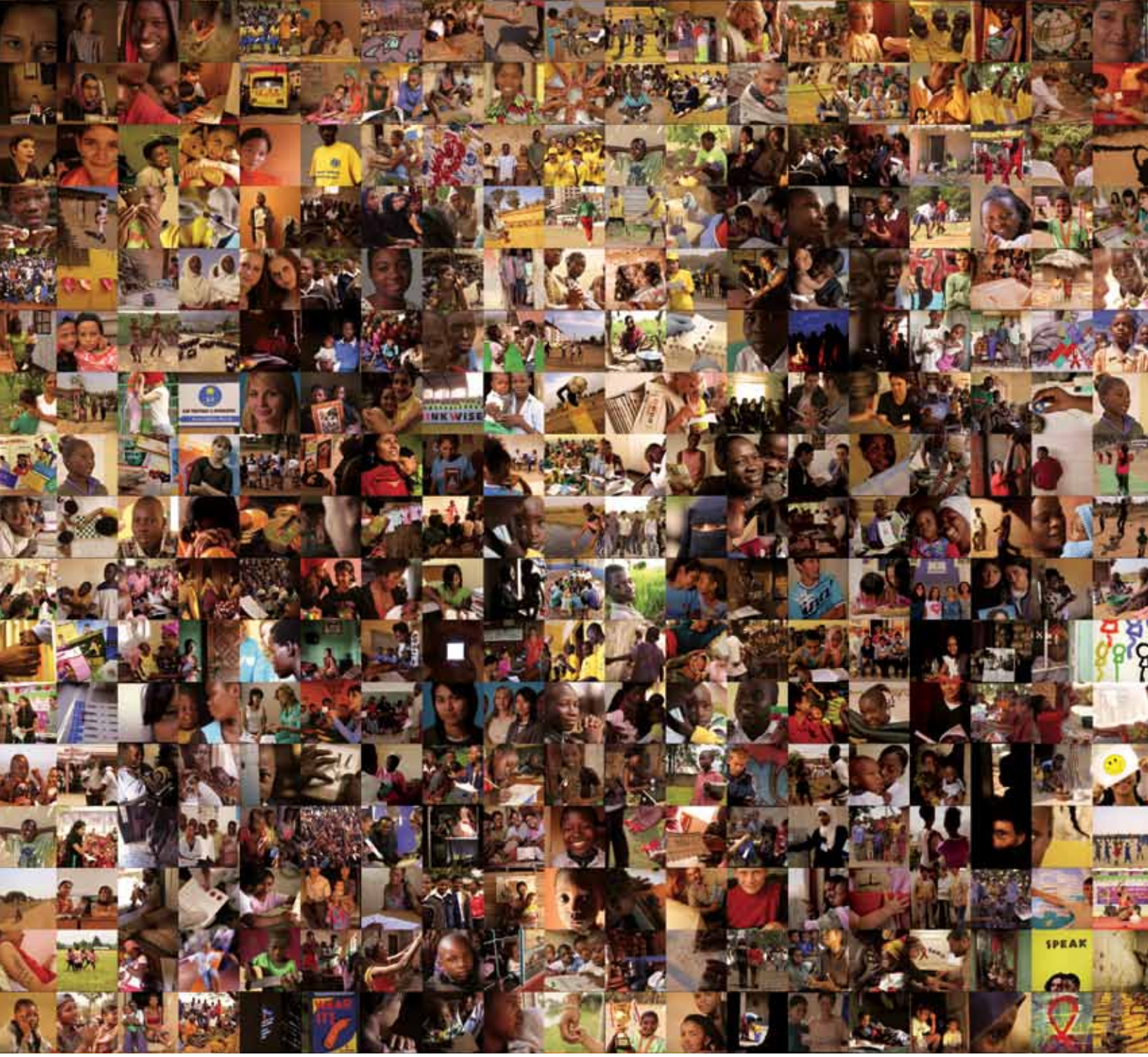

OPPORTUNITY in CRISIS

Preventing HIV from early adolescence to young adulthood

Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood

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United Nations Educational, Scientific and Cultural Organization
UNFPA
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World Health Organization
THE WORLD BANK

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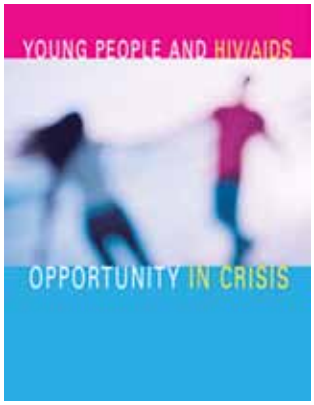
1. INTRODUCTION

The past decade has held high hopes for reducing the rate of new HIV infections among young people. In 2000, world leaders adopted the Millennium Declaration, affirming their collective responsibility to ensure equitable development for all people, especially children and the most vulnerable, in the 21st century. The Declaration was translated into action by eight Millennium Development Goals (MDGs), the sixth of which commits the global community to using every resource possible to halt and reverse the spread of HIV.

Building on that commitment, at the UN General Assembly Special Session on HIV and AIDS in 2001, the world made a promise to reduce the prevalence of HIV in young people globally by 25 per cent by the end of 2010 and to increase young people's access to essential prevention information, skills and services so as to reach 95 per cent of those in need by the same date. The first *Opportunity in Crisis* report, published in 2002, put forward 10 steps to help move countries closer to their prevention goals (*see Then and Now, on page 34*).



Since then, some countries have experienced gains in knowledge and positive changes in the sexual behaviour of their young people, and some countries have achieved declines in HIV prevalence and incidence. Many of these achievements can be attributed to the efforts of young people and their schools, families, health workers and communities, as well as to the efforts of some political leaders. But neither the efforts made nor the progress achieved so far have been sufficient.

Globally, an estimated 5 million [low estimate: 4.3 million – high estimate: 5.9 million] young people aged 15–24 were living with HIV in 2009, a 12 per cent reduction since 2001, when there were 5.7 million [5.0 million–6.7 million] young people living with HIV.[1] Yet the 2010 target – a 25 per cent reduction – is unlikely to be met. The young women and men living with HIV today are the most visible evidence of the world's failure to keep its promise to prevent HIV infection among young people and to empower them to protect themselves and live healthy, AIDS-free lives.

A continuum of prevention can lower young people's vulnerability to HIV

What causes the transmission of HIV among young people is no mystery: unprotected sex with an HIV-positive person or contact with infected blood or other fluids through the sharing of non-sterile injecting equipment.

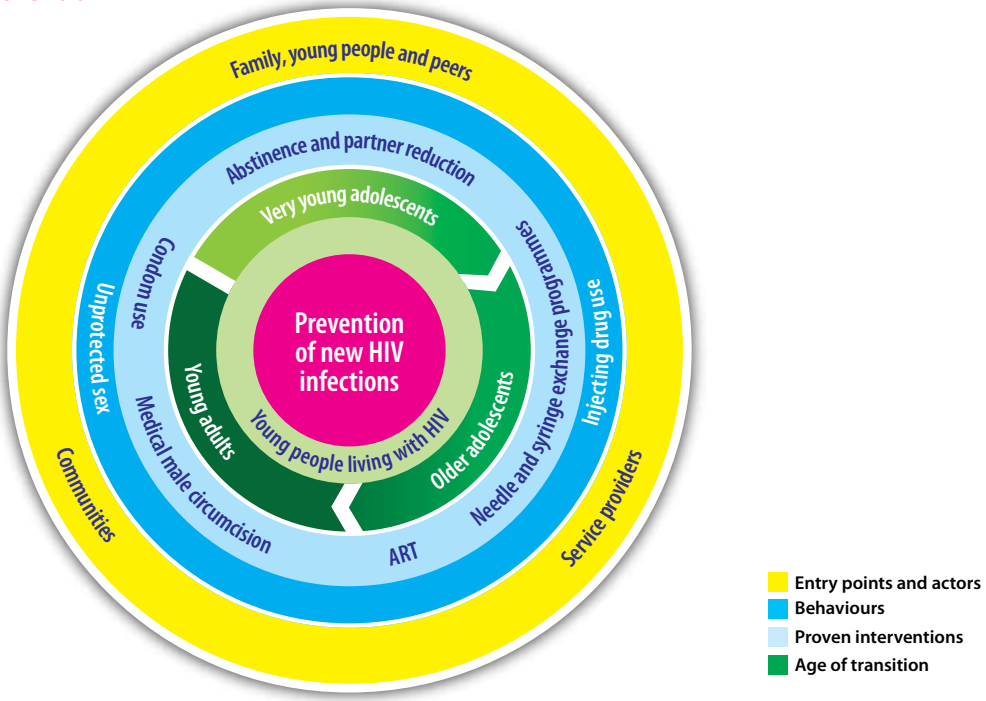
What works to prevent HIV transmission in young people is no mystery either:

- Abstaining from sex and not injecting drugs
- Correct and consistent use of male and female condoms
- Medical male circumcision
- Needle and syringe exchange programmes as part of a comprehensive harm reduction programme
- Using antiretroviral drugs as treatment (which lowers the chance of transmission) or as post-exposure prevention
- Communication for social and behavioural change

In 2009, young people aged 15–24 accounted for 41 per cent of new HIV infections in people aged 15 and older.[2] Reducing this level of incidence requires not a single intervention but a continuum of HIV prevention that provides information, support and services to adolescents and young people throughout the life cycle, from very young adolescents (aged 10–14) through older adolescents (aged 15–19) to young adults (aged 20–24) *(see Figure 1)*.

A continuum of prevention not only helps protect adolescents and young people but ensures that they can access HIV testing and maternal and child health care in response to their needs, including services to prevent mother-to-child transmission of HIV. Ultimately, a continuum of HIV prevention will replace the negative cycle of HIV passing from young people to their partners and the next generation with a positive cycle of HIV-free living.

FIGURE 1: Continuum of prevention



Along with a continuum of HIV prevention, there is a need to address the underlying problems that lead to young people's risk: lack of opportunity, gender inequality and poverty. This is why the MDGs are so crucial to the success of the AIDS response. And while the goal is to prevent new HIV infections in young people, it is also to help those young women and men already living with HIV to manage their chronic illness in a way that gives them as much chance to succeed in life as their HIV-negative peers.

There are opportunities to use proven prevention strategies in all epidemic contexts

In countries with generalized epidemics (a number of countries in sub-Saharan Africa and Haiti and Papua New Guinea), there are opportunities to foster an environment that will encourage healthy attitudes and behaviours, ensure greater gender equality and allow protection against vulnerability to take root and become the new norm. This is particularly important for young women and girls, who in these countries are at greater risk of HIV infection than young men and boys. Here, the same social norms that tolerate domestic violence also prevent women from refusing unwanted sexual advances, negotiating safe sex or criticizing a male partner's infidelity. The silence and complicity around this inequality must, and can, be broken.

In low-level and concentrated epidemics (Central and Eastern Europe and the Commonwealth of Independent States, East Asia and the Pacific, Latin America and the Caribbean, the Middle East and North Africa, and South Asia[3]), where HIV infections among youth are driven by injecting drug use, sex work or male-to-male sex, there are opportunities to reshape a legal and social milieu that compounds vulnerability and marginalization and to reach out in a sustained, effective way to make young people aware of the risk factors and facilitate their access to protection and health care.

Everywhere, young people themselves are central to the success of prevention efforts. In the KwaZulu-Natal province of South Africa and in Kenya, adolescent boys and young men are participating in programmes that offer medical male circumcision.[4] In Malawi, a small study has indicated that girls using cash transfers to stay in school are in the process also reducing their risk of HIV because they are choosing fewer and younger, rather than older, sexual partners.[5] In Romania, nearly 20 per cent of young injecting drug users and sex workers accessing services at a drop-in centre also requested an HIV test.[6]

Communities are integral to successful HIV prevention

Young people's families, peers, elders, teachers and co-workers have a crucial role to play in advocating on their behalf for the services they need to stay healthy and thrive. This community also sets norms for acceptable behaviour and the tone of discussion around issues of sexuality. In Southern Africa, for example, sex with multiple partners and age-disparate relationships are fuelling HIV transmission among young people, and changes in cultural norms related to sexual partnering will be required to sustain people's protection against HIV.[7] Efforts at changing community norms have been effective on a small scale in the United Republic of Tanzania, where the image of men seeking relations with younger women and girls was effectively turned into an image of ridicule,[8] and in Zimbabwe, where the visibility of AIDS-related mortality appears to have been a decisive factor in large-scale behavioural and social change with respect to multiple partnerships.[9]

But many communities turn a blind eye to such common practices as multiple sexual partnerships and age-disparate relationships, and they may also ignore intimate partner violence that limits women's ability to make effective choices for HIV prevention. A recent study in Swaziland documents the threat to young women and girls of a widespread practice of sexual violence: About one third of adolescent girls under the age of 18 had experienced sexual violence, with violence towards all young women, perpetrated by boyfriends, husbands and male relatives, taking place in their homes, in their neighbourhoods, and at school.[10]

Community support is particularly important in times of emergency, when the breakdown of social structures and the adoption of certain behaviours as a means of coping, combined with disruptions in the delivery of HIV prevention services, may increase young people's risk of HIV infection. Particularly in emergencies, food and livelihood insecurity may encourage the practice of sex in return for food, shelter and other necessities.

Governments shape the legal and policy landscapes that can help prevent HIV

Governments and parliaments are front-line actors for revising laws regarding the age of consent for HIV testing and care-seeking. South Africa's Children's Act, passed in 2005, lowered the age of consent for HIV testing and contraceptives to 12 years old, effectively opening up access to full sexual and reproductive health care for adolescents in a country where an estimated 11 per cent of young men and 6 per cent of young women become sexually active before the age of 15.[11] A number of countries in Eastern Europe and Central Asia have recently passed laws lowering the age of consent for testing and treatment in response to extensive advocacy on the part of UNICEF and partners.

The way governments and policymakers address education, training and employment needs in their countries influences young people's ability to navigate HIV risks in their environment and shapes how they see their future. Yet, in many places government action is falling short. Strategies and plans are devised, but money is not allocated, or when it is, efforts are not effectively coordinated, are not at sufficient scale or are not of sufficient quality to ensure the greatest impact from the investment.[12]

Donors must also step up to the challenge. They must work with governments to ensure that money is directed to where the problem is and spent effectively. It will take years before investments in social and behavioural change, systems improvement and community empowerment show results in terms of infections averted. Nonetheless, donors and governments must not shy away from making these investments.

It is time to revitalize prevention efforts for adolescents and young people

The Joint United Nations Programme on HIV/AIDS (UNAIDS) Getting to Zero strategy highlights the need to revolutionize prevention, because progress to date has been inadequate to stop and reverse the epidemic. In order to contribute to a 30 per cent reduction of new infections in young people by 2015, the UN business case on preventing HIV in young people, developed in 2010, asks UN partners to work for three measurable results: In priority countries, at least 80 per cent of young people are to have comprehensive knowledge of HIV; the number of young people using condoms during their last sexual intercourse will have doubled; and the number of young people who know their status through counselling and testing services will also have doubled.

The challenge in achieving these results is on both the supply and demand sides: making HIV prevention services and commodities available and accessible to young people and encouraging those at greatest risk to use the ones that are relevant to them. Using equity as a guidepost will help ensure that those hardest to reach are not last in line, that services are available to them and used by them. Realizing prevention gains among young people and sustaining them will be crucial to achieving "zero new HIV infections, zero discrimination and zero AIDS-related deaths".[13]

2. **STATE** of the **EPIDEMIC** among **YOUNG PEOPLE**

It is estimated that 5 million [4.3 million–5.9 million] young people (aged 15–24) and 2 million [1.8 million–2.4 million] adolescents (aged 10–19) were living with HIV in 2009.[14] Although they could be found in countries on all continents, most of them lived in sub-Saharan Africa *(see Table 1)*.

Globally, young women make up more than 60 per cent of all young people living with HIV; in sub-Saharan Africa their share jumps to 72 per cent *(see Figure 2)*. Thus the overall picture of young people living with HIV is predominantly African and predominantly female. Beyond these dimensions, the epidemic is highly varied.

In many countries, the road from childhood to adulthood is a perilous trajectory for young people, and for young women in particular, and the risk that they will become infected with HIV en route is high. In Swaziland, where HIV prevalence among people aged 15–49 in 2009 was about 26 per cent [25–27 per cent], the highest in the world, the likelihood that a young woman aged 15–19 years old will be infected with HIV is 10 per cent, based on the 2006–2007 Demographic and Health Survey; by age 20–24 it leaps to 38 per cent, and by age 25–29 it rises to 49 per cent.[15]

In sub-Saharan Africa, the lower the household income, the less likely both young men and young women are to have accurate knowledge of HIV and AIDS.[16] Young people are less likely to have accurate knowledge in rural areas than in urban areas.[17] The larger the age gap between sexual partners, the greater the likelihood of being HIV-infected, as is shown by data available in three countries: Swaziland, the United Republic of Tanzania and Zimbabwe.[18]

FIGURE 2: Estimated number of young people aged 15–24 living with HIV, 2009