Inter-Agency Task Team
on HIV and Young People

GUIDANCE BRIEF

HIV Interventions for Most-at-Risk Young People

Purpose

This Brief has been developed by the Inter-Agency Task Team (IATT) on HIV and Young People[1] to assist United Nations Country Teams (UNCT) and UN Theme Groups on HIV/AIDS[2] in providing guidance to their staffs, governments, development partners, civil society and other implementing partners on HIV interventions for most-at-risk young people.[3] It is part of a series of seven global Guidance Briefs that focus on HIV prevention, treatment, care and support interventions for young people that can be delivered through different settings and for a range of target groups.

The purpose of these Briefs is to help decision makers understand what needs to be implemented, based on the latest global evidence on effective interventions for young people. The Briefs provide an overview of evidence-informed interventions (not a blueprint for national programmes) in response to specific epidemic scenarios in different countries.[4] Special attention should be directed to young people most at risk of HIV in all countries. In generalised and hyperendemic settings, interventions to prevent HIV also need to be directed to the general population of young people.[5]

The Briefs do not deal in any depth with "how to" implement the interventions outlined, although key resources are listed to provide further guidance. The Briefs also do not attempt to address the many cultural, institutional and structural specificities and factors that confront decision makers in different countries. They are therefore likely to require further adaptation and translation if they are to be used by national counterparts. The engagement of young people in the adaptation of the materials will enhance their usefulness.

Introduction

Globally HIV adversely affects young people. It is estimated that in 2007 about 40 per cent of new infections among people over the age of 15 were in youth between the ages of 15 to 24 years.[6] *The Global Guidance Brief on HIV and Young People* describes the global targets to reduce HIV prevalence in young people and to ensure their access to information, education, life skills and services. Particular attention is paid in this Brief to the younger age cohort-adolescents-and explores what interventions should be in place for young people already engaging in high HIV risk behaviours.

Definitions

Behaviours[7] that put people at greater risk of HIV infection include multiple unprotected sexual partnerships, unprotected anal sex with multiple partners, and injecting drugs with non-sterile equipment.[8] Thus, the term ***most-at-risk young people*** is used throughout this Brief to include young:

- Male and female injecting drug users (IDUs) who use non-sterile injecting equipment
- Males who have unprotected anal sex with other males
- Females and males who are involved in sex work, including those who are trafficked for the purpose of sexual exploitation and have unprotected (often exploitative) transactional sex
- Males who have unprotected sex with sex workers

Further, some young people engage in multiple risk behaviours, such as both injecting drugs and having unprotected sex. It is important to undertake situational assessments of young people's risk and vulnerability to HIV infection and map areas of high HIV transmission ("hot spots")[9] to understand who is at increased risk and where they are located.

Working with most-at-risk young people is challenging, especially if they are below the age of 18, being sexually exploited or engaging in illegal behaviours. Any human being below the age of 18 is defined as a child in the Convention on Rights of the Child, Article 1. For children involved in sex work and injecting drugs, it is not simply a case of providing clean injecting equipment and condoms. It is also important to ensure that these individuals are removed from exploitative situations and referred to appropriate health, legal and social services in accordance with their best interests, as laid out in the Convention on Rights of the Child.

Some young people may be especially vulnerable to HIV, or just one step away from engaging in high-risk behaviour, because of such factors as displacement;[10] ethnicity and social exclusion; having parents, siblings or peers who inject drugs; migration (internal and external);[11] family breakdown and abuse; harmful cultural practice; and poverty. The presence of these factors does not automatically lead to HIV risk behaviour, as there may be several protective factors at work (education, supportive family and peer networks).[12]

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[1] The Inter-Agency Task Team on HIV and Young People was established in 2001 to enhance the effectiveness of the global response to AIDS in the context of young people. Further information about the IATT on HIV/YP is contained at the end of the document.

[2] This includes Joint UN Teams on AIDS (JUNTA) and/or Technical Working Groups (TWG) on AIDS.

[3] The UN defines young people as age 10 to 24 years, youth as 15 to 24 years and adolescents as 10 to 19 years.

[4] Detailed information on what actions (for populations of all ages) should be taken for each stage of the epidemic can be found in UNAIDS (2007) Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. UNAIDS, Geneva.

[5] Information and education about HIV should be available to all young people, irrespective of the stage of the epidemic. There are global indicators to monitor the percentage of youth 15 to 24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

[6] UNAIDS (2007) AIDS epidemic update: Core slides: Global Summary of the HIV and AIDS epidemic. UNAIDS, Geneva. http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/epi_slides.asp

[7] It is the behaviour that puts the young person at risk of HIV. Various different sub-groups of young people may engage in HIV risk behaviours and they will vary from country to country. The need to know "your epidemic" and to identify hot spots where HIV risk behaviours take place is critical.

[8] UNAIDS, UNICEF, WHO, United States Agency for International Development, Centre for Diseases Control, Measure evaluation and Family Health International (2007). A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations. UNAIDS, Geneva. UNAIDS/07.15E/JC1338E.

[9] For information on how to conduct hot spot mapping see Weir, S.S., Tate, J., Hileman, S.B., Khan, M., Jackson, E., Johnston, A. and Herman, C. (2005) Priorities for Local AIDS Control Efforts (PLACE): A Manual for Implementing the PLACE Method. USAID and MEASURE , Carolina Population Centre, Chapel Hill.

[10] See Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global Guidance Brief on HIV Interventions for Young People in Humanitarian Emergencies for more information on vulnerability to HIV among young people.

[11] See Inter-Agency Task Team (IATT) on HIV and Young People (2008) Global Guidance Brief on HIV Interventions for Young People at the Workplace.

[12] WHO (2002) Broadening the horizon: Balancing protection and risk for adolescents. WHO, Geneva.

However, gender inequality and human rights violations both impede participation by vulnerable populations in sound and timely HIV prevention planning and access to prevention information and services.[13]

"Settings" such as juvenile detention facilities and prisons are places where there is a greater likelihood of HIV transmission through injecting drug use or anal sex. Similarly, young people living without parental care, or on the street, may be pressured to sell/exchange sex or inject drugs.

Young people living or working on the street

There are about 120 million "street kids" worldwide: boys and girls living in both rich and poor countries.[14] They are subject to the everyday risk of being sexually abused and experience violence at the hands of both adults (parents, police and others) and their peers. Many of them do not have access to appropriate health services. Their major concern is survival, and they are often involved in theft or sell/exchange sex because they do not have other means of earning money.[15] Many of them use psychoactive substances and may inject drugs. As a result, HIV prevalence rates are worryingly high among this sub-population. Recent research from Saint Petersburg (Russian Federation) found 37.4 per cent of 313 street children to be HIV-positive with the highest levels among those street children who inject drugs.[16]

Young people in juvenile detention/correctional institutions

Overcrowded conditions, drug use and limited adequate services in prisons may adversely affect the health of inmates, including exposure to HIV, hepatitis C and tuberculosis. For young males in prison,[17] there are additional risks, as they are often physically weaker than other inmates and may be forced to take part in drug and/or sex-related activities. Anal sex, forced or consensual, is common in prison and is generally unprotected[18] as is the use of non-sterile needles and syringes. Young people in juvenile detention urgently need HIV interventions, including access to clean needles and syringes, drug treatment services, counselling and health education, both within and beyond correctional settings.[19] [20] However, the main intervention should be to prevent juveniles being placed in correctional facilities. Programmes diverting young offenders from the juvenile justice system should be established and, where these programmes do not exist, young people should be placed in custodial care/juvenile detention facilities separate from adults.

[13] UNAIDS (2007) Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. UNAIDS, Geneva.

[14] UNAIDS (2002) HIV/AIDS stigma and discrimination. UNAIDS Best Practice Collection, UNAIDS, Geneva.

[15] ILO (2001) In-depth analysis of the situation of working street children in Saint Petersburg 2000. ILO/IPEC Working Paper, ILO Saint Petersburg.

[16] Kissin, D. M. et al (2007) "HIV sero-prevalence in street youth, St Petersburg, Russia," AIDS, 21(17):2333-2340, November.

[17] Minors are not always incarcerated separately from adults.

[18] International Federation of Red Cross and Red Crescent Societies (2003) Spreading the light of science: Guidelines on harm reduction related to injecting drug use. IFRC, Geneva.

[19] Shakarishvili et al. (2005) "Sex work, drug use, HIV infection and spread of sexually transmitted infections in Moscow," Lancet, Vol. 366, pp 57-60.

[20] WHO Regional Office for Europe (2003) Promoting the health of young people in custody. WHO Regional Office for Europe, Copenhagen. http://www.euro.who.int/prisons/publications/20050610_1

Key Issues in Working with Most-at-Risk Young People

The HIV risk behaviour that needs to be addressed when working with most-at-risk young people may be illegal (injecting drugs, selling sex and male-to-male sex), making it more difficult for at-risk young people to access services. Because of legal and other barriers, young people involved in HIV risk behaviours are marginalised and not reached by mainstream HIV prevention and treatment efforts. They may experience stigmatisation, discrimination and social exclusion.[21]

Although young people engaging in HIV risk behaviour need many of the same types of HIV prevention treatment, care and support interventions as their older counterparts, they also require programmes tailored to their specific needs, including those related to age and psychosocial development.

Young men who have sex with other males may be unsure about their sexuality and not have anyone to talk to because of the stigma surrounding homosexuality and bisexuality. In many countries evidence is beginning to emerge that transgendered young people are the most discriminated against and hardest to reach.[22]

Young people who inject drugs are more likely than their older counterparts to be influenced by peers. They are less aware of the dangers of injecting drugs and of HIV, hepatitis B and C and how to reduce their risks. The younger the age, the less likely a person is to understand the consequences of his or her drug use. Early age of injecting drug use is often connected with polysubstance use. There is less access to appropriate,[23] confidential services for young injecting drug users than older users. Young injecting drug users (IDUs) often drop out of (or are expelled from) school, are often unskilled and experience economic instability. This may lead to crime and/or selling sex to obtain money for drugs. They may also lose contact with their families. A lack of money may also prevent them from seeking health care, as they may not be able to afford care or medication. Young IDUs have been found to engage in higher levels of use of non-sterile injecting equipment than older IDUs and they perceive less risk in doing so.[24] [25]

In some countries the involvement of young people in sex work is linked with criminal organizations and trafficking in children for the purpose of sexual exploitation. In many countries children and young women who sell sex on the street are the most vulnerable. Most children and young people who sell sex, whether on the street, in brothels, at truck stops or in bars, are subjected to violence by their clients and the police.

[21] It is estimated that less than one in 20 men who have sex with men have access to the HIV prevention, treatment and care services they need - UNAIDS (2006) Report on the global AIDS epidemic. UNAIDS, Geneva.

[22] Acceptance or societal rejection of transgender people is culturally constructed. In Thailand, for instance, transgendered people face less discrimination than men who identify as homosexual.

[23] Health services, treatment and counselling services are often designed for adults or hard-core drug users and the needs of young people, in the early phases of drug use who often do not consider themselves as dependent, are not catered for.

[24] UNAIDS and UNDCP (1999). Drug Abuse - HIV/AIDS: A devastating combination. UNAIDS, Geneva.

[25] UNODC and the Global Youth Network (2004) HIV prevention among young injecting drug users. UNODC, Vienna. http://www.unodc.org/pdf/youthnet/handbook_hiv_english.pdf

Girls involved in sexually exploitative situations are often tightly controlled by managers[26] and criminal gangs. Global research on girls and young women involved in sex work shows that many of them have suffered some form of sexual abuse (at home, by "friends" or by traffickers) and have low self esteem; in some countries the cultural practice of early marriage is also associated with involvement in sex work. Often recruitment into sex work or trafficking is through family, kin and community members. Recent studies provide evidence that children and young people trafficked into sex work are at increased risk of HIV infection.[27] Similarly, the younger the age of entry into sex work and the greater the number of movements from sex work establishments, the higher the risk of HIV infection.[28] At the time of selling sex, many will use alcohol and/or drugs at the request of clients or managers because of dependence, as self-medication or for recreational purposes. Studies suggest that sex workers who inject drugs may be even younger than those who do not.[29] Also linked with the young age of selling sex are high rates of other high-risk behaviours, for example non-use of condoms, which results in high reported rates of STIs. Both injecting drugs and unprotected sex contribute to high HIV prevalence rates.[30]

For all groups of most-at-risk young people, greater attention needs to be paid to legal and psychosocial support, access to alternative education opportunities and, for those under 18, child protection services.

Effectiveness of Interventions

There is sufficient evidence to show that many risk-reduction efforts do work among young people and merit strengthening.[31] [32] These include the following five interventions irrespective of the stage of the HIV epidemic:

- information on HIV prevention and treatment (in a form they can understand);
- condoms;
- harm-reduction services (if injecting drugs);[33]
- services for the prompt diagnosis and treatment of STIs;
- counselling and testing for HIV, with referral to HIV treatment, care and support services if HIV positive[34] and HIV-prevention counselling if HIV-negative.

Evidence shows that static services will also need to be complemented by outreach services, and separate services may be needed for young women and transgendered young people who inject drugs and exchange sex, as their needs are different from males. Also there is a strong body of evidence concerning the protective factors (such as family, school and community ties) which protect young people against HIV-risk behaviour.

Effectiveness is hindered by the lack of systematic attention to gender in designing programmes for most-at-risk young people. Most countries do not have accurate data on the population of young men and women,[35] nor do they maintain records by sex of young people's use of services.

Knowing your epidemic

In order to develop appropriate HIV interventions for young people, it is critical to "know your epidemic," as programme responses differ according to the stage of the epidemic.[36] Evidence-informed programming requires that data are available on the number of people living with HIV who are young people, how many are male and female, their particular characteristics and HIV risk behaviour. With this information available, interventions can be most effectively targeted towards most-at-risk young people:

- In ***all countries***, targeted interventions for young injecting drug users, young men who have sex with men, and young people involved in sex work and their clients should be in place.
- In ***low-prevalence countries,*** targeted interventions should be in place for young men and women who inject drugs and sell sex and for young men who have sex with males.
- In ***concentrated epidemics,*** targeted interventions for young injecting drug users, men who have sex with men and young people involved in sex work should be in place, as well as targeted interventions for their sexual partners and other country-specific vulnerable groups.
- In ***generalised epidemics,*** targeted interventions should follow those needed for concentrated epidemics, including age- and gender-appropriate HIV information, skills and services for all young people.

Data on HIV and age may not be routinely disaggregated, and international commitments only call for data on the age group 15 to 24,[37] with the result that data for 10 to 14 years are often missing.[38]

[26] These are colloquially referred to as "pimps": however, the preferred terms are "controllers" or "managers."

[27] See Silverman reference in reference section.

[28] Gray, J. A., Dore, G. J., Li, Y., Supawitkul, S., Effler, P. and Kaldor J.M. (1997) "HIV-1 infection among female commercial sex workers in rural Thailand," AIDS, Vol.11:89-94. - article demonstrates that 14 to 19 year old girls and those from the ethnic minority Hill tribes had higher rates of HIV than the older cohorts.

[29] Platt, L., Rhodes, T., Lowndes, C.M., Madden, P., Sarang, A., Mikhailova, L., Renton, A., Pevzner, Y., Sullivan, K. and Khutorskoy, M. (2005) "The impact of gender and sex work on sexual and injecting risk behaviours and their association with HIV positivity among injecting drug users in an HIV epidemic in Togliatti City, Russian Federation." Sexually Transmitted Diseases, Vol. 32, No. 10, 605-612.

[30] Gray, J. A., Dore, G. J., Li, Y., Supawitkul, S., Effler, P. and Kaldor J.M. (1997) "HIV-1 infection among female commercial sex workers in rural Thailand," AIDS, Vol.11:89-94

[31] UNAIDS (1998) Expanding the Global Response to HIV/AIDS through Focused Action: Reducing Risk and Vulnerability: Definitions, Rationale and Pathways. UNAIDS, Geneva.

[32] WHO (2006) Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries. Eds. Ross, D., Dick, B., and Ferguson, J. WHO and Inter-Agency Task Team (IATT) on HIV and Young People, Geneva.

[33] Harm reduction comprises of three principles: i. reaching out to injecting drug users; ii. discouraging the use of non-sterile injecting equipment and providing sterile equipment and disinfectant materials; and iii. making substitution treatment available.

[34] The evidence base for the effectiveness of these interventions among young people has been established by WHO (2006) Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries. Eds. Ross, D., Dick, B., and Ferguson, J. WHO and Inter-Agency Task Team (IATT) on HIV and Young People, WHO, Geneva. See also IATT on HIV and Young People (2008) Global Guidance Brief on HIV interventions for Young People in the Health Sector.

[35] It is estimated that in any one country about one-quarter of the total population is between 10 and 24 years, but in some countries this can be much higher.

[36] Guidance is provided on the measures that need to be in place based on the stage of the epidemic - UNAIDS (2007) Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access. UNAIDS, Geneva.

[37] Almost two thirds of countries studied by UNAIDS had insufficient or no data on HIV prevalence and/or sexual behaviour trends among young people, including several countries with exceptionally high HIV prevalence in southern Africa - UNAIDS (2007) AIDS epidemic update: Briefing Booklet. UNAIDS, Geneva.

[38] UNGASS (2007) Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators: 2008 reporting requires governments to disaggregate data for young people under 25 years from data for adults age 25 and over. Some indicators for most-at-risk populations request data for youth age 15 to 19 years and 20 to 24 years.

A Human-Rights Approach

A human-rights approach is fundamental for effective and sustainable national responses to HIV prevention among most-at-risk young people and those living with HIV. They have the same rights as other adolescents and young people to:

1) Information, confidential counselling and education
2) Privacy so that their personal behaviour, HIV status and health records are not disclosed to anyone without their explicit consent
3) HIV protection for themselves, their families and their sexual partners by taking necessary precautions, such as using sterile injection equipment or male/female condoms.[39] A rights-based approach contains measures to reduce stigma and discrimination against most-at-risk young people, as this clearly affects their access to information and services as well as their ability to participate meaningfully in their care.[40]

However, providing HIV interventions for adolescents below age 18 can be problematic. The Convention on the Rights of the Child (CRC) implicitly acknowledges the evolving capacity of adolescents to make decisions for themselves based on their competency to consent to medical treatment.[41] However, the law dealing with this varies and some countries designate specific ages (ranging from 10 to 18) at which an adolescent is judged to have capacity.[42] In some places not all key stakeholders are familiar with the CRC[43] or with national legislation relating to risk behaviours (drug injection, male same sex relations or sex work), and health care providers may not be familiar with the legal situation regarding performing medical interventions on young people below the legal age of majority.

For any medical intervention, such as an HIV test, informed consent should be obtained. The information should be provided in an easily understood format and be relevant to their age and life circumstances. The provision of information should not end with the intervention but continue to ensure that the adolescent can deal appropriately with the outcome (to avoid becoming infected, begin treatment and avoid infecting others). Informed consent is thus inextricably linked with counselling, and an assessment of "best interests" should be made in pre-test counselling to determine whether it is in the best interests of the adolescent to access services without parental consent.[44]

Issues of child protection arise where adolescents under 18 are in situations of sexual exploitation and abuse. They need to access HIV prevention interventions as well as child protection services and to be removed from the exploitative situation.

[39] UNDP (2006) Positive people know your universal human rights. UNDP HIV/AIDS Regional Programme in the Arab States. http://www.harpas.org

[40] An index to measure stigma towards PLHIV has been developed and can be adapted for use with young PLHIV. International Planned Parenthood (IPPF), GNP+, ICW and UNAIDS (2008) The People Living with HIV Stigma Index User Guide. IPPF, London.

[41] United Nations (1989) Convention of the Rights of the Child CRC Article 5. UN, New York.

[42] The concept of the "mature minor" standard is adopted by the Court if he or she has sufficient understanding and intelligence to understand fully what is proposed.

[43] The WHO training course on Child Rights is intended to provide detailed guidance for training on child rights, WHO (2002) Child Rights Capacity Building Training Course: Facilitator Guide. WHO, Geneva.

[44] WHO (2005) Increasing access to HIV counselling and testing for adolescents: Consent and confidentiality. WHO, Geneva.

Key Interventions

Behaviour change communication (BCC) for most-at-risk young people should promote individual behaviour change such as the use of condoms, use of sterile injection equipment and reduction in number of sexual partners. The intervention needs to be based on sex, age and level of biological and social maturity. For those below the legal age of majority, issues of parental consent will need to be considered. BCC should also promote positive behaviours associated with treatment, care and support, including adherence to antiretroviral therapy and the diagnosis and treatment of sexually transmitted infections (STIs).

Advocacy to raise awareness of the situation of most-at-risk young people and to stimulate increased investments from decision makers on their behalf is also called for. BCC can be effective in promoting broader societal change using advocacy, social and community mobilisation,[45] especially to inform young people about the dangers of trafficking in children for the purpose of sexual exploitation, the unacceptability of gender-based violence and harm associated with injecting drugs.

Participation of young males and females engaging in HIV risk behaviours in the planning of services and decision-making about HIV interventions is critical. They should also be involved in the implementation and monitoring of national and sub-national policies and programmes. National AIDS authorities should include representatives of NGOs working with most-at-risk young people.

Risk-reduction skills are important for most-at-risk adolescents and youth to help them negotiate condom use, develop strategies for refusing unprotected sex and avoid clients who are alcohol/drug affected and potentially violent. In areas, for example, where injecting drug use is the main driver of the epidemic, a risk-reduction intervention might focus on safer injecting practices as well as skills for safer sexual practices.

Mass media can also be effective in reaching stigmatised young people who are not part of formal organizations, and youth involvement and peer-based media programmes are effective when properly conducted.[46] The Internet is becoming increasingly popular among young men who have sex with men (MSM) as a means of contacting other MSM and accessing information about health, HIV and legal services. The Internet is also being used extensively to provide information on substance use issues among young people.[47] The results of these interventions have yet to be evaluated.

[45] Family Health International (2005) Strategic Behavioural Communication. FHI, Arlington.

[46] WHO (2006) Preventing HIV in Young People: A Systematic Review of the Evidence from Developing Countries. Eds. Ross, D., Dick, B., and Ferguson, J. WHO and Inter-Agency Task Team (IATT) on HIV and Young People, Geneva.

[47] Global Youth Network - Using the Internet for Drug Abuse Prevention http://www.unodc.org/youthnet/youthnet_action_good_practice_net_for_dap.html.

Peer education is an effective mechanism for increasing most-at-risk young people's knowledge and skills about HIV and STIs and contributes to enabling them to be responsible and protect themselves and others from HIV.[48] [49] It should be conducted by well-trained and motivated people working with peers (similar to themselves in age, gender, background or interests) over a period of time. Trained peer educators who are themselves young injecting drugs users (or ex-users), men who have sex with men and sex workers are able to provide age, gender and culturally appropriate risk-reduction information to their peers. This is more likely to result in behaviour change, and outreach peer educators[50] have been critical to the success of programmes by mobilising their communities or social networks.

Outreach strategies are essential when working with out-of-school adolescents and youth who engage in HIV-risk behaviours, as they are not likely to seek help on their own and may not be covered by existing health or information services. Outreach aims to take information, commodities, education and services to them in their own milieu, rather than waiting for them to consult static services.[51] [52] The most effective outreach programmes create strong partnerships with community-based organizations[53] and utilize peer educators and counsellors. Outreach can also play a critical role in referring most-at-risk young people to static services.[54]

HIV Services For Most-at-Risk Young People

Young people engaging in HIV risk behaviours are often unable to access the prevention and treatment services they need, especially if they are minors. Services designed for young people (such as youth-friendly health services)[55] [56] need to be adapted to meet the needs of most-at-risk young people to ensure they are appropriate to their age, sex, level of maturity and legal status and configured around their risk behaviour and vulnerability to HIV infection.

Staff providing harm-reduction services for adult injecting drug users and health workers in STI and HIV testing and counselling services will need training in how to work with adolescents.[57] Health care providers who have been trained in adolescent or youth-friendly approaches may need further training to work with young people who

Partnerships and Multi-Sectoral Approaches

To address the challenges in working with most-at-risk young people, a broad range of adult-youth, governmental, civil society, private-sector and community partnerships need to be established. These should include staff from health, legal and social services, caregivers, schools, faith-based and youth organizations, other authorities and communities. Such partnerships should address issues of stigma and discrimination towards most-at-risk young people and those living with HIV. Community development work with families and community leaders is also necessary to enable most-at-risk young people to live in/or return to their home communities. Support networks of young people living with and affected by HIV should be developed as well as capacity building in organizations working with young people engaging in HIV-risk behaviours.[59]

An example of a global partnership against child prostitution in the tourism industry has been promoted by the World Tourism Organization's multi-stakeholder initiative. Tourist industry associations have endorsed the global statement and adopted their own statements or codes to address the issue.[60]

Monitoring and Evaluation

Data need to be disaggregated by age, gender, diversity, HIV risk behaviour and use of services to show whether interventions directed towards most-at-risk young people are reaching them.[61] A framework has been developed for use with most-at-risk populations[62] and can be adapted to the age-specific situation of most-at-risk young people. Health service coverage indicators for most-at-risk young people have also been developed to assist programme managers.[63]

Actions for UN Country Teams and UN Theme Groups on HIV/AIDS

- Review the national HIV and AIDS Strategy and Plan of Action to assess the extent that interventions are supported for reducing HIV-risk behaviours in adolescents and young people. Where gaps exist, advocate for national HIV/AIDS programmes to integrate most-at-risk young people into a costed national HIV and AIDS