraagu and TV Maldives around Male and the atolls. In addition, a special campaign website [www.wakeup.mv](http://www.wakeup.mv) was created to help children, youth and parents learn more about the drug issue and where to go for help.

[www.unodc.org/pdf/india/posters_01.pdf](http://www.unodc.org/pdf/india/posters_01.pdf) © UNDOC
Pakistan: Mapping behaviours

**Project:** Mapping and Behavioural Study of Adolescents in 7 Districts of Pakistan

**Implementing organization:** The National AIDS Control Programme, Ministry of Health, Pakistan

**Location:** Karachi, Larkana, Quetta, Faisalabad, Lahore, Mardan and Peshawar

**What**

This study was conducted in seven districts in Pakistan to map adolescents aged 10-19 years who live on the streets, work in automobile workshops or work in carpet weaving factories. It was assumed while selecting these three contexts that due to certain vulnerability factors such as lack of parental guidance and disposable income, these adolescents would either be especially vulnerable or most at risk for HIV infection. For the study’s purpose, street adolescents were further considered in the following contexts: hawkers, cleaners, beggars, garbage pickers, sex workers (who sell sex as a full time activity) and ‘others’.

**How**

To determine the mapping locations, geographical mapping was used to consisting of 150000 -20000 overall population in each zone. Zones were then mapped for the three contexts in which adolescents lived.

The mapping survey those most at risk based on their behaviours. To get a better sense of the specific risk behaviours for HIV, an additional behavioural survey was done with a representative sample of adolescents in each district. The survey determined risk practices to differentiate the especially vulnerable from those most at risk. Adolescents who inject drugs and/or sell sex were classified as most at risk. Those who lived on the streets 24/7 were also determined as most at risk in Pakistan context.

**Key findings and recommendations**

- The number of adolescents who beg on the streets is higher in each city than any other activity. This finding shows that child protection programmes need to extend beyond community dialogue and advocacy to develop services with social welfare and social protection components that include cash transfers and economic development.

- Though not as many adolescents sleep 24/7 on the streets (9.5 per cent of those mapped), over 17 per cent were either selling sex or exchanging sex for gifts. Girls made up 43 per cent of those who exchanged sex for gifts. In many of these situations, the adolescents had no power over the act or in negotiating safe sex practices like using condoms.

- It was recommended that multiple approaches must be taken in which Commercial Sexual Exploitation of Children (CSEC) programmes provide sexual and reproductive health and HIV information and strongly promote condom use so that adolescents are safe and protected from consequences like HIV/STI or unwanted pregnancy.
Behavioural study findings that highlight that adolescents and young people ARE part of the most at risk population

- Over half the adolescents (51 per cent) had already had sex. Of those, 54 per cent had had sex within the last week (the figure was 75 per cent in Peshawar).
- 37 per cent had paid for it, implying that they do choose to have sex voluntarily and therefore could use a condom if they have information and access.
- 43 per cent had it for some kind of gain. More in-depth study is needed to understand what they trade sex for and to ensure that current and future programmes address their needs (e.g., shelter, food, psychosocial needs, etc).
- 33 per cent had forced sex, the highest in Karachi at 50 per cent. More in-depth study is needed to understand who has forced the sex and in what circumstances to design appropriate information and advocacy programmes. Child Protection units at hospitals for rape response should be promoted through NGOs working with young people and through street-based promotion. These units must link with HIV services where indicated such as Voluntary Counselling and Testing (VCT) services.

- Condom use is rarely practiced by sexually active adolescents (<15 per cent of them used it). The rate of condom use was higher among carpet weaving adolescents probably due to better accessibility and generally higher rate of education among them. It may also be due to good life-skills programming in these factories by NGOs such as Amal in Quetta. Among street-based females only 1 per cent reported condom use.
- Sex with gang leaders and/or bosses was 4 per cent.
- Addiction to inhalants is significantly high at 22 per cent overall. Solvent abuse is often the first addiction among adolescents who inject drugs. The percentage of adolescents who inject drugs though not significant at 4 per cent is noteworthy because 77 per cent of those adolescents have shared needles. Programming for most at risk and especially vulnerable adolescents should include specific risks of sharing needles and syringes in relation to Hepatitis B and C, and HIV, as well as information on where to obtain free/affordable clean needles and syringes or treatment for their behaviours if they want it voluntarily.

![Young boys living on the streets](https://example.com/young_boys.png)
An example of a best practice behaviour change approach

Family Health International’s SMARTgirl Cambodia is a good example of a behaviour change approach programme

The SMARTgirl programme:

- **Celebrates** women and the contribution entertainment workers have made in HIV prevention efforts: no ‘labeling’ of women as sex workers, as bad women, etc.
- **Repositions HIV** in a broader sexual health context; identifies benefits for positive behaviour change/development (for example, beauty, children, etc rather than exclusively disease prevention)
- **Uses a positive, fun, modern and trustworthy tone** that links all messaging, programming and people for greater impact
- **Establishes new partnerships** (e.g. The private sector) and mobilizes peer leadership.

Read more at SMARTgirl: http://www.fhi.org/en/CountryProfiles/Cambodia/res_SMARTgirl.htm

HIDDEN VOICES: seeking the perspectives of young drug users

The consultation with young drug users at Response Beyond Borders Conference, Bangkok, January 2010, funded by UNICEF was led by Dr Helen Cahill, Youth Research Centre, The University of Melbourne, Australia. At the consultation, young drug users presented Hidden Voices to raise issues and give voice to what they think. Among their presentations, they shared the following, which are good points to take on board during programme planning.

What we need from adults

- More care from teachers for “bad” as well as “good” kids
- Support from family: care, love, safety, food, and shelter
- Programs reaching into rural areas
- De-stigmatisation of drug use so people who use drugs can get jobs
- Government programs to help poor kids to stay in school
- Not to have to work nights while still in school
- Job opportunities and job programs for former drug users – regardless of drug use history

We need adults to make sure

- Government has programs to support young people with disabilities
- We are NOT abused by the police when questioned – and are free from sexual and physical abuse from the police
- We are not put in jail
- There are proper treatment facilities
- We get educated about HIV transmission – we find out after we have got it
- There is access to HIV medications
- There is access to good treatment that is not like prison
Working in partnership with young people
Ekta Mahat, 20, Nepal

I work for the NGO LALS - Life Giving and Life Saving Society. I mostly do work in harm reduction. I work on the streets with people living with HIV/AIDS, female sex workers, and injection drug users. We call these people the hidden community (Juncton). I go to temples and public toilets distributing, pamphlets on HIV/AIDS and STDs, condoms, information about safe sex, and information about injection drug use and how to sterilize needles. I try to inspire people to stop using. I started working to combat HIV/AIDS through workshops and education because I had seen so many of my friends die because of HIV/AIDS and whose children have been left behind to suffer. I used to be an injecting drug user. I started injecting when I was 14 years old. I was 17 or 18 when I met my husband and I didn’t know how important it was to use condoms. I had heard about HIV/AIDS but I didn’t really know anything about them. Now I have a three-month old baby and a husband who still injects. I am very concerned because, if I relapse and start injecting again there will be nobody to take care of my baby. I have already hurt him so much by injecting when I was pregnant. “He is my light, he got me to stop wanting to use drugs. I have to concentrate the most on trying to be the best mother.” I want to work for young people. I want to work for the children who have been infected or affected by HIV/AIDS. These are the people that we really have to worry about. When their parents die they are going to be orphans, no food, no education, and then what will happen to them? If we are going to stop HIV/AIDS we need “fair” awareness, I mean true data. No government reports true data so people don’t realise how big this problem really is. “If they don’t know, they will never listen to us.” The hardest thing for me is that in my country and in the other South Asia countries nobody wants to talk about it. It’s not just older people, but young people too. The cultural barriers are so strong that everybody is scared, embarrassed, or they think that talking about HIV/AIDS and spreading information is just talking about sex. I don’t see a safe future when it comes to the AIDS problem in Pakistan, because nobody can spread information. For instance, if I talk about HIV/AIDS and prevention people will shun me; even my own friends won’t accept me. The attitudes of people make me want to scream - the boys are not taught to act responsibly and girls have not been taught how to stand up to boys, and nobody talks about it because of religion or culture - everything is very orthodox in my culture. People have a right to be educated. I am the most worried about the people who are affected by HIV/AIDS.
These are the people who are left alone in the world after the one infected has died. They don’t have the disease but are still treated so badly by their community. It must be very traumatic and depressing for them. They did nothing; only lack of education makes people treat them like this. If I could have one wish it would not be to find a cure. That would be nice but then there will be something else. It would be for everyone to be able to get a quality education. Education targets every problem: poverty, unemployment, etc. It is the one solution for all the problems.

**Al-Amin Prodhan, 15, Bangladesh**

For the last year and a half I’ve been a peer educator with APON, the adolescent peer network of the NGO BRAC. Once a week I run a class for thirty boys from my school. We talk about things like drug abuse, gender discrimination, early marriage, HIV/AIDS, and sex abuse. I became interested in doing this work because of the risks young people face. I feel it’s my duty and responsibility to save young people, and BRAC gives me scope to do this. I’ve been able to do things like stop my friends from smoking marijuana and using drugs, and I’m very happy about this. Young people can’t talk about their own problems with adults, like problems of puberty. But they’re very interested to talk about these things with their friends, and among themselves young people can talk about anything. For me tolerance is the most important thing.

**Ahsan and Vikas, 13, India**

There are many children living on the streets in our country and in many other countries around the world. Only children associated with NGOs know a little bit about HIV. The problem is that too many do not. We want to make them aware. Through our NGO Butterflies we have a radio station – Butterflies Broadcasting Children – it is a children’s radio station and we use it to make other children aware. We also have a theatre team and a newspaper and we go to different places in Delhi to talk to street children and other children about HIV and AIDS. We use all of these things to spread all of the information we have learned about HIV/AIDS, safe sex, drug use, and prevention. The hardest part is that when we try to share our knowledge with other children they do not always listen. They say that we are children too and that we also live on the streets so how do we know anything? We tell them that we have been given information and that we know about it. We know it is up to them if they take our information about HIV and AIDS with them, we know that sooner or later they will have to listen because they will see it on the street. We try our best and we will keep trying because other kids need to know! The best solution for stopping HIV from spreading is through sharing information by using the radio, TV, newspapers, and street theatre. We cannot go everywhere but these things can reach every person in every place. But they have to be organised and run by children so that children can raise their voices without being dependent on older people. If we are independent we can do anything.
Resources

- Comprehensive HIV prevention for most at risk adolescents in the context of injecting drug use: A study visit to Indonesia, UNICEF 2007
- Responding to the HIV prevention needs of adolescents and young people in Asia: Towards (cost-) effective policies and programmes. Paper prepared for discussion within the AIDS Commission in Asia, UNICEF, UNFPA, UNESCO 2007
- Asia AIDS Commission 2009 report
- UNAIDS 2007 and 2008 AIDS epidemic update
- UNAIDS Coordination on Young People and HIV/AIDS, May 2007, UNFPA, New York
- Sills building workshop among Injecting Drug Users in Goa, India, January 2008 report, UNICEF Regional Office for South Asia (ROSA)
- Practical guidelines for intensifying HIV prevention: Towards universal access, UNAIDS 2007
- Programming Note on HIV prevention with and for adolescents, UNICEF CEE/CIS, October 2006
- HIV Programme Information Note: Injecting Drug Users, UNICEF
- Guidance on Programming to prevent HIV in most at-risk adolescents, May 2006
- The Lancet’s HIV prevention series, August 2008
- Country Fact Sheets for South Asia – UNICEF and South Asia Country Fact Sheets for Adolescents - WHO
- FHI 2007 Manual on HIV Counselling and Testing for youth
- UN Convention on the Rights of the Child
- Bhutan study on HIV issues among out of school youth
- BSS surveys by Maldives, India, Pakistan and Sri Lanka
- Afghanistan desk review of male-male sexuality
- The truth about men, boys and sex, IPPF 2009
- HIV prevention among young injecting drug users, UNODC 2004
- Guidance on Ethics and equitable access to HIV treatment and care, WHO 2004
HIV prevention for young people

FHI  http://www.fhi.org/en/Youth/YouthNet/Publications/index.htm#peered
Change  http://www.changeproject.org/technical/hivaid/stigma.htm
HIV for youth  http://www.hivcareforyouth.org/
UNICEF  http://www.unicef.org/aids/index_orphans.html
http://www.unicef.org/aids/index_documents.html
http://www.hivimplementers.com/agenda/pdf/C3/C3
http://www.hivimplementers.com/agenda/pdf/C3/C3
per cent20Akhmedov per cent20abstract per cent20970.pdf
Endnotes

1 Report of 2006 high level UNGASS meeting

2 These include meetings of the UNGASS 10 year review of drugs, Commission on Narcotic Drugs (CND) Political Declaration, UNAIDS Programme Coordinating Board (PCB), Asia AIDS Commission, Economic and Social Council (ECOSOC) resolution, and the UNAIDS Outcome Results Framework

3 UNAIDS Guidance Note on HIV and Sex work, 2009; UNAIDS Action Framework – Universal Access for men who have sex with men and transgender people; WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users

4 Draft strategy for prevention of HIV/AIDS infection among most at risk adolescents in Afghanistan, 2009


6 The epidemic in South Asia is considered ‘low’ i.e. HIV prevalence is below 1 per cent among pregnant women in the general population but ‘concentrated’ i.e. HIV prevalence is consistently above 5 per cent in specific sub-populations

7 Comprehensive HIV prevention for most at risk adolescents in the context of injecting drug use (UNICEF study visit to Indonesia, 2007)

8 2008 situation assessment of most at risk adolescents and young people in Nepal

9 2008 Maldives BBS Survey; 2008 situation assessment of most at risk adolescents and young people in Nepal; 2008 desk review of male-male sexualities in Afghanistan; 2007 Mapping and behavioural study of most at risk and especially vulnerable adolescents in 7 districts of Pakistan

10 2007 paper prepared for the Commission on AIDS in Asia: Responding to the HIV Prevention needs of adolescents and young people in Asia – towards (cost) effective policies and programmes UNICEF/UNESCO/UNFPA, 2007, page 5

11 2005 MAP report on male-male sex and HIV/AIDS in Asia


13 UNAIDS Guidance Note on Sex Work, 2009 (Young people, in this document refers only to 18-24 years of age)

14 2008 Maldives BBS Survey; 2008 situation assessment of most at risk adolescents and young people in Nepal; 2008 desk review of male-male sexualities in Afghanistan; 2007 Mapping and behavioural study of most at risk and especially vulnerable adolescents in 7 districts of Pakistan

15 Rapid Assessment of male vulnerabilities to HIV and sexual exploitation in Afghanistan. NACP, Naz Foundation International and UNICEF, 2009


17 UNODC (2004). HIV prevention among young injecting drug users

18 UNAIDS practical guidelines for intensifying HIV prevention, 2007

19 UNICEF CEE/CIS: Guidance on Programming to prevent HIV in most at risk adolescents (Second draft, May 2006)

20 HIV prevention strategy for young people in Pakistan, Ministry of Health and National AIDS Control Programme of Pakistan, June 2006

21 Adapted from WHO and DFID, 2004 with some modifications to reflect South Asia context

22 Derived from 2008 UNICEF South Asia Country Fact Sheets and PMTCT Fact Sheets

23 Steps recommended by MARP networks, stakeholders and UN partners working in Asia at the ‘Consultation on the ROSA Programme Guidance Note on Most at Risk and Especially Vulnerable Adolescents and Young People in South Asia’, Bangkok, November 2009

24 Peer Education – A Programme Guidance Note, UNICEF Regional Office South Asia (ROSA)
Endnotes

25 Based on suggestions from transgender community representative from Asia Pacific Network of Sex Workers at the ‘Consultation on the ROSA Programme Guidance. Note on Most at Risk and Especially Vulnerable Adolescents and Young People in South Asia’, Bangkok, November 2009

26 HIV prevention among young injecting drug users, UNODC, 2004

27 Ethical approaches to gathering information from children and adolescents in international settings – Guidelines and resources (Horizons, Population council, IMPACT and FHI, 2005)

28 Mandala drawings or Rangoli as they are called in India, were part of a range of workshops offered by and for young people at the ‘Peer Convention on HIV Prevention’ held in Bangalore, India, May 2008 in partnership between UNICEF and NACO of India

29 Using TV serials to promote women’s rights is an example to emulate for HIV issues (http://www.digitalopportunity.org/news/tv-series-educates-on-womens-rights)

30 A radio programme in Nepal ‘Chatting with my best friend’ which includes HIV/AIDS related topics (http://www.searo.who.int/LinkFiles/Initiatives_ii-3cwmbf.pdf)

31 Mapping and behavioural study of adolescents in 7 districts of Pakistan, 2007 by The National AIDS Control Programme, Ministry of Health, Pakistan


33 These points derived from suggestions by MARP networks, stakeholders and UN partners working in Asia at the ‘Consultation on the ROSA Programme Guidance Note on Most at Risk and Especially Vulnerable Adolescents and Young People in South Asia’, Bangkok, November 2009

34 2007 FHI manual on HIV counselling and testing for youth

35 UNODC, HIV prevention among young injecting drug users, 2007

36 2008 Lancet HIV prevention series #3: Behavioural strategies to reduce HIV transmission: how to make them work better


38 Based on suggestions from members of 7sisters Alliance and Asia Pacific Network of Sex Workers at the ‘Consultation on the ROSA Programme Guidance Note on Most at Risk and Especially Vulnerable Adolescents and Young People in South Asia’, Bangkok, November 2009

39 Based on ‘The truth about men, boys and sex’, IPPF, 2009

40 Based on ‘The truth about men, boys and sex’, IPPF, 2009

41 UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People, 2009

42 Adapted from UNODC (2004). HIV prevention among young injecting drug users, page 61


44 The truth about men, boys, and sex. page 28 (IPPF, 2009); this case study was adopted from the IPPF publication

45 Mapping and Behavioural study of adolescents in 7 districts of Pakistan, National AIDS Control Programme, Ministry of Health, Pakistan, 2007
Programme Guidance Notes

HIV prevention among most at risk and especially vulnerable adolescents and young people in South Asia

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