Adolescents Most-at-risk to HIV: Still an unaddressed group
What we know and what needs to be done?

INFORMATION RESOURCE PACKAGE

Centre for Adolescent Health and Development (CoAHD)
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Conceptualised and Authored by
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Adolescents neglected in HIV response

Adolescents aged 10–19 years constitute nearly one-fifth of the world’s population\(^1\), and they are among those most affected by HIV. While major advances have been made in almost every area of the response to HIV, progress for adolescents is far behind. Adolescents are one of the critical population groups that are under-represented and most neglected. The global response to increasing adolescent HIV infections and AIDS deaths is intensifying. More recently, the United Nations General Assembly High-Level Meeting (HLM) on Ending AIDS (June, 2016) have called the governments and organisations of different countries to focus their HIV response towards reducing the disproportionate and heightened vulnerability of adolescents most-at-risk from HIV especially adolescent girls.

Beyond 2015: global targets and commitments for ending HIV in adolescents

In response to the growing HIV epidemic among adolescents, UNAIDS has set new Fast-Track Targets to be achieved by 2020 for adolescents that include reducing new HIV infections by at least 75%, reducing AIDS-related deaths by 65% and achieving zero discrimination. Achieving the targets would put the world on track towards ending adolescent AIDS by 2030 and ending the global AIDS epidemic as a public health threat. UNAIDS 2016-2021 strategy provides a roadmap to end AIDS by 2030, by ensuring healthy lives for all (SDG 3), fully committing to the principles of equality (SDGs 5 and 10) and inclusion (SDG 16) that are essential to leaving no one behind. The report emphasizes that HIV response can only be fast tracked if it addresses people who are left behind- i.e. most affected adolescents.

The earlier Alliance Centre for Adolescent Health and HIV (2015) and now the more encompassing Centre for Adolescent Health and Development (CoAHD) at MAMTA-HIMC, has been established with the prime aim of strengthening adolescent health and HIV programme and policy response in Low and Middle Income Countries (LMIC). The CoAHD aims to support implementation research directed towards policies and programmes for adolescent health, with a focus on India and South/South East Asia and regions in Africa. Key thematic areas to be covered are SRH/HIV, nutrition, NCDs, mental health, violence and injuries. The Adolescent health and HIV unit is spearheading the agenda of addressing SRH/HIV needs of adolescents who are most-at-risk from HIV in Asia and Africa regions. It endeavours to play a unique role in promoting health and development for adolescents and young people through strengthening partnerships and solutions in Low and Middle Income Countries (LMICs) with focus on South-South East Asia and Africa regions.

The Centre undertook a series of initiatives in 2015 to build knowledge, perspective and expertise on various issues related to adolescents most affected by HIV (including learning from the Linking Organisations (Los) - supported by International HIV/AIDS Alliance). The exercise conducted was to ensure that the Centre's work is informed by evidence, experience and ground-realities. To advance and share collective knowledge and learning from the last year, the need to develop an information resource package with consolidated and synthesised knowledge was felt. This Information Resource Package is intended to strengthen the CoAHD and wider network of International HIV/AIDS Alliance (including LOs) initiative in aligning, focusing and addressing the current programmes and policy gaps in HIV response for most-at-risk adolescents.

Information Resource Package

Objective

The aim of the information resource package is to advance understanding of existing evidence based programmes (effective strategies/approaches) and national HIV policies for most-at-risk adolescents and outline priorities for future action in regions of Asia and Africa.

Methodology

The information resource package was developed by conducting desk research and synthesizing information and data from primary and secondary sources. These include: technical meetings with global experts (2015), survey with linking organizations (LOs), systematic review of programmes and policies for adolescents in S and SE Asia and Africa, consultation with adolescent key population networks (2015) in India.

Scope and limitation of Information Resource Package

- This IRP provides a succinct overview (may not be all inclusive) of existing epidemiological evidence, policy and programmes (including) for most-at-risk adolescents to HIV in regions of Asia and Africa.
- The IRP focuses on adolescent most-at-risk groups – namely SWs, MSMs, TGs and PWID’s, and therefore information on certain groups like adolescent prisoners migrant and street children is limited.
- There is limited information on adolescents who are at risk to HIV in terms of data (epidemiological evidence, programmes, and policies). Therefore this package contains information for adolescents and also for young people most-at-risk to HIV.

Structure: The information resource package comprises of

Section 1: Overview of the global and regional HIV burden of HIV on adolescents

Section 2.1: Current Progress: Policy and Legal Environment

Section 2.2: Evidence based/promising programmes for adolescents most affected by HIV

Section 3: Case Studies from different countries

Section 4: Priorities for future action for most-at-risk adolescents
Adolescent AIDS-related deaths on the rise

Globally, adolescents (10-19 years) comprise of 17 per cent of the total world population (1.2 Billion). HIV continues to be a major public health concern among adolescents worldwide. AIDS-related illnesses are the second leading cause of death among adolescents globally and the leading cause of death among adolescents in Africa. While major advances have been made in almost every area of the response to HIV, progress for adolescents is far behind. This is the only age group where AIDS-related deaths are increasing. The recent Lancet Commission on Adolescent Health (2016) highlights that HIV contributes a greater proportion of disease burden in adolescents in 2013 than it did 13 years earlier. AIDS-related deaths among adolescents have tripled since 2000 while decreasing among all other age groups, which can be attributed largely to a generation of children infected with HIV perinatally, who grow into adolescence without access to life-saving interventions. In 2014, about 2.1 million adolescents between ages 10 and 19 were living with HIV worldwide.

Regional Burden/Disparities

Sub-Saharan Africa, particularly Southern Africa, remain the most heavily affected by the epidemic. The majority of adolescents/young people living with HIV are in low and middle-income countries, with 85% in sub-Saharan Africa. Of the 2.0 million adolescents living with HIV, about 1.6 million (82 per cent) live in sub-Saharan Africa. Outside sub-Saharan Africa, South Asia had the highest number of adolescents living with HIV (130,000), accounting for 6% of the global burden of HIV among adolescents. About half of adolescents (15-19) living with HIV are mostly in Africa. The New HIV infections among adolescents are not decreasing as quickly as they should. In 2013, an adolescent falling in the age group of 15 and 19 was newly infected with HIV every two minutes. Progress is also uneven across different regions; for example, the number of new HIV infections in adolescents has remained relatively stable in Asia and the Pacific since 2005, while they have decreased in eastern and southern Africa.

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Adolescents most-at-risk from HIV are the most marginalized

Girls disproportionately affected by HIV particularly in Sub-Saharan Africa

Adolescent girls and young women in most of the regions make up majority of new HIV infections. According to the latest UNAIDS data, adolescent girls and young women aged 15–24 years are at particularly high risk of HIV infection, accounting for 20% of new HIV infections among adults globally in 2015\(^4\). In comparison, adolescent boys and young men account for an estimated 14 per cent of new HIV infections worldwide. In geographical areas with higher HIV prevalence, the gender imbalance is more pronounced. The gender gap in HIV is highest in sub-Saharan Africa where twice the number of adolescent girls and young women account for new HIV infections (25%) compared to adolescent boys and men (12 %) (2016).

Adolescents and young people belonging to key populations account for 95 % of new infections in Asia.

According to the report of the Commission on AIDS in Asia\(^5\), nearly all new infections (95%) among adolescents in Asia are found in key populations (PWID, MSM and SWs). Although there is a lack of global data pertaining to estimates of adolescent and young key populations, their HIV prevalence, the epidemic results from selected studies indicate that adolescents and young people (15-24 years) who are part of key populations are disproportionately infected by HIV than the general population. Among young MSM, HIV incidence was very high across multiple countries, and global reports estimate an HIV prevalence of 4.2% for young gay men under the age of 25 compared to 3.7%\(^6\) among all MSM. HIV prevalence among young people who inject drugs worldwide was 5.2%\(^7\).

\(^4\) UNAIDS 2016 Estimates  
This section presents overall learning from various HIV related interventions that have been proven to be effective/promising mostly from low and middle income countries (LMICs), focusing on regions of South and South East Asia and Africa.

National Strategic plans for HIV: Reaching out to adolescents and young populations

There is an acknowledgment across many countries of the importance of creating adolescent-specific HIV policies and youth-friendly services in their strategic plans as reflected in table 1.

<table>
<thead>
<tr>
<th>Countries</th>
<th>National HIV Strategic Plans (NSP) / other policies for selected countries</th>
</tr>
</thead>
</table>
| South Africa    | • NSP for HIV and AIDS emphasized on prevention, treatment, care, and support components targeting adolescents.  
                  • Primary HIV prevention for adolescents is a priority.           |
| Kenya           | • The national HIV prevention program includes adolescents in 15-24 years and HIV education is part of the national school curriculum. |
| Uganda          | • NSP (HIV/AIDS) emphasize on improving HIV care/treatment, no specific section for adolescents. |
| Burundi         | • National Guideline HIV/AIDS including key populations                  |
| India           | • NACP IV Targeted intervention (MSMs, FSWs, IDUs) including young populations.  
                  • Adolescent Education Programme implemented in schools (HIV education). |
| Pakistan        | • NACP – specific strategy for young people.                             |
| Bangladesh      | • National HIV/AIDS strategic plan for age and gender-specific services for most at-risk adolescents. |

Sources: National HIV Strategic Plans for various countries

Most-at-risk adolescents and young people belonging to key populations are unaddressed in national strategic plans (HIV) of many countries. Only few countries include national strategic plans affecting young people belonging to the key populations. Selected examples include:

Pakistan: Has specific HIV prevention strategies for young people that include distinction of young people as ‘high risk’, ‘vulnerable’ (e.g. street children/young migrants etc.) and ‘low/no risk’.

HIV Testing and Counselling (HTC) related policies

**Global Guidelines:** WHO recommends that HTC services need to consider best interest of the child.

According to the latest WHO guidelines HIV testing and counselling should be accessible to all adolescents, including key populations, and be linked to prevention, treatment and care. For those under 18 years of age, testing and counselling services need to consider the best interests of the child as well as appropriate and safe referrals to child protection services when children have been abused and are at risk of abuse. The LinkUp tools on “Safeguarding the rights of children and young people” can be served as a useful resource for assessing capacity for decision making and child protection.

**Age of consent to HTC services**

The age of consent for HIV testing in many countries in sub-Saharan Africa (at least 14) and south Asia (India, Pakistan, and Philippines etc.) is 18 years and above. Age restrictions and parental consent requirements impede access to HIV services, including testing for HIV and other STIs, condoms and contraception services. The two very extensive reports by WHO (2013) and UNESCO (2013) provides comprehensive information on HIV testing policies in Asia and Africa.

**Exceptions for HIV Testing: Below 18 years**

Around 20 countries in sub-Saharan Africa and few countries in Asia had exceptions in their national laws and enacted policies/guidance recognizing the capacity of adolescents to consent to HIV testing without parental consent after they reach a prescribed age. These conditions (also demonstrated in table 2) include:

- Mature behaviour (discretion on HCP)
- Symptomatic adolescents
- Most at-risk adolescents
- Abandoned children
- Young commercial SWs
- Street children

<table>
<thead>
<tr>
<th>Conditions for HIV testing below 18 years</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shows maturity and understanding - HCP discretion 10 countries</td>
<td>Swaziland (16), South Africa (12) Uganda (12), Ghana (18, but exception is limited to 15 years)</td>
</tr>
<tr>
<td>At risk of contracting HIV (e.g. sexually active) 7 countries</td>
<td>Zambia (16), Ethiopia (15), Malawi (13) Kenya (no age limit)</td>
</tr>
<tr>
<td>Symptomatic</td>
<td>Swaziland (16), Liberia (14), Kenya (no age limit)</td>
</tr>
<tr>
<td>Commercial sex workers - 3 countries</td>
<td>Zambia (16), Ethiopia (15), Liberia (14)</td>
</tr>
<tr>
<td>Street children 2 countries</td>
<td>Ethiopia (15), Liberia (14)</td>
</tr>
<tr>
<td>Child assessed mature by a counsellor</td>
<td>Nepal (14), Vietnam (16)</td>
</tr>
</tbody>
</table>


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8 http://www.aidsalliance.org/assets/000/001/094/LinkUp_safeguarding_manual_original.pdf?1417450674
8 Young people and the law in the Asia and the Pacific- A review of laws and policies- UNESCO, 2013.
Punitive laws hindering HIV Response: Criminalization of conduct of adolescents

Countries across Asia (India, Bangladesh, Bhutan, Malaysia, Myanmar, and Pakistan) and Africa criminalize same-sex relations, some aspect of sex work, and drug use. Adolescents and young people from key populations (MSM, TGs, PWIDs, and SWs) fear arrest (as shared by one participant in network consultation), prosecution and detention due to punitive laws that criminalize their conduct. Such laws are barriers to accessing HIV services and can increase stigma and violence towards young people.

Protective laws/policies (Positive Policy environment)

Introduction or removal of punitive laws that are protective of the human rights of key populations has been highly challenging in many countries. In a few countries progressive change has been achieved11:

- **Nepal**: The new constitution (September 2015) provides explicit protections for LGBT people. E.g. sexual and gender minorities have rights to benefit from State services.
- **India**: Supreme Court of India recognized transgender as a third gender and directed government to formulate special health and welfare programmes to support their needs.
- **Fiji**: Decriminalization of sex between men (2010)

Emerging Legal/Policy Gaps: Some of the legal/policy gaps that emerged across countries include

1. Lack of legal provisions/policy guidelines regarding HIV testing of unaccompanied minors or without a parent/guardian, and orphans and minors in institutional settings, street children.
2. Lack of specific action (national strategic plan) for addressing HIV among adolescent populations belonging to high risk groups/key populations in many countries.
3. In countries where adolescents can access HTC services without parental consent face many challenges including:
   - Adolescent specific counselling is not available (HTC) (e.g. Zimbabwe)
   - Quality of counselling is an issue, along with issues of privacy, confidentiality
   - Lack of awareness among HCP regarding HIV testing services (age at consent) for adolescents (e.g. Nigeria)

## Section 2.2
### Learning from Evidence Based HIV Prevention Interventions

This section presents overall learning from various HIV related interventions that have been proven to be effective and promising for most-at-risk adolescents, mostly from LMICs. These interventions are presented in detail in table 3 below.

### Peer-based Interventions

Many of the interventions that were reviewed used peer-based approach for most-at-risk populations in countries across Asia and Africa. The influence of peers was a critical factor in both condom use and dissemination of information, and increased knowledge.

**Key Strategies:** Peer mobilization, education and counselling, outreach

**Target Populations:** MSM, SWs, TGs

**Age Group:** 15-24 years (many interventions)

**Examples:** Linkup programme (Myanmar-ref 18), Avahan (India-ref 15), RoLi (Philippines-ref 17), SHARPER (Ghana-ref 5)

**Key Learning:**
- Peers are in a unique position to reach vulnerable adolescents, build education for HIV, promote condom use, provide social support (self-confidence/esteem etc.)
- Peer educators are most effective when involved in development of HIV prevention messages as they are more likely to communicate to peers.

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<tr>
<th>Internet/mobile based outreach programmes</th>
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Mobile and internet based interventions are promising approaches to engage with hidden and stigmatized populations especially MSMs and TGs in LMICs. They have gained immense popularity in Asian and African countries and have shown to be effective in increasing HIV testing, counselling and knowledge among MSMs and TGs.

**Key Strategies:** Chat rooms, messages, social media (Facebook, Twitter, Instagram).

**Target Population:** MSM, TGs

**Age Group:** 13-26

**Examples:** Put in Mouth (US-ref 9), Mass media-based intervention (Thailand- ref 20), SHARPER project (Ghana-ref 5)

**Key Learning:**
- Most effective in reaching adolescents that are most-at-risk and difficult to reach (MSM, TGs).
- Less evidence on impact of these programmes on long term behavioural /health outcomes.
Community Empowerment Interventions
Community empowerment based interventions for sex workers and adolescent girls in particular have shown improved HIV outcomes (increase in condom use, reduced HIV) and other health challenges, particularly violence.

**Key Strategies:** Communication, relationship and decision-making skills (HIV, gender, violence).

**Target Populations:** SWs, Adolescent girls

**Age Group:** 15-24

**Examples:** Avahan (India-ref 15), MLMC (India-Ref 13) SHARE (Uganda-ref 29), Stepping Stone (South Africa-ref 8).

**Key Learning**
- Community empowerment interventions towards changing attitudes and social norms; and behaviours related to violence and sexual coercion show a positive response.
- Combination of approaches: community level empowerment along with standardized protocol of HIV service package works better.

Sensitizing Health Care Providers for Respectable Care and Reducing Stigma
Interventions that sensitize and build skills of health care providers (HCP) in the provision of non-judgmental, non-stigmatizing counselling and confidential care can result in better uptake of HIV services. HCP may not have sufficient skills, competence or knowledge to deal with the specific health and social needs of these populations.

**Key strategies:** Participatory group training, outreach services.

**Target Populations:** Health Care Providers, MSMs, FSWs

**Age Group:** 18-24

**Examples:** Link Up (Bangladesh-ref 16); SHIPS project (Nigeria-ref 28)

**Key Learning**
- Participatory stigma training methods with collective reflection with HCPs can be an effective approach for stigma reduction among providers.
- Integrated intervention with health care providers and peer outreach works better in increasing HIV testing uptake among adolescents.

Existing Gaps that have emerged in Adolescent Health Interventions for Most-at-Risk Adolescents
- Limited evidence based interventions targeted towards most-at-risk adolescents especially for very young adolescents (10-14).
- Interventions for street children, young transgender were scarce.
- Limited interventions and evaluations targeting behaviour change stigma and violence for most-at-risk adolescents.
<table>
<thead>
<tr>
<th>S. No</th>
<th>Interventions</th>
<th>Key strategies</th>
<th>Age</th>
<th>Country</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PWIDs</strong></td>
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<tr>
<td>1.</td>
<td>Clinic based HIV intervention using - Pre-exposure prophylaxis (PREP) Intervention.</td>
<td>Clinic based HIV counselling and testing, methadone treatment</td>
<td>20</td>
<td>Bangkok</td>
<td>Reduction in HIV incidence</td>
</tr>
<tr>
<td>2.</td>
<td>Incentives based programme (vouchers/coupons)</td>
<td>Incentives based programme (vouchers/coupons)</td>
<td>18</td>
<td>Albania</td>
<td>Improved uptake of harm-reduction services (needle and syringe programme), HIV and hepatitis testing. Voucher incentives seemed less effective for changing certain behaviours such as returning used needles.</td>
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<td><strong>MSMs</strong></td>
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<tr>
<td>1.</td>
<td>Integrated peer outreach and clinic based intervention (Link-Up)</td>
<td>Outreach by Peer Educators Clinic-based service package (included HIV counselling and testing, psychosocial support)</td>
<td>18-24</td>
<td>Myanmar</td>
<td>Increased uptake of HIV testing and counselling and sexual health services</td>
</tr>
<tr>
<td>2.</td>
<td>Group-level and community level interventions</td>
<td>Peer based approach to access counselling, education and support Formation of support groups</td>
<td>15-24</td>
<td>Costa Rica</td>
<td>Increase in self-reported condom use by adolescents Impact on reported risk behaviour among MSM</td>
</tr>
<tr>
<td>3.</td>
<td>Community-level M-powerment program</td>
<td>Personal empowerment, peer influence and community outreach</td>
<td>18-27</td>
<td>United States</td>
<td>Self-reported HIV sexual risk reduction</td>
</tr>
<tr>
<td>4.</td>
<td>Mass media/Internet facilitated HIV prevention intervention</td>
<td>Instant messaging, chat rooms, mobile phones coordinated through peers</td>
<td>18-24</td>
<td>Thailand</td>
<td>Significant outreach to young MSM Increase Voluntary Counselling and Testing uptake</td>
</tr>
<tr>
<td>5.</td>
<td>Put in Mouth</td>
<td>Use of Social Media outlets (Facebook, Twitter, Integral)</td>
<td>13-26</td>
<td>US, Baltimore</td>
<td>Decreased stigma - Made testing &quot;sexy&quot; Increased awareness about testing, linked to care</td>
</tr>
<tr>
<td>S. No</td>
<td>Interventions</td>
<td>Key strategies</td>
<td>Age</td>
<td>Country</td>
<td>Outcomes</td>
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<tr>
<td>SWs</td>
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<tr>
<td>1.</td>
<td>Community HIV prevention intervention (female sex workers- FSWs)</td>
<td>Mobile teams provided user-friendly STI services for FSWs</td>
<td>20-29</td>
<td>Vietnam</td>
<td>Decline in the prevalence of STIs Reduction in gonorrhoea (GC) and/or Chlamydia trachomatis</td>
</tr>
<tr>
<td>2.</td>
<td>Community mobilization interventions</td>
<td>Risk reduction counselling/condom promotion through peers</td>
<td>20</td>
<td>Ethiopia</td>
<td>Increasing self-reported condom use</td>
</tr>
<tr>
<td>3.</td>
<td>Kenya AIDS NGO Consortium (KANCO)</td>
<td>Peer educators outreach and referral</td>
<td>18</td>
<td>Kenya</td>
<td>Increased uptake of HCT services among SWs</td>
</tr>
<tr>
<td>4.</td>
<td>River of Life initiative (Men who sell sex)</td>
<td>Peer to peer outreach, workshops</td>
<td>13-17</td>
<td>Philippines</td>
<td>Increased awareness and access to HIV services</td>
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<td>High Risk Groups</td>
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<tr>
<td>1.</td>
<td>Strengthening HIV/AIDS Response Partnership with Evidenced-Based Results (SHARPER) (F/MSWs and MSM), FHI, 360</td>
<td>Peer-to-peer outreach Social media, social networks, cell phone-based counselling and health messaging</td>
<td>15-24</td>
<td>Ghana</td>
<td>Improved knowledge and access to HIV services in adolescents Many MSM reached by this approach were never reached before by any intervention</td>
</tr>
<tr>
<td>2.</td>
<td>Reducing provider held stigma and improving young client satisfaction (Link Up)</td>
<td>Participatory, small-group trainings and sensitizations of health care providers (HCP)</td>
<td>15-24</td>
<td>Bangladesh</td>
<td>HCP became more self-aware Fear and value-based stigma (FSWs, MSMs) reduced clients’ perception and self-delivery improved</td>
</tr>
<tr>
<td>3.</td>
<td>Clinic based youth services MSMS and Tgs:</td>
<td>The clinics provided a youth friendly space for</td>
<td>20</td>
<td>Thailand</td>
<td>Change in sexual behaviours</td>
</tr>
<tr>
<td>4.</td>
<td>Peer Based Intervention</td>
<td>Peer based outreach service, and counselling</td>
<td>22-36</td>
<td>Nigeria</td>
<td>Increase in HIV testing</td>
</tr>
<tr>
<td>5.</td>
<td>Avahan Intervention</td>
<td>Peer education program, STI clinics, condom provision from peer educators</td>
<td>25</td>
<td>India</td>
<td>Increase in consistent condom use Decline in STI prevalence (Syphilis)</td>
</tr>
<tr>
<td>S. No</td>
<td>Interventions</td>
<td>Key strategies</td>
<td>Age</td>
<td>Country</td>
<td>Outcomes</td>
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<tr>
<td>1.</td>
<td>Stepping Stones</td>
<td>Participatory learning approaches to build knowledge, risk awareness, communication and relationship skills (gender, violence, HIV)</td>
<td>15-24</td>
<td>South Africa</td>
<td>Impact on risk factors for HIV (men reported less violence, less drug misuse, drinking)</td>
</tr>
<tr>
<td>2.</td>
<td>Safe Homes and Respect for Everyone (SHARE)</td>
<td>Community-level mobilization Standard of care HIV services (HIV screening and safe HIV disclosure and risk reduction)</td>
<td>15-49</td>
<td>Uganda</td>
<td>Significant increase in HIV disclosure and condom use Reduction in forced sex, HIV</td>
</tr>
<tr>
<td>3.</td>
<td>Meri Life Meri Choice (MLMC)</td>
<td>Safe Space, Life Skills Education, Financial literacy and sessions on GBV</td>
<td>10-19</td>
<td>India</td>
<td>Increased awareness of HIV/ SRH issues, uptake of condoms, testing and reduce GBV</td>
</tr>
<tr>
<td>5.</td>
<td>MEMA Kwa Vijana</td>
<td>School-based, teacher-led lessons Youth-friendly services, Peer led approach</td>
<td>10-19</td>
<td>Tanzania</td>
<td>Significant, sustained and positive impact on SRH/HIV knowledge</td>
</tr>
<tr>
<td>6.</td>
<td>Cash Transfer Programme</td>
<td>Conditional Cash Transfer</td>
<td>13-22</td>
<td>Malawi</td>
<td>Decreased prevalence of HIV&amp;HSV-2 infection in girls Reduced unintended pregnancies</td>
</tr>
<tr>
<td>7.</td>
<td>Family life and HIV Education</td>
<td>Comprehensive sexuality education in social science, extra-curricular activity in schools</td>
<td>10-18</td>
<td>Nigeria</td>
<td>Improved knowledge about HIV/SRH issues, improved gender equity attitudes</td>
</tr>
</tbody>
</table>
This section presents case studies from countries that have demonstrated good practices in addressing needs of most-at-risk adolescents and young key populations at policy, programmes and health system levels. Case studies are included from a) Programmes (experience of Linking organisations in implementing youth driven peer-led approach, b) Brazil (Policy), c) Programme using safe space approach with adolescent girls (India), d) Scale-up of adolescent HIV/SRH intervention at a national level (Mozambique), e) M-health- an emerging solution for health interventions among young people (Kenya).

A: Peer-led Approach and Youth Leadership/Participation

Background
Linking organizations (supported by International HIV AIDS Alliance) distinctively work with adolescents and young people most affected by HIV (MSM, TG, SWs, and IDUs, adolescent girls ) in regions of Asia, Africa, Latin America and Eastern Europe. Most linking organizations (who were surveyed) identified empowering adolescent and young people through community mobilization and peer-led interventions as a most effective strategy in working with adolescents. Some of the examples include Uganda, Nigeria and Ethiopia.

Key Approach
Peer-led approach used in interventions by LOs have proved to play a significant role in relaying services to their peers including outreach activities, condom distribution, referral for counselling and linking with health services , particularly those who are most-at-risk of HIV. “The Peer Education and Outreach is a key approach that has shown efficiency in imparting HIV prevention messages and persuading young people to access HIV services. Young people often prefer to listen to their peers more than adults.” - as said by one of the member Los.

Youth leadership and participation has also been integral to the programme design and implementation. This had a great impact in ensuring that the programme is reflective of young people’s needs, rights and aspirations. One of the member LOs shared:

“Youth leadership and participation is high in our programmes. We put young key affected populations at the centre of the project activities. This increases the likelihood of programmes being tailored to respond to young people’s needs and also empowers them to challenge their marginalized status.”

Key Messages/Learning

- LO’s programme in many countries was able to reach highly vulnerable and most marginalized groups through peer-led approach (e.g. adolescents living on the streets, adolescent migrants).
- Peers have better access to most-at-risk young people and understand their reality and language better
- Building communication skills for safe sex negotiation is a challenge and critical area faced by peer educators.
- Peer educators (who work with MSM, SWs, TGs) also require safety measures for their physical and legal security.
B: Brazil’s Policy to Protect Health and Human Rights of LGBT Community

Background
The government of Brazil has undertaken series of rights-based legal and policy initiatives to prevent violence and discrimination against LGBT people and promote their social inclusion in school and health policies.

Key initiatives undertaken to protect human rights of LGBT people:

- Legalized same-sex marriages.
- National media campaign undertaken to promote citizenship rights of homosexuals and diversity of sexualities.
- Set up a national system and public policies to prevent violence against LGBT and punish perpetrators.
- National Health policy for LGBT on comprehensive Health assistance set up to provide training for health care workers to eliminate discrimination of gay men and other MSM.
- Made sex education mandatory in schools. Education of school teachers, school managers, staff, on issues related to gender equality and sexual diversity undertaken.

Key Messages/ and Learning

- HIV prevention policies were grounded in rights based approach to sexuality (Respect for Sexual Diversity).
- Campaigns encouraged condom use as safe and ‘sexy’ choice rather than “abstinence and self-control’.
- Concerted efforts undertaken by civil society and government to reduce homophobia and vulnerability of MSMs.

C: Addressing Adolescent Vulnerability to HIV in India through Safe Space Approach

Background
Adolescent girls face several vulnerabilities to HIV in India. Few interventions have focused on HIV/SRH services for the adolescent girls, and also brought adolescent boys and young men into the programme. In light of this, MAMTA implemented Meri Life Meri Choice project (MLMC) funded by EJAF with both married and unmarried adolescent girls (10-14 and 15-19 years) and unmarried and married boys and men (brothers- 10-19, and husband- 15-29) in rural areas of North India.

Key Approach
The intervention used safe-space approach along with peer education and established Gender Resource Centres that offered a safe space for girls (and boys) to network with peers. Adolescent girls and boys acquired knowledge on HIV/SRH issues, gender based violence, developed life skills and financial literacy skills, and were linked with vocational training programmes.

Key Messages/Learning

- Able to reach most vulnerable adolescent girls through a systematic vulnerability mapping process
- Increase uptake of HIV testing services and condom use
- Decline in gender based violence among unmarried and married girls
- Evaluation (EJAF, MLMC project) demonstrates that a safe space model and peer educator model was effective and acceptable.
D: Scale up of Adolescent Health Initiative into a National Program - Geracao Biza-PGB, Mozambique

**Background**

Adolescent sexual and reproductive health gained particular relevance in Mozambique after the International Conference on Population and Development. It led to the inception of Programa Geracao Biz (PGB), a multi-sectoral initiative that was piloted in 1999 and fully scaled-up to all provinces by 2007.

**Key Approach**

PGB intervention package for adolescents and young people (15-24) adopted a three-pronged approach to reach out to young people with sexual and reproductive health interventions through health clinics, schools, and the community. It involved integrating adolescent sexual and reproductive health services into existing public-sector health facilities in Mozambique.

**Key Messages and Learning**

- Significant impact on young people’s SRH/HIV knowledge, attitudes, and behaviour was found.
- Adequately addressing social norms that contribute to ASRH outcomes was a challenge.
- The national government exhibited commitment and ownership to PGB through budgetary support and integration into multiple policies.

E: M-Health: an emerging solution for health interventions among young people, Kenya

**Background**

Heroin use and injecting drug have been documented in Kenya for more than two decades. Despite interventions, the government of Kenya faces many formidable challenges pertaining to monitoring and evaluation which result in either poor or inadequate reporting or huge delays in reporting. These in turn lead to poor capture of programmatic data for timely use to either improve programmes or assess quality of interventions and coverage targets. An IT group called Dure Technologies has launched the ‘Kenya RTM’ platform to support the government of Kenya in January 2016.

**Key Approaches**

Dura is an innovative software solution and service provider for Public Health and Social Development sectors. The Real time monitoring mobile application is designed to capture data for the PWID program of the country. It has been initiated in 4 locations in (Likoni, Changmwe, Kisauni, Mombasa Island). The application facilitates the local ORW/CSOs in registration of the PWIDs.

**Key Messages and Learning**

- Real-time data capturing facilitates progress to improve the delivery of services to young PWUDs.
- This has the potential to track PWIDs progress remotely at anytime from anywhere.
- The software solution provides government with an interactive dashboard that monitors activities and events, track field workforce, and assess the status and performance of daily operations.
Section 4
Priority Action: What Needs to be Done?

The target of fulfilling SDGs to leave no one behind in HIV response demands priority action for most-at-risk adolescents in countries and regions with high burden of HIV. Based on review of reports, and data gatherings, the following set of priority areas of action have emerged for preventing HIV among most-at-risk adolescent and young key populations.

1. Advocate for Reducing Age for HIV testing and Counselling Services among Adolescents

The demand to reduce the age of testing to less than 18 years without parental/guardian consent has emerged strongly among adolescents. It is therefore imperative to push and advocate this demand with policy makers so that adolescents can access and utilize HIV services without parental consent.

2. Mainstream needs of Adolescents and Address Vulnerabilities (stigma, discrimination, violence) of most-at-risk adolescents into national HIV strategies, policies/plans

Comprehensive social and health needs and vulnerabilities (stigma, discrimination, and violence) faced by most-at-risk adolescents/young key populations (MSM/SWs/TGs, IDUs) should be integrated in national HIV response of countries in Asia and Africa as it is currently absent. Specific strategies to address violence, stigma, and discrimination against SWs, MSM and TG and IDUs should be advocated. Legal provisions/policy guidelines regarding HIV testing of unaccompanied minors or without a parent, legal guardian, and orphans and minors in institutional settings, street children should be included.

3. Age Appropriate Comprehensive Sexuality Education in Schools

Age appropriate comprehensive sex education should be imparted in schools during early adolescence to provide comprehensive knowledge on SRH issues including perspective building on sexuality, sexual behaviour, sexual orientation, identity formation etc. Equally important is to lay stress on what constitutes sexual coercion in a relationship, bullying etc.

4. Include Community Engagement and Empowerment Approach in HIV Prevention Package (especially for adolescent girls)

Community level engagement and empowerment approaches focussed on developing knowledge, negotiation, and decision-making skills have shown promising results with FSWs and adolescent girls in increasing risk perception, condom use and reducing sexual coercion. These approaches should be included in HIV prevention package intervention especially for young sex workers and adolescent girls.

5. Peer-led Approach can be included in HIV Interventions

Evidence has shown that peer educators and peer support led interventions have an important role in reaching adolescents and supporting service uptake and delivery. This approach can be scaled up/used in future intervention designs for most-at-risk adolescents.
6. Internet and Mobile based Outreach Programmes (esp. with MSMs and TGs) should be evaluated and scaled up

Internet and mobile based interventions are innovative approach for reaching out to most-at-risk adolescents and young people for increase in uptake of HIV testing. They represent innovative new platforms for delivering interventions and should be then scaled up for interventions with MSMs and TGs. Evaluation of internet/m-health interventions show positive short-term outcomes for health. Further evaluation is however needed to understand the potential benefit of these programmes on long-term health outcomes.

7. Sensitize and Build Capacity of Health Care Providers for Reducing Stigma and Providing Age Differentiated and Tailored Services

- **Develop skill and competence of HCPs** to deal with specific health and social needs of most-at-risk adolescents. For example train and sensitize HCPs to the needs of MSM to provide non-judgmental and non-stigmatizing counselling and services within a human rights framework.

- **Provide awareness and knowledge regarding HTC polices and services to HCPs**: Many health providers are unaware of revised provisions on age of consent for testing without parental consent and denied unaccompanied adolescents for HIV testing. HCPs should be made aware of the latest HIV testing policies for adolescents.
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