HIV prevention, treatment, care and support for adolescents and youth

Resource kit for high-impact programming

This Guidance Note is part of the resource kit for high-impact programming that provides simple, concise and practical guidance on key areas of the AIDS response. The resource kit is jointly developed by Joint United Nations Programme on HIV/AIDS (UNAIDS). The resource kit can be accessed at http://www.unaids.org/en/ourwork/programmebranch/countryimpactsustainabilitydepartment/globalfinancingpartnercoordinationdivision/.

For more information, please contact highimpact@unaids.org.

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This Guidance Note was prepared by the Inter-Agency Task Team on HIV and Young People (IATT/YP), convened by the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF), and provides an overview of effective HIV responses designed for adolescents and youth for the purposes of strengthening national responses. For further resources, please visit the IATT/YP website at http://youngpeopleandhiv.org/, the website for the Community of Practice on Young People and HIV (https://knowledge-gateway.org/youngpeople_hiv) or write to info-iattyp@unfpa.org.

WHAT IS NEW?

- This Guidance Note aligns guidance with the HIV investment approach to ensure better coherence of support to HIV programming for adolescents and youth with evidence for impact.
- This Guidance Note emphasizes the need to attend to adolescents and youth across all the global priorities in the UNAIDS strategy.
- This Guidance Note stresses the need to address and monitor responses for key neglected and vulnerable groups including adolescents and key affected populations.
- This Guidance Note updates key resources (technical guidance and reports).

Why adolescents and youth

Worldwide an estimated 4.5 million youth (aged 15–24 years) and 2.1 million adolescents (aged 10–19) were living with HIV by the end of 2012.[1] Young people aged 10–24 years represent approximately 15% of all people living with HIV. In 2012, youth aged 15–24 accounted for 39% of new HIV infections in people aged 15 and older.[2]

Definitions

Young people are defined by the United Nations as people aged 10–24 years. Although this category varies by country, it is generally divided into adolescents (aged 10–19 years) and youth (aged 15–24 years). In this document, the term is used to refer to adolescents and youth between the ages of 10 and 24 years.

Significant progress has been seen in the prevention of new HIV infections in youth aged 15–24 globally. Between 2001 and 2012, new HIV infections fell among young women and men aged 15–24 in every region except the Middle East and North Africa. In the Middle East and North Africa, new HIV infections among this age group increased by approximately 50% during this period.[3] By contrast, in sub-Saharan Africa, the number of new HIV infections among young people declined by 36 % from 2001 to 2012 and by 55% in the Caribbean.[4] Global, regional and even country data, however, do not adequately describe the heterogeneity and reality of key locations and micro-epidemics; therefore, countries need to look closely at the epidemiology of their epidemics and focus responses accordingly.

Global aggregate data on the HIV epidemic in adolescents and youth in particular mask significant gaps and challenges. First, adolescent girls and young women face unique challenges and vulnerabilities and are at increased risk of HIV infection in many contexts. Globally, HIV prevalence remains nearly twice as high among young women and girls than it is among young men and boys, which is driven by the disproportionate number of young women and girls aged 15–24 years living with HIV in sub-Saharan Africa.[5] In 2012, approximately two thirds of new

1 Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: Joint United Nations Programme on HIV/AIDS; 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf, accessed 26 July 2014).

2 Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: Joint United Nations Programme on HIV/AIDS; 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf, accessed 26 July 2014).

3 Unpublished estimates from Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: Joint United Nations Programme on HIV/AIDS; 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf, accessed 26 July 2014).

4 Thematic segment: HIV, adolescents and youth. Background note for the thirty-third meeting of the UNAIDS Programme Coordinating Board. UNAIDS/PCB (33)/13.22. Geneva: Joint United Nations Programme on HIV/AIDS; 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2013/pcb33/agendaitems/20131121_Thematic-segment-HIV-%20youth-adolescents%20.pdf, accessed 26 July 2014). In sub-Saharan Africa, the total number of new HIV infections among young people declined from 800 000 in 2001 to 560 000 in 2012, and in the Caribbean from 8300 to 3700 over the same time period according to 2012 unpublished estimates from UNAIDS.

5 Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: Joint United Nations Programme on HIV/AIDS; 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf, accessed 26 July 2014).

infections globally in adolescents aged 15–19 were among girls.[6] Social and economic inequalities and age-disparate sex are key factors in the epidemic affecting young women and girls, and much more needs to be done to significantly reduce their risk of infection.

Second, global trends in new infections and AIDS deaths do not reflect trends in young people from key populations.[7] Key populations of all ages continue to experience significant stigma and discrimination affecting access to effective prevention, treatment, care and support services. They remain poorly represented in national strategies and the resources provided to respond to their unique needs are inadequate to meet them. Young people from key populations face unique vulnerabilities because of their age. In addition, their access to services is even more difficult because of various factors such as age-related restrictions to HIV and sexual and reproductive health services and the limited availability of youth-friendly services.

Lastly, the responses for adolescents aged 10–19 including adolescents living with HIV are often inadequate and/or ineffective as illustrated by the poor trends for this age group. AIDS-related deaths in adolescents increased between 2005 and 2012, demonstrating the gaps in HIV testing and counselling and the need for linkages to care and treatment and quality support for adolescents aged 10–19 years.[8]

1. Key elements

Adolescents and youth are critically important to the long-term global AIDS response. They represent an opportunity to end the AIDS epidemic through leadership and behavioural and social changes which would have an impact on new HIV infections, AIDS-related deaths and the way the world responds to HIV and AIDS. This would also impact the human rights priorities in the global response for generations to come. In order to achieve better results among adolescents and youth, better investment is needed in the following areas:[9]

- Improved linkage to proven and effective HIV prevention services (including cash transfers antiretroviral care and treatment; comprehensive condom programming; harm reduction; prevention of mother-to-child transmission (PMTCT); social and behaviour change programming as well as comprehensive sexuality education; and voluntary male medical circumcision (VMMC) in high HIV prevalence settings with low male circumcision rates).

6 Towards an AIDS-free generation. Children and AIDS: sixth stocktaking report. New York: United Nations Children's Fund; 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20131129_stocktaking_report_children_aids_en.pdf, accessed 26 July 2014).

7 UNAIDS in its 2011–2015 strategy 'Getting to Zero' defines key populations as follows: "Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However, each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context."

8 Towards an AIDS-free generation. Children and AIDS: sixth stocktaking report. New York: United Nations Children's Fund; 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20131129_stocktaking_report_children_aids_en.pdf, accessed 26 July 2014).

9 Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: Joint United Nations Programme on HIV/AIDS; 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf, accessed 26 July 2014).

- Improved access to and demand for HIV testing and counselling, treatment and care.
- Improved management of care and the transition of adolescents from paediatric to adult care particularly addressing adherence, disclosure and retention.
- Development and empowerment of adolescents and youth through improved access to quality health care, protection, education and skills development including gender-sensitive comprehensive sexuality education.

All ten commitments and targets set by Member States in the 2011 United Nations Political Declaration on HIV and AIDS are relevant to adolescents and youth aged 10–24 years. These include:

1. Reduce sexual transmission by 50% by 2015.

2. Reduce transmission of HIV among people who inject drugs by 50% by 2015.

3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths.

4. Reach 15 million people living with HIV with life-saving antiretroviral treatment (ART) by 2015.

5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015.

6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries.

7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV.

8. Eliminate stigma and discrimination against people living with and affected by HIV through the promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms.

9. Eliminate HIV-related travel restrictions on entry, stay and residence.

10. Eliminate parallel systems for HIV-related services to strengthen the integration of the AIDS response in global health and development efforts.

National strategies must be better defined to meet these commitments and the related targets specifically among adolescents and youth by ensuring that:

- Targets for adolescents and youth aged 10–24 years, specifically those living with HIV, are explicitly included in the strategies to deliver on each one of the 10 priority areas above.
- Data on adolescents and youth aged 10–24 years are collected and reported routinely to ensure progress related to this population is well monitored with respect to the above targets and that timely decisions can be made to improve HIV outcomes among this population.

- Adequate investments are made in the scale up of high-impact HIV programmes for adolescents and youth and these investments are monitored to ensure that impact is sustained.
- Adolescents and youth are involved in planning, monitoring, reviewing and supporting programme implementation to ensure relevance of the response to their experience.

2. Focus populations

An important aspect of working with young people is the fact that this age group includes adolescents under 18 and young people aged 18 and above. In addition, work with these two groups involves significantly different legal, policy and programmatic implications. In terms of HIV risk and vulnerability, the subpopulations listed below which were identified through know your epidemic analyses are important to focus on. Also important to note is the fact that these population groups overlap since young people may have multiple behaviours that place them at risk of HIV infection, exclude them or make them vulnerable and in need of protection, care and support. These subpopulations are as follows:

- young people living with HIV,
- all sexually active young women and men in generalized epidemics,
- pregnant young women and girls,
- adolescents (aged 10–19), particularly adolescents living with HIV including both those vertically infected and those who acquire HIV during adolescence and
- young people from key populations (including adolescents and youth who inject drugs, young males who have sex with other males, young women who sell sex, sexually exploited adolescents and young transgender people, transgender women and girls).

3. Data requirements

The availability of data is essential to programme design. Data are needed to justify the selection of the intervention, to analyse any existing gaps, to set targets and to monitor progress.

To better understand the extent of the epidemic in young people, a situation analysis presenting data disaggregated by age, sex and key population should be conducted that seeks to answer the following questions which are grouped according to topic.

Epidemiology of HIV in adolescents and youth

- What is the prevalence and incidence of HIV among young people (considering sex and age (groups of 10–14 years, 15–19 years and 20–24 years); including young people from

key populations particularly young people who inject drugs, young men who have sex with men, transgender people and young people who sell sex)?

- Where are they (geographically) and what factors could explain the increased risk of HIV infection among adolescents and youth in these settings? What are the cultural, economic, gender, social, structural and political factors that make young people vulnerable to HIV or lead them to adopt high-risk behaviours?
- What are the trends in new infections and AIDS-related deaths among adolescents and youth? What factors could explain the observed trends? What are young people themselves telling us about risks, vulnerability, trends, etc.?
- What are the estimated sizes of the adolescent and youth populations or subpopulations in need of HIV prevention, treatment, care and support services?

Programmatic response

- What mechanisms are in place to ensure that adolescents and young people actively participate and are engaged in the design, implementation, monitoring and evaluation of HIV policies, services and programmes that target them?
- What HIV prevention, treatment and care services are available to adolescents and youth and where?
- What specific priorities and targets are defined in the national HIV strategy and related strategic plans that reduce HIV risk and transmission and HIV-related morbidity and mortality in adolescents and youth?
- Who are the key actors serving adolescents and youth in support of the national programme? What other protective factors are present and can be leveraged for young people (e.g. family support)?
- What norms, standards, laws and policies exist that are related to HIV prevention, treatment and care for adolescents and youth that might affect service delivery to and uptake among those in need?
- What is the current coverage (disaggregated by age, sex and key population (where possible)) of HIV testing and counselling (HTC) and high-impact HIV prevention, treatment and care interventions (such as PMTCT, condoms, ART, VMMC, targeted interventions for key populations and behaviour change communication) among adolescents and youth? If unknown, why?
- What is the quality of HTC and high-impact HIV prevention, treatment and care services for adolescents and youth (from the perspectives of adolescents and youth as well as service providers)? What strategies exist to engage adolescents in these services?
- What programme responses are in place to address gender equality and sexuality education?
- What programme strategies are in place to address the needs of young women and girls who often carry the responsibility of caring for family and community members living with HIV?

Financial

- What are the estimated costs associated with the delivery (planning, implementation, monitoring and evaluation) of HIV testing and counselling and high-impact HIV prevention, treatment and care services to adolescents and youth in need in the national context? If this does not exist are there processes in place to estimate costs?
- What is the current investment level and who are the current investors the HIV response targeting adolescents and youth and where is the money spent (i.e. on what interventions, for which adolescent and youth populations and in which geographic areas)?
- What additional resources are required to mount an effective HIV prevention, treatment and care response for adolescents and youth?
- What priority changes are required to better align investments in HIV services targeting adolescents and youth to the epidemiological profile and human rights challenges which affect an optimal response?
- What are the major sources of funding for HIV services targeting adolescents and youth?
- What proportion of those investments are dedicated to youth organizations and building their capacity to serve the community?

Legal and regulatory environment

- What are the legal and policy barriers to effective HIV responses for young people including young people among key populations at higher risk of HIV infection?
- What is the age of consent for accessing different HIV services (e.g. HTC, condoms, VMMC, harm reduction)
- To what extent are the age of consent laws enforced and implemented?

4. Implementation challenges

The following represent challenges to implementing high-quality programmes to address HIV among youth and adolescents:

- A lack of data and monitoring related to adolescents and youth limiting effective decision-making.
- The quantity, sustainability and focus of funding for adolescent and youth programming.
- The quality of programming for adolescents and youth.
- A lack of comprehensive sexuality education in schools and lack of support for young people to stay in school.
- Social norms, gender and perspectives on adolescents and youth.
- Stigma, especially experienced by young people living with HIV and from other key populations.

- Legislative barriers (e.g. the age of consent to access services, laws criminalizing same-sex relationships, sex work and injecting drug use) impact access to and the delivery of services).
- Other general legal and ethical issues around accessing services, including consent and disclosure.
- Service delivery models for HIV testing and counselling, care and ART, as well as community outreach and clinical and health-related services.
- Issues related to the provision of HIV prevention services, HIV testing and counselling, condoms, harm reduction services including needle-syringe programmes (NSPs), voluntary male medical circumcision, etc. (and integration with other sexual and reproductive health services).
- A lack of support to pregnant adolescents to ensure that they can make informed choices about continuing or terminating pregnancies.
- Income inequality and social exclusion which impacts the choices adolescents and youth make with respect to partnerships.
- Socially excluded adolescents and youth also face significant barriers to access effective interventions and commodities.

5. Main activities

There is now very strong evidence which can be used to inform the development of strategies appropriate to each epidemic's context. The UNAIDS strategic investment framework[10] identifies three categories of interventions critical for an optimal impact from HIV investments. In planning for adolescents and youth, these programme areas need to be analysed and adapted specifically for adolescents and young people who have a very different legal status, and who often lack the authority and agency in social and civic transactions including the ability to access information or services. The three categories are as follows:

- *Basic programmes*. These are interventions with a proven efficacy in reducing HIV risk, transmission, morbidity or mortality. These include ART, condoms, prevention of mother-to-child transmission, voluntary male medical circumcision,[11] targeted interventions for key populations and social and behaviour change programmes.
- *Critical enablers*. These interventions are essential for the effective utilization and delivery of HIV prevention, treatment and care interventions that have been demonstrated as effective. These include social enablers such as efforts to enhance HIV testing and counselling, HIV-sensitive legislation and policy, community mobilization and engagement cash transfers, as well as programme enablers such as the investment in capacity strengthening for community organizations and strategic planning.

10 Schwartländer B et al. Towards an improved investment approach for an effective response to HIV/AIDS. Lancet. 2011;377(9782):2031-2041. doi:10.1016/S0140-6736(11)60702-2.

11 This intervention is specifically intended for countries with a high HIV prevalence and low rates of male circumcision.

- *Development synergies*. Here, the focus is on development sector investments that contribute to reducing vulnerability, lead to the empowerment of adolescents and youth and improve the sustainability of HIV-specific investment results.

The following table presents some illustrative activities that should be included in programme responses for adolescents and youth. The activities presented reflect the target areas of the UNAIDS 2011–2015 Strategy and the three domains of the investment framework. In addition, it is important that each programme activity outlined below is conceptualized and implemented through a gendered lens that acknowledges and accounts for the gender-specific impact of the epidemic on young people and which is tailored to a specific context.

This table is not exhaustive and the interventions shown here can only have an optimal impact if they form a part of a comprehensive package. At the end of this Guidance Note, a list of guidance documents that provide more detailed recommendations on interventions for a comprehensive response for specific populations can be found.

Table 1

Examples of programme activities targeting youth and adolescents

Target	Programme activity	Key development synergy
1. Reduce sexual transmission by 50% by 2015	Increase knowledge, access and utilization of condoms among adolescents and youth including adolescents living with HIV (ALHIV) and young people living with HIV (YPLHIV) and young key populations Increase knowledge, access and utilization of safe VMMC and other interventions in the prevention–treatment continuum among adolescent boys in the 14 priority countries Social and behaviour change communication to change social norms and for the promotion of service utilization and provision among adolescents and youth, including specific programmes for YPLHIV and young key populations Increase demand for and use of HTC among adolescents and youth, including young key populations Increase uptake of VMMC among adolescent boys and youth and enhance gender- and age-specific adolescent sexual and reproductive health (ASRH) messages	Strengthen school health services and outreach to schools Comprehensive sexuality education within and beyond schools Enhance links between adolescent sexual and reproductive health, VMMC and other HIV services Strengthen access to care for sexually transmitted infections and family planning services Linkages with community services and services in closed institutions/prisons Strengthen social protection systems to address social and economic drivers of vulnerability to HIV for adolescents and youth, particularly girls and young women Advocate for and support expansion of cash transfer programmes for girls and young women in national social protection development plans
2. Reduce transmission of HIV among people who inject drugs by 50% by 2015	Increase access to clean needles and syringes among adolescents and youth who inject drugs as part of a comprehensive and youth-friendly harm reduction package Opioid substitution therapy and other interventions from the comprehensive harm reduction package Overcoming legal and social challenges Comprehensive education on drugs, drug use prevention and harm reduction within and beyond school settings	Human rights: access to evidence-based and voluntary HIV and drug dependence services Linkages with community services and services in closed institutions/prisons

Target	Programme activity	Key development synergy
3. Reduce new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths children by 90% by 2015	Strengthen access to PMTCT services and ART access and retention in care among adolescents and youth	Prevention of unintended pregnancies in adolescents and youth including ALHIV and YPLHIV Access to antenatal care (ANC)
4. Reach 15 million people living with HIV with life-saving ART by 2015	Strengthen access to ART, retention and transition management among ALHIV and YPLHIV Special considerations around retention in care and adherence to treatment	Linkages with community services and services in closed institutions/prisons
5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015	Develop youth- and adolescent friendly community services for tuberculosis diagnosis and treatment adherence	Strengthen linkages between sexually transmitted infections, tuberculosis and HIV treatment services for adolescents and youth to increase tuberculosis care for ALHIV and YPLHIV Linkages with community services and services in closed institutions/prisons
6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries		Monitor resource allocation to adolescent and youth development in key sectors
7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV	Develop and implement gender-sensitive services for adolescents and young people Address violence against young women, particularly those who are involved in intergenerational relationships, forced into sex work, trafficked, forced into early marriage, etc. Address violence against young people who inject drugs by police/prison authorities; provide training for law enforcement agencies (police/drugs officials) on HIV and young key populations	Strengthen protection systems and prevent and address sexual violence among adolescent girls, young women and young people from key populations Address harmful gender norms in all communication and education

Target	Programme activity	Key development synergy
8. Eliminate stigma and discrimination against people living with and affected by HIV through the promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms	Increase access for adolescents and youth to legal services, social protection programmes and services against stigma and discrimination Meaningfully involve young people in decision-making processes for policies and laws targeted at protecting their human rights Strengthen laws and policies affecting access to HTC and key prevention, treatment, care and support services for adolescents and youth including key populations	Justice for children and access to the criminal justice system Support the closing of compulsory rehabilitation centres for young people who inject drugs and young people who sell sex Access to education, workplace policies, etc.
9. Eliminate HIV-related travel restrictions on entry, stay and residence		Meaningfully involve young people in advocacy for the elimination of these restrictions
10. Eliminate parallel systems for HIV-related services to strengthen the integration of the AIDS response in global health and development efforts		Meaningfully involve young people in the discussions and advocacy for change
11. Cross-cutting activities	Adolescent and youth participation and capacity strengthening for youth networks and leaders Social protection measures to reduce vulnerability among adolescents and youth affected by HIV Monitoring and evaluation focused on adolescents and youth Documentation of best practice, operational research and knowledge transfer Evidence-informed and context-specific advocacy focused on young people, their rights and gender equality	

6. Key indicators

National responses should include indicators to track progress against milestones and universal access targets. For adolescents and young people, data should be disaggregated by the following variables: age ranges of 10–14, 15–19 and 20–24; sex; educational level; and the use of services to show whether the programmes are having the intended effect and to make the appropriate changes based on the results.

Several tools have been developed to assist countries with the monitoring of indicators for young people consistent with the 2011 United Nations Political Declaration on HIV and AIDS. The 2014 Global AIDS Response Progress Reporting (GARPR) guidelines elaborate 31 core indicators (with one additional indicator under development to track stigma) which are combined with a special questionnaire to track national HIV and AIDS programme commitments and policy instruments.

While all 31 core indicators in the GARPR are relevant to HIV prevention, treatment and care among adolescents and youth, only 11 are adolescent- and/or youth-specific or have been recommended to be reported with clearly disaggregated figures for adolescents and youth. These include the following indicators:

Target 1: Reduction of sexual transmission of HIV in the general population

1.1 Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission, disaggregated by sex and age (15-19 and 20-24)

1.2 Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15, disaggregated by sex and age (15–19 and 20–24).

1.3 Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months, disaggregated by sex and age (15-19, 20-24 and 25-49)

1.4 Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse, disaggregated by age sex and age (15-19, 20-24 and 25-49)

1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results, disaggregated by sex and age (15-19, 20-24 and 25-49)

1.6 Percentage of young people aged 15–24 who are living with HIV (no disaggregation).

1.7 Appendix 6. Male circumcision indicators

1.22 Percentage of men 15-49 that are circumcised, disaggregate by age (15-19, 20-24 and 25-49)

1.23 Number of male circumcisions performed according to national standards during the last 12 months, disaggregate by age (1, 1-9, 10-14, 15-19, 20-24, 25- 49, and 50+)

In addition to GARPR, the UNAIDS Inter-Agency Task Team on Education has recommended 15 core indicators for measuring the education sector's response to HIV and AIDS, all of which are relevant to adolescents and young people in educational settings.[12]

Target 7: Eliminating gender inequalities

7.1 Proportion of ever-married or partnered women aged 15–49 who experienced physical or sexual violence from a male intimate partner in the past 12 months, disaggregated by age (15–19, 20–24 and 25–49) and HIV status (if available).

Target 10: Strengthening HIV integration

10.1 Current school attendance among orphans and non-orphans (10–14 years old, primary school age, secondary school age), disaggregated by sex.

The other GARPR indicators are also critical for the monitoring of progress among adolescents and youth, but current guidelines for reporting on these indicators do not provide for the distinct disaggregation and reporting of data on adolescents. Thus, country analysis and reporting on adolescents as well as national and global perspectives on progress in relation to the responses targeted to adolescents and youth in these areas remain weak and should be strengthened. Data for these indicators are only reported for populations under 25 and over 25 years, respectively, and include the following:

Target 1: Reduction of sexual transmission of HIV in the general population

1.7 Percentage of sex workers reached with HIV prevention programmes, disaggregated by sex (female, male, transgender) and age (<25/25+)[13]

1.8 Percentage of sex workers reporting the use of a condom with their most recent client, disaggregated by sex (female, male and transgender) and age (<25/25+).

1.9 Percentage of sex workers who received an HIV test in the past 12 months and know their results, disaggregated by sex (female, male, transgender) and age (<25/25+)

1.10 Percentage of sex workers who are living with HIV, disaggregated by sex (female, male and transgender) and age (<25/25+).

1.11 Percentage of men who have sex with men reached with HIV prevention programmes, disaggregated by age (<25/25+).[14]

12 Measuring the education sector response to HIV and AIDS: guidelines for the construction and use of core indicators. Paris: United Nations Educational, Scientific and Cultural Organization; 2013 (http://unesdoc.unesco.org/images/0022/002230/223028E.pdf, accessed 27 July 2014).

13 Refer to the target setting guide for the full set of recommended interventions. In particular, refer to: Technical guide for countries to set targets for HIV prevention, treatment and care for sex workers, men who have sex with men and transgender people. Geneva: World Health Organization; 2014 (in publication).

14 Refer to the men who have sex with men target setting guide for further details on the recommended interventions. In particular, refer to: Technical guide for countries to set targets for HIV prevention, treatment and care for sex workers, men who have sex with men and transgender people. Geneva: World Health Organization; 2014 (in publication).

1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner, disaggregated by age (<25/25+).

1.13 Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results, disaggregated by age (<25/25+)

1.14 Percentage of men who have sex with men who are living with HIV, disaggregated by age (<25/25+).

Target 2: Reduction of transmission among people who inject drugs[15]

2.1 Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes (no disaggregation).

2.2 Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse, disaggregated by sex and age (<25/25+)

2.3 Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected, disaggregated by sex and age (<25/25+)

2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results, disaggregated by sex and age (<25/25+).

2.5 Percentage of people who inject drugs who are living with HIV, disaggregated by sex and age (<25/25+).

Target 4: Antiretroviral therapy[16]

4.1 Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV, disaggregated by sex and age" (less than 15 years, 15 years and older, 15-49, <1 year, 1-4 years, 5-9, 10-14, 15-19, 20-24, 25-49, 50+))

4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy, disaggregated by sex and age <15 and 15+), pregnancy status at start of therapy, and breastfeeding status at start of therapy

Target 5: Reducing tuberculosis deaths in people living with HIV

5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV (no disaggregation).

15 World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS. WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. 2012 revision. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf, accessed 27 July 2014).

16 Indicator 4.2 and target 5 (expanding access to ART) and 5 (reduction of tuberculosis deaths in people living with HIV) are also critical for adolescents and youth living with HIV. Again, guidelines on reporting do not recommend disaggregation of country reports to allow tracking of progress among adolescents and youth. Reporting on these is important and should be strengthened.

7. Approaches to costing

Key items to be included in the costing of effective responses to HIV for adolescents and youth could include the following:

- Basic analysis of the epidemic and the response to identify gaps, strengths and priorities for strategic support and to establish population size estimates (baseline estimates of need) and programme baselines.
- The scale-up of all interventions including basic programmes, critical enablers and synergies defined in each context. Modelling conducted by UNICEF using the investment framework to cost the adolescent response[17] defined these costs as being comprised of two components:
    1. Service delivery (drugs and other commodities, labour and equipment).
    2. System support including information, education and communication, the provision of training, supervision and quality assurance, logistics, management, infrastructure and monitoring and evaluation.
- Operational research, documentation and dissemination for knowledge transfer.
- Participatory review and strategic planning.
- Youth engagement and capacity strengthening.
- Advocacy
- Community mobilization.

8. Addressing gender, human rights and equity issues

HIV programmes that target adolescents and youth should be guided by the following principles:

- A human rights–based and gender-responsive approach. Such an approach is fundamental to effective and sustainable national responses to HIV prevention among young women and young men, and, in particular, for young key populations.
- Collaboration and partnerships between adults and young people, and among different organizations. The development of comprehensive HIV programmes for young women and men across different sectors and organizations requires the provision of sustainable funding and a national coordination mechanism.
- Meaningful participation of young people. Young people (including people living with HIV and other young key populations) should be involved in the design, implementation and evaluation of programmes and services targeting them. The meaningful participation of adolescents and youth is critical to the success of any intervention. Young people should also be engaged within national decision-making processes, including but not limited to national strategic planning and participatory budgeting exercises. To ensure

17 Stover J, et al. How can we get to zero? The role of new technologies and strategic investment approaches for an effective response to AIDS. 2013 (unpublished working paper).

that this participation is meaningful, it is important to ensure participation of diverse youth groups, and that youth groups that are representative of and accountable to young people. Programmes that aim to strengthen community systems are a good opportunity to help develop young people's ability to engage meaningfully in the development of HIV programmes and services, as well as the AIDS response more broadly. Involving young people requires an enabling environment which can be achieved through advocacy, community mobilization and bringing young people's voices to critical strategic discussions within and beyond the communities in which they live.

- Recognition that young people are not homogeneous. Programmes must be tailored to meet the individual characteristics and circumstances of young people, such as age, sex, religion, socioeconomic status, marital status and domestic arrangements among other factors. Programmes should specifically address the needs of vulnerable young people and young people from key populations.
- Programmes should be gender-sensitive, youth-friendly and designed, implemented and evaluated in collaboration with young women and young men. Resources are available that describe the critical components of youth friendly services.[18]
- Improvements in monitoring and in availability of data on adolescents and youth are essential. To effectively track progress towards the fulfilment of human rights and to ensure equity, programmes must assess and measure access, progress and resources allocated to programming for adolescents and youth.

With these principles in mind, some clear gender, equity, equality and human rights challenges stand out:

- Adolescent girls and young women remain disproportionately affected by HIV in eastern and southern Africa. Thus, a higher priority needs to be given to engaging adolescent girls and young women and to addressing the special needs of these groups in the prevention of HIV or to the prevailing social norms that lead to this imbalance.
- Adolescents remain neglected in HIV prevention, treatment and care programming overall, in part as a result of the lack of data needed to enhance strategic planning for interventions among this population. Thus, inadequate resources are made available and, when resources are available, they are not applied adequately to ensure a comprehensive and effective response to deliver HIV results among this population.
- Laws and policies in place continue to present significant barriers to accessing interventions for adolescents and young people from key populations in all geographic regions and epidemic settings and this contributes to discrimination and social marginalization resulting in disproportionately poor health outcomes.

18 See, for example, Youth-friendly health policies and services in the European region: sharing experiences. Copenhagen: World Health Organization Regional Office for Europe; 2010 (http://www.euro.who.int/__data/assets/pdf_file/0017/123128/E94322.pdf, accessed 27 July 2014).

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