HIV/AIDS Prevention and Care among Especially Vulnerable Young People

A Framework for Action



World Health Organization

safe passages to adulthood

DFID

Safe Passages to Adulthood

In 1999, the UK Department for International Development (DfID) funded a major programme of research into young people's sexual and reproductive health in poorer country settings.

Coordinated jointly by the Centre for Sexual Health Research at the University of Southampton, the Thomas Coram Research Unit at the Institute of Education, University of London and the Centre for Population Studies at the London School of Hygiene and Tropical Medicine, the principal objectives of the Safe Passages to Adulthood programme are to:

- fill key knowledge gaps relating to the nature, magnitude and consequences of reproductive and sexual health problems amongst young people;
- identify situation-specific key determinants of young people's sexual behaviour;
- identify culturally-appropriate means by which barriers to good sexual and reproductive health can be overcome;
- identify new opportunities to introduce and evaluate innovative programme interventions;
- develop concepts and methods appropriate to the investigation of young people's sexual and reproductive health.

The programme does not define young people through the use of rigid age boundaries. Rather, it adopts a life course perspective in which the focus of interest is on individuals in the period prior to the transition to first sex, and up to the point of entry into marriage or a regular partnership. This spans the key transitional events of 'adolescence', and captures a period of high sexual health risk and distinctive service needs.

Sexual and reproductive health includes physical and physiological processes and functions in addition to psychological and emotional aspects. It encompasses young people's capacity to decide if and when to have children; the ability to remain free from disease and unplanned pregnancies; freedom to express one's own sexual identity and feelings in the absence of repression, coercion and sexual violence; and the presence of mutuality and fulfilment in relationships.

Beyond young people themselves, the Safe Passages to Adulthood programme focuses on policy makers and practitioners as 'gatekeepers' to the promotion of young people's sexual and reproductive health.

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Preface

In the year 2003, it was estimated that some 2,2 million young people between the ages of 15 and 24 were newly infected by HIV, bringing to 11,8 million the total number living with HIV/AIDS. All over the world, certain groups of young people are at special risk for HIV and AIDS by virtue of their sex, age and social position in society. While young people in general are often denied the knowledge and resources they need to protect themselves and their partners against infection, certain groups find themselves especially vulnerable. These include young migrants and refugees, young homeless people, young people who inject drugs, young sex workers, young men who have sex with men, and young girls forced to have sex.

This timely review of evidence for action identifies some of the priority issues facing such groups, and the steps that must be taken to develop and scale up a meaningful response. It points to five principles, in particular, that should be central to future work at national or local level. First, it is necessary to place the young person and her or his needs and experiences at the centre of our work. Second, steps must be taken to ensure meaningful participation in programme and project design and development. Third, the most successful approaches are those that work with a commitment to protecting and promoting the rights of young people. Fourth, a clear gender focus must be present if the needs and interests of young women and young men are to be respected. Finally, we must work to tackle both societal vulnerability and individual risk in our prevention efforts. The evidence is clear that one approach on its own is simply not enough.

HIV/AIDS prevention and care for especially vulnerable young people: a framework for action is the second joint publication between the World Health Organisation's Department of HIV/AIDS and the DFID supported Safe Passages to Adulthood programme. It offers a straightforward guide to priority setting and next steps. It suggests a focus on three key arenas for action – risk reduction, vulnerability reduction and impact mitigation – and provides guidance on key elements for the development of effective programmes. Different groups of young people have different circumstances and different needs, and to effectively deliver interventions to them programme design must reflect this. I commend it to you as a resource that is likely to stand the test of time and will, we hope, lead to more innovative programme development that utilises principles of best practice.

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Assistant Director-General
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Background

Every day, more than 6,000 young people between 15 to 24 years of age and 2,000 children under the age of 15 are infected with HIV. Over 14 million children have been orphaned by AIDS, and an estimated 1,600 children die of AIDS each day. Children and young people under 18 represent around 10% of the global total of more than 40 million people living with HIV, and half of all new infections today occur in people between the ages of 15 and 24.

The five year follow up to the Cairo International Conference on Population and Development (ICPD+5),[1] the Millennium Summit,[2] the 2001 UN General Assembly Special Session on HIV/AIDS[3] and the 2002 UN General Assembly Special Session on Children[4] all agreed targets for action against HIV/AIDS. These include a pledge to reduce HIV prevalence among young people in the hardest-hit countries by 25% by 2005, and, globally, by 2010. Beyond, this the 2001 UN General Assembly Special Session on HIV/AIDS committed to ensuring that

> 'By 2005, at least 90%, and by 2010 at least 95% of young men and women should have access to the information, education, including peer education and youth-specific education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health care providers'.

Targets like these will be little more than empty gestures unless concrete steps are taken fast. Action is needed on several fronts. Service coverage oa prevention of mother-to-child transmission programmes remains virtually non-existent in many heavily HIV/AIDS-affected countries and must be dramatically scaled up. By the end of 2002, coverage was extremely low (less than 1%) in the countries hardest hit by HIV/AIDS (apart from Botswana, where 34% of pregnant women were able to access these services).[5] Children orphaned by AIDS need the help of governments and communities to stay in school, feed themselves adequately, and benefit from income-generating activities. And good quality HIV/AIDS prevention programmes for young people must be expanded, providing information and skills and overcoming stigma and taboos.

[1] http://www.unfpa.org/icpd/
[2] http://www.un.org/millennium/declaration/ares552e.pdf
[3] http://www.unaids.org/html/pub/publications/irc-pub03/aidsdeclaration_en_pdf.pdf
[4] http://www.unicef.org/specialsession/
[5] http://www.unaids.org/ungass/en/exec/ungassexec00_en.htm

In going about this work, some important challenges have to be faced. A recent UNICEF, UNAIDS and the World Health Organization report entitled People and HIV/AIDS: Opportunity in Crisis[6] revealed that in 60 countries surveyed, more than 50% of young people aged 15 to 24 continued harbour serious misconceptions about how HIV/AIDS is transmitted. In some of the most seriously affected countries, the proportion of young people who have correct knowledge to protect themselves is as low as 20%. In many countries, young people's access to condoms and clean needles and syringes remains severely limited. Yet there is clear evidence that, together with knowledge and skills, prevention is both efficient and cost-effective.[7]

The challenge, therefore, lies in focusing and bringing to scale a range of programme components of proven effectiveness. These include mass media campaigns; public sector condom promotion and distribution; condom social marketing; voluntary counselling and testing programmes; prevention of mother-to-child transmission; school-based programmes; programmes for out-of-school youth; workplace programmes; treatment of sexually transmitted infections; peer counselling for sex workers; outreach to men who have sex with men; and harm reduction programmes for injecting drug users (Stover et al., 2002).

Yet how should such work proceed and where should the priorities be placed? The starting point must be the bringing together of relevant scientific information about what has been learned about prevention success (and failure). Next, there must be concerted efforts of advocacy and education to ensure that regional and national authorities act on the basis of what is known. This can require addressing complex and sometimes sensitive issues of tradition, morality and context. Finally, there must be concrete partnerships between government, international agencies, non-governmental organisations and civil society to operationalise the scientific principles for success in concrete programmes and strategies.

Success in turning back the epidemic calls for a multi-levelled effort. Politically and economically, steps must be taken to address the links between HIV/AIDS, poverty and sustainable development. Educationally, work on life skills and sex and relationship education is needed both in and out of school. With respect to the productive sphere of the economy, urgent steps need to be taken to make good

[6]http://www.unicef.org/publications/index_4447.html
[7]http://ari.ucsf.edu/pdf/CostEffectiveness.pdf

Young people in some cultures may be regarded as lacking in the competence to make decisions about future education, employment and marriage, for example, or they may be viewed as needing to be kept innocent about sexual matters. In both poor and richer countries, local traditions and popular beliefs also set limits on what young people may openly do. They may enhance vulnerability to HIV/AIDS by ensuring, for example, that girls remain relatively ignorant about sexual matters while boys are encouraged to acquire sexual experience with a variety of partners (UNAIDS, 1999).

Despite these similarities, there are also important differences between young people, differences that can be seen in the patterning of the epidemic nationally, regionally and globally. There are, for example, major differences in the epidemic affecting young people across different regions of the world. In sub-Saharan Africa, for example, more than eight and a half million young people aged between 15-24 years are estimated to be living with HIV/AIDS. In Western Europe, on the other hand, only 89,000 young people are believed to be infected (UNAIDS/WHO, 2001).

In several regions, young women are considerably more likely to become infected than young men. These include sub-Saharan Africa, South and South East Asia, the Caribbean, North Africa and the Near East. In other parts of the world, however, the pattern is reversed, with young men being more likely to be infected than young women. These regions include East Asia and the Pacific, North, Central and Southern America, parts of Eastern Europe and Central Asia, and Western Europe (UNAIDS/WHO, 2001).

In some countries, young people of colour and young people from minority ethnic communities have been identified as being especially vulnerable to infection. Disproportionately high rates of infection, for example, can be found among African-American young women in the USA, and higher than expected rates of infection have also been reported among indigenous people in Canada and Australia, and among the hill tribe communities of Thailand and Myanmar. The response to the epidemic needs to be sensitive to these differences and what they signify.

While globally, sexual transmission is the major route of HIV transmission patterns vary in different parts of the world. In the Commonwealth of Independent States (CIS) and in some Central and Eastern European Countries (CEE), for example, drug injection has been reported as accounting for up to 70% of new infections,

many of them among young people. Globally, an estimated 80% of drug injectors are men including an increasing number of young men (Foreman, 1999). Yet the factors that predispose to HIV transmission frequently interact. Among those who inject drugs, for example, sexual transmission of HIV not infrequently takes place and, in some contexts, substance use (including the consumption of alcohol) can be a precursor to unprotected sex.

Matters are further complicated by the fact that sex workers, injecting drug users, young people and men who have sex with men are not discrete populations. Indeed, they often overlap, it being possible for an individual to fall into more than one of these categories at any one moment in time. Moreover, as recent research has shown in countries such as Bangladesh, Lao PDR, Vietnam and Cambodia, sexual mixing between populations of sex workers, truck drivers, young people, men who have sex with men and injecting drug users can potently fuel the epidemic.[9] This makes the challenge of undertaking HIV/AIDS prevention that much greater. Sensitivity to local patterns of transmission is vitally important in developing programmes and planning interventions, if health is to be promoted.

Young people's vulnerability to HIV/AIDS also varies according to economic, political, social, cultural and religious context. In countries where they are provided with access to the full range of knowledge and the resources whereby to protect themselves and their partners against infection, sexual transmission rates tend to remain low. Likewise, epidemics of HIV among injecting drug users have been successfully managed through the provision of a services emphasising harm minimisation. These broad-based strategies have incorporated outreach work, risk reduction counselling and drug dependence treatment as well as syringe and needle exchange. Yet in contexts where information is not provided, or where young people find it difficult to access the resources that can protect, HIV remains uncontrolled.

Given this variability in the global HIV/AIDS epidemic, it is important to recognise that not all young people are equally vulnerable. The challenge therefore lies in accurate diagnosis and response. A coherent yet differentiated public health response is called for. This should be sensitive to local specificities, and should be operationalised together with other non-health sector work, while working from core principles central to what is globally recognised as good prevention practice. In the following section, these principles are spelled out in detail.

[9]See, for example, http://www.nfi.net/Reports/dhaka%20report.pdf and http://www.adb.org/Documents/Books/HIV_AIDS/Mobility/A.pdf

Some principles for success

Five core principles underpin effective HIV/AIDS prevention programming with young people. While of relevance to work with young people in general, they establish a framework within which to meet the needs of especially vulnerable young people such as those already described.

Putting the young person first

The words we use to describe people have important implications for how we understand their circumstances and needs. Terms such as 'young people', 'adolescents' and 'children' have wide currency, and official definitions exist of each of them.[10] For us, however, the term young people is the most relevant to understanding where much of the action should be focused. From the point of view of HIV/AIDS prevention, it implies three important things:

- concern for a relatively wide age range (10-24 years in WHO's definition) in which risk and vulnerability can occur;
- awareness of social variability (via the emphasis on diversity implied by the word 'people') in the transition from childhood to adult life; and
- concern for individual dignity and respect (through notions of 'personhood' and an emphasis on the individual as a bearer of rights).

Young people is an inclusive term. Yet within any context, needs and potential vary enormously. Careful analysis of these differences is necessary to provide a sound basis for the planning, provision and monitoring of appropriate services. While often valuable as a mean of raising general awareness, approaches targeting young people 'as a whole' run the risk of either ignoring those who are most marginalized and vulnerable (including young drug injectors, young sex workers, young gay and bisexual young people, young people living on the streets and young migrants), or of failing to recognise the culturally and socially differentiated nature of the stage of life we call youth.

All over the world, important differences between people exist with respect to wealth, gender, sexuality, ethnicity and culture. Interacting with these 'primary distinctions' are socio-economic, political and legal factors. Social inequality, social exclusion, migration and lack of

[10] See, for example, http://www.un.org.in/Jinit/who.pdf

access to health services are just a few of the contextual influences known to facilitate HIV transmission (Sweat and Dennison, 1995). Other factors include sexism, racism, homelessness, homophobia, and sexual coercion, together with actions that damage self-esteem, eliminate choices and make it harder for individuals to stand up for themselves (Harper and DiCarlo, 1999).[11]

While each of the above factors influences adult vulnerability to health problems, each also affects the likelihood that a young person will become infected. It is, however, the interaction between age, each of the primary distinctions and the socio-economic, political and legal factors mentioned above, that determines a young person's unique status in the face of the epidemic.

Some young people, by virtue of their age, poverty, gender and prevailing political and economic realities are rendered more systematically vulnerable than others – young injecting drug users, and young migrants and refugees, for example (Aggleton and Rivers, 1999). Others may be more systematically protected – better off and well-supported young people offered good quality education in sex and relationships, for example. Understanding and responding to systematic vulnerability is central to an effective public health response.

Numerous instances of successful socially differentiated HIV/AIDS prevention work exist. The well documented Tribes Project,[12] run by the New South Wales Users and AIDS Association, fine-tuned its harm reduction work so as to meet the needs of a variety of very different groups of young people (young surfers, young aboriginal people, young bikers, for example), and its success stimulated greater sensitivity in project planning in countries all over the world.[13] Among men who have sex with men, the Naz Foundation in India and the Bandhu Social Welfare Association in Bangladesh carefully differentiated the work they carried out among kothis and panthis, two distinct groups of men involved in male to male sex.[14] And all over the world, sex worker projects involving young people draw important distinctions between the kinds of activities that need to be undertaken in brothel-based contexts and those more relevant to street settings.[15]

Taken together, what can we learn from this work? There are two key lessons at least. In each of the above cases, it is the young person

[11] http://www.caps.ucsf.edu/adolrev.html
[12] http://www.communitypartnerships.health.gov.au/casestudies/casestudy16.htm
[13] See, for example, Airi-Alina Allaste (2002)
[14] See, http://www.nfi.net/ and http://www.nfi.net/Essays/97/Comments%20on%20MSM%20-%2097.DOC
[15] http://www.walnet.org/csis/groups/nswp/handbook.html

who is especially vulnerable, and their needs, that has been made central in the HIV/AIDS prevention response. This, together with an effort to address health needs in a pragmatic and non-discriminatory way, is the key to success.

Promoting meaningful participation

One of the principles central to successful HIV/AIDS prevention is that of participation. This is no less true of work with young people than with other groups. Young people's participation in the identification of needs and in programme design and development, leads to greater acceptability and appropriateness. It can also result in programming that is inclusive rather than stigmatising and discriminating. Through meaningful participation, young people become a potential resource in addressing the global pandemic.

Negative and stereotypical images of young people abound. With respect to HIV/AIDS, and particularly within the field of public health, it is not uncommon to encounter views of young people as irresponsible, chaotic, risk taking and ignorant (Runyan et al., 1998). Such notions are unhelpful in that they disengage young people and hamper possibilities to promote their participation. Beyond this, however, they provide a rationale for some adults to fail to listen carefully to what young people say, thereby heightening social isolation and enhancing vulnerability.

Numerous UN system documents, best practice reviews and other sources of information point to the importance of participation.[16] With respect to HIV/AIDS and other health issues, social participation is vitally important to health. High levels of 'social capital' – community trust, reciprocal help and support, a positive local identity, and high levels of civic engagement in a dense network of community associations – have been shown to be positively associated with the health and well-being of children and young people (Rivers and Aggleton, 1998). One of the most important dimensions of health-enhancing social capital is the 'perceived power to get things done' (Campbell et al., 1999). This is present when people (of no matter what age) feel that their needs and views are respected and valued, and when they have channels to participate in decision-making.

One of the clearest rationales for the participation and involvement of young people in HIV/AIDS programming derives from the United

[16] See, for example, R. Hart (1997)

Nations Convention on the Rights of the Child (CRC). This assigns to children and young people the right freely to express their views and opinions, and have them considered, in relation to many walks of life. This includes the manner in which they are treated by adults and society more generally, as well as the services that are provided, and to which they have access. Taking seriously the words of this convention should be the cornerstone of any coherent future public health response.

While efforts have been made to promote youth participation in specialised of targeted HIV/AIDS-related activities, fewer programmes have tried to promote young people's participation as part of a more encompassing strategy (Morrow, 1999a). Research suggests that young people not untypically feel excluded from wider societal decision-making and are sceptical about their tokenistic representation on school councils, youth councils and other community bodies (Morrow, 1999b). The challenge therefore lies in developing policy frameworks and participation opportunities that respect young people's interests and needs, and which are perceived as valuable by young people concerned.[17]

A commitment to rights

The links between health and human rights are increasingly well documented.[18] Promoting human rights within the context of HIV/AIDS is important not only as a means of tackling the structural factors that render some groups systematically more vulnerable than others, it is also important with respect to unleashing the power of individuals and of communities to make a difference to their own lives.[19]

The right of children to express their views and opinions, and have them considered, is but one of a number of fundamental rights enshrined in the UN Convention on the Rights of the Child (CRC). Another article in this convention recognizes the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and the rehabilitation of health (Article 24). Article 27 recognizes the right of every child to a standard of living adequate for physical, mental, spiritual, moral and

[17]See, for example, Aggleton and Campbell (2000), and Campbell and Aggleton (1999). For examples of such programmes, see UNICEF/WHO (1994).
[18]See, for example, http://www.hsph.harvard.edu/fxbcenter/FXBC_WP10--Gruskin_and_Tarantola.pdf for a discussion of general issues and http://www.unaids.org/publications/documents/human/HIVAIDSHumanRights_Guideline6.pdf for their application to HIV/AIDS prevention and care.
[19]See, for example, J. Mann and D. Tarantola (1996)

social development. Articles 28 and 29 recognize the child's right to education directed towards the development of personality, talents and mental and physical abilities to their fullest potential. Two additional optional protocols seek to protect children against participation in armed conflict and recruitment to the armed forces; and against sale, illegal adoption, child prostitution and involvement in pornography. These articles and the optional protocols offer a sound basis around which to develop a coherent and committed public health response. [20]

There are numerous other international human rights instruments of public health relevance to young people and HIV/AIDS. These include the Universal Declaration on Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic Social and Cultural Rights; the Convention on Elimination of All Forms of Discrimination Against Women; the Convention on the Elimination of All Forms of Racial Discrimination, regional charters, and specific rights in relation to living with or being affected by HIV/AIDS. Beyond these conventions, there are international agreements that offer a normative framework within which to couch a response. These include ICPD+5, the Beijing Declaration and Platform for Action and its five-year follow up, and the Millennium Development Goals.

Already, rights-based programming for prevention, care and impact alleviation is showing success. In the Mekong Region, for example, a rights approach has been implemented in inter-agency work with children and young people affected by HIV/AIDS. The rights most likely to be denied children affected include: the right to freedom from discrimination (CRC Article 2); the right to life, survival and development (CRC Article 6); the duty of the state to support parents or legal guardians in child-rearing (CRC Article 18); the right to health and medical care (CRC Article 24); the right to standard of living and access to social welfare (CRC Article 27); the right to education and access to information (CRC Articles 28 and 13); the right to be heard (CRC Article 12); the right to protection from abuse and exploitation (CRC Articles 19 and 34); and the right to appropriate alternative care (CRC Articles 20 and 21) (UNICEF 2001). Among the many activities promoted by this work are actions to support family care, create child friendly schools and support the involvement of Buddhist monks in counselling and support, all developed within the framework of respect for human rights.[21]

[20] http://www.who.int/child-adolescent-health/RIGHTS/crc.htm
[21] http://www.unicef.org/eapro-hivaids/action/children_affected.htm

Promoting gender equity

Globally, young women are disproportionately affected by HIV/AIDS, and most markedly so in parts of Africa. Half of all HIV infections worldwide occur in women in Africa and, throughout sub-Saharan Africa, HIV infection rates among teenage women are up to five times higher than rates for teenage men. In Kenya, nearly one teenage woman in four is living with HIV, compared to one man in 25 of the same age (UNFPA, 2000). The physical immaturity of younger women and women's status in society enhance vulnerability to HIV infection. Women's lower social status may prevent them from exerting control over their sexual relationships.

For many girls and young women, first sexual experience takes place within the context of marriage, which is often construed as a safe and moral context. Girls, more than young men, are encouraged to 'wait' until marriage before having sex. Yet, marriage for young women is often at an early age, to older and more sexually experienced partners, and in contexts where marriage is not synonymous with monogamy for many men. The result is both risk of infection at an age when young women are biologically most vulnerable, coupled with ill-conceived notions of security and safety through marriage. All over the world, dominant images of femininity mean that young women have to negotiate between being knowledgeable, and appearing innocent, in order to protect their sexual and social reputations (Rivers and Aggleton, 1998).

But it is not only young women that are made vulnerable to HIV/AIDS by existing gender norms. In the Americas, in East Asia and throughout much of Europe, greater numbers of young men than young women are infected, and an estimated quarter of the world's population with HIV infection consists of young men under the age of 25 (UNAIDS, 2000).[22] Dominant stereotypes and ideologies of masculinity and 'manliness' can make it difficult for boys to seek sexual and reproductive health advice. Men are supposed to be knowledgeable and experienced about such issues, and to seek help is to risk being perceived as less of a man (Rivers and Aggleton, 1998b).

Young women and young men are socialised differently from birth and receive very different messages in relation to sex and sexuality, social norms and behaviours. In perhaps the majority of countries, masculinity is associated with physical and psychological strength, independence and sexual activity as proof of virility. Masculine values are constructed and reinforced by culture and by peer pressure,

[22] http://gbgm-umc.org/programs/wad00/wacmene.stm

although they can appear as 'natural', since they are so well entrenched in every day life. Such values are in stark contrast to the more nurturant femininity of women symbolised by virginity, fidelity and fertility.

Promoting sexual responsibility among men is central to the health of both men and women. Until recently, gender based approaches to sexual and reproductive health, including HIV and STI prevention, have focused on empowering young women to assert themselves and redress the balance through their increased knowledge and ability to take control. This approach has a number of flaws, however, in that it tends to adopt a stereotypical notion of men, their desires, motivations and interests, and assumes that all aspire to the same expressions of masculinity.

Gender is also of relevance in understanding patterns and processes of drug injection, and concomitant HIV/AIDS risks. While the majority of young injectors are men, the ratio is beginning to change as drug injecting becomes more socially acceptable among young women. But young women are often more vulnerable to HIV infection, being more likely than men to be the recipients of already used needles and syringes. They are, moreover, less likely than men to access harm reduction programmes, these often having been designed with the male user, and his needs, in mind.

It is important, therefore, that the public health response to HIV/AIDS and young people starts from the diverse needs and interests of both men and women. There is a pressing need to unpack the multiple ideologies of gender that exist, and the manner in which these are influenced by class, race and sexuality. While dominant forms of masculinity and femininity may be divisive and harmful, predisposing to greater vulnerability and risk, alternative and oppositional ways of living are possible. These should be made the starting point for future HIV/AIDS prevention efforts in ways attuned to local specificities and needs (Mane and Aggleton, 2001).

Ultimately, and for lasting success, programmes need to address young people's gender vulnerability in a variety of ways, within both short- and longer-term time frames. In the short term, gender-sensitive programmes may offer some hope. Efforts can be made to address young women and young men's vulnerability by continually adapting to and meeting gender and age-specific needs within the current social and cultural context. But in the longer-term, gender-

sensitive programming will not radically change the unequal gender relations that fuel the epidemic and make women and men differentially vulnerable. Socially transformative and empowering programmes must be implemented alongside gender-sensitive programmes in the hope of ultimately challenging the very foundations of the epidemic (Rao Gupta et al., 2002). Evidence of success with respect to such work can be seen in numerous programmes working with both young women[23] and young men.[24]

Tackling risk and vulnerability

Risk

In the context of HIV/AIDS, risk can be defined as the probability that a person may acquire infection. Certain behaviours create, enhance and perpetuate risk. They include unprotected sex with an infected partner, multiple unprotected sexual partnerships, and injecting drug use where injecting equipment and drug preparations are shared. Globally, early responses to HIV/AIDS aimed mainly at reductions in risk-taking behaviour through the targeting of individuals and groups. Examples of 'targeted interventions' here include the provision of information and education about HIV/AIDS, life skills education, drug risk education, and programmes to enhance women's and young people's capacity to ask for, and 'negotiate', protection.

The importance of context

Experience has shown, however, that in order to be successful HIV/AIDS prevention should focus not only on risk-taking behaviours, but also on the environmental and societal factors. In many cultures, decisions relating to sex (for example) involve the family and community as well as the individual. Young women may be pressurized to remain ignorant about sexual matters and physically abstinent, whereas young men may be encouraged to brag about sex while gaining experience through liaisons with girl friends and sex workers. Likewise, with respect to drug use, the peer group and social networks may be influential in determining whether or not a young person injects, and does so safely.

Political, economic and social inequalities influence young people's sexual and reproductive health, as well as their opportunities for

[23] See, for example, http://www.un.org/womenwatch/daw/csw/hivaids/Gupta.html and http://www.icrw.org/docs/UNICEF_GirlsHIV_infobull_702.pdf

[24] See, for example, papers given at the 'Young Men as Allies in the Promotion of Health and Gender Equity' International Conference and Workshop 27-30 August 2002, Rio de Janeiro, Brazil. Shortly to be available from http://www.promundo.org.br/first.html

involvement in injecting drug use. The options available to wealthy young people can be very different from those available to their poorer peers. While the former may have access to television, the Internet and high quality health services, the latter may have to make do with very little. In conditions of poverty, not only may opportunities to seek information and harm reduction resources be restricted, but also what is available may be less comprehensive or of poorer quality. All of these issues relate to what is best understood not as risk, but as social and sexual vulnerability.

Vulnerability

Vulnerability to HIV/AIDS is influenced by three sets of variables, and the interactions between them:

(i) factors such as group or subculture membership;

(ii) the quality and coverage of services and programmes; and

(iii) broader societal and environmental influences.

The first set of factors includes the social networks of which an individual is a part. Some young people, for example, may find themselves at enhanced vulnerability for HIV infection by virtue of their membership of a group in which HIV infection is particularly prevalent (e.g. by being young injectors, by being young and homeless, or by being involved in sex work where levels of infection are high).

Service and programme factors on the other hand include the cultural appropriateness (or inappropriateness) of HIV/AIDS prevention programmes; the accessibility (or inaccessibility) of services due to distance, cost and other factors, and the capacity of health systems to respond to growing demand. Many young people may be rendered especially vulnerable to HIV/AIDS through a deficiency in young person friendly reproductive health service provision. Young injecting drug users not infrequently find it difficult to access services set up with the adult injector in mind.

Broader, societal and environmental factors influencing vulnerability include political decisions, economic inequalities, laws and cultural norms that act as barriers or facilitators to prevention. Such influences may lead to the inclusion, neglect or social exclusion of individuals depending on their lifestyles and behaviours, as well as

socio-cultural characteristics. It is frequently the case, for example, that governments decide to restrict young people's access to health information about HIV/AIDS (including safer sex education and harm reduction equipment) in the belief that young people should remain 'innocent' about such matters. They may do so feeling that parents or communities may object. But young people have the right to the knowledge and resources to protect against infection, and organisations such as WHO have a special role to play in ensuring that this occurs.

Among the broader forces structuring young people's vulnerability are inequalities of age, gender, sexuality, poverty and social exclusion. With respect to gender, for example, inequalities in access to education, in income distribution, in the ownership of property and in employment opportunities can enhance young women's vulnerability to HIV/AIDS. With respect to poverty, economic disparities within a country are critical in determining vulnerability. Violations of rights, physical abuse and sexual exploitation can deepen the gap between those who benefit from economic growth and those who suffer its ill effects. Development policies and programmes can sometimes have negative effects by increasing the economic gap between their immediate beneficiaries and others. The latter may become vulnerable to HIV/AIDS as a result of increased economic marginalization, and the need to depend on alternative means of livelihood (e.g. sex work), which may expose them to HIV/AIDS.

Developing policies and programmes to address vulnerability can sometimes be challenging because the effects of structural inequalities are rarely clear-cut. For example, while in many countries, poverty facilitates HIV transmission, the trend is not uniform. In some places, for example, there are epidemics of HIV among the better-off, due partly to their economic power to buy sex or inject drugs. But economic power also creates possibilities for engaging in safer behaviours, such as buying and using condoms, or ensuring the single use of needles and syringes. Which forms of behaviour – unsafe or safe – are adopted will depend upon individual as well as situational and contextual factors.

Vulnerability-reduction measures are, of course, necessary as part of broader moves towards enhanced social justice and overall development. But they are also central to effective HIV/AIDS prevention among young people. Sometimes they can be applied

within the context of broad-based programmes addressing young people as a whole – e.g. through specialist youth friendly service provision or through legal reform to enhance young people's access to condoms. On other occasions, they may be applied in a more focused way in contexts of special or complex vulnerability.

Just as not all young people are 'risk takers', not all young people find themselves equally vulnerable. Young people in poverty, for example, may be more systematically disadvantaged than others. Young people displaced by internal migration, war and civil conflict may be without access to their families, education and employment. Young homeless people may find themselves exchanging sex for food and a place to stay. Young sex workers may find themselves in contexts where drug use is common. Young drug users may trade sex in order to purchase the drugs that make life seem more bearable.

In contexts of especially complex vulnerability such as these, the ability of young people to take charge of their lives may be very limited. Multi-levelled actions, sensitive to the contextual and environmental factors structuring young people's circumstances and lives, will be required in order to bring about and sustain change. With respect to HIV/AIDS prevention, such measures should aim to create an enabling environment in which risk reduction can occur.

HIV/AIDS prevention with young people therefore consist of two principal components: the reduction of risk through specific prevention, care and impact-alleviation efforts; and the reduction of vulnerability through more broad based social, cultural and economic change. These two components need to be present regardless of whether the focus of our work is with young people as a whole, or with young people in who find themselves in contexts of special vulnerability.

Recognition of the need for both risk and vulnerability reduction if HIV/AIDS prevention is to take place, is not of course new. Examples of successful programmes and interventions exist in countries all over the world. These vary from syringe and needle exchange programmes together with the provision of HIV/AIDS information in countries through Europe, Asia and the Americas, to the development of young person friendly voluntary and confidential counselling and testing programmes in sub-Saharan Africa. Of particular note, however, have recent been efforts to tackle simultaneously the multiple and especially complex kinds of vulnerability that can emerge in contexts of economic and political crisis.

To take but two examples, young people involved in, or displaced by, war and civil conflict may face multiple threats to their health and well-being. In this kind of context, HIV/AIDS may at first sight appear low on the agenda, both of policy makers and practitioners, and young people themselves. Food and shelter, safety from being threatened or attacked, gaining paid employment, and being reunited with the family and friends can take greater priority. Yet these are the very situations in which vulnerability to infection can be greatest, as research from countries such as Angola, Burundi, Bosnia and Rwanda shows.[25]

Likewise, in contexts of rapid economic and political transition, rising unemployment, price increases, diminished public services and a general decline in opportunity can dash young people's hopes for the future. In such circumstances, increasing levels of injecting drug use, youth prostitution and sexual exploitation have been widely reported. These contexts of especially complex vulnerability facilitate HIV transmission and pose major challenges for health programme development.

Global experience shows that with appropriate personal support, young people are not without the capacity to take charge of their lives, particularly where there is good public policy for health and a supportive environment. The need, therefore, is for action that is genuinely supportive in providing young people with relationships that matter, a place to live, education, work and health services attuned to their needs. Clearly, this calls for a multi-sectoral effort, but the health sector should be central within this process. Only this way, will young people be helped to acquire the dispositions and competences that will enable them avoid HIV infection or, if infected, live better with the disease (Wilkinson and Marmot, 2000).

Summary

Together, the five core principles outlined above – putting the young person first, promoting meaningful participation, working with a commitment to rights, promoting gender equity, and working with vulnerability as well as risk – offer the basis for a coherent and structured response to young people and HIV/AIDS (Figure 1).

[25]See, http://www.unaids.org/publications/documents/human/gender/una99e16.pdf and UNAIDS (2002) p.27



Figure 1: Principles for prevention success

Three priority fields of action

Two decades of global learning have identified three priority fields or areas of work, within each of which action must taken if HIV/AIDS prevention and care are to succeed:

- the reduction of risk;
- the reduction of vulnerability; and
- the reduction of impact.[26]

Each of these fields is inter-related, such that action within any one of them impacts upon the others. Simultaneous action across all three domains lays the foundations for a successful response (Figure 2).

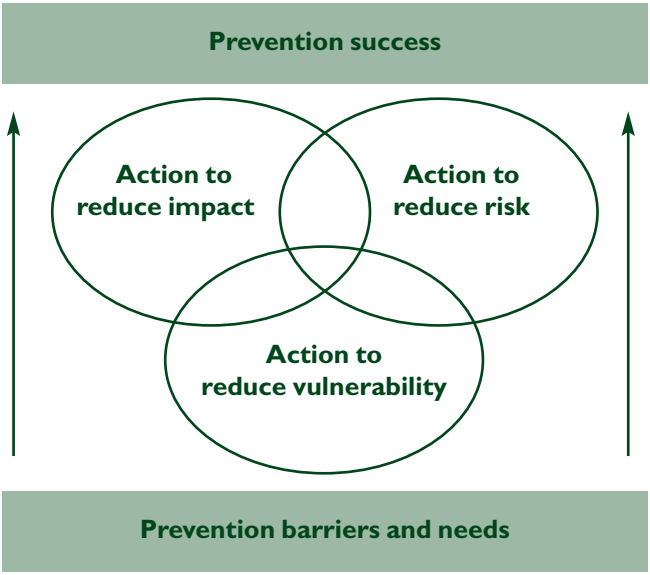


Figure 2: Three priority fields of action

Action to reduce risk

Risk reduction among young people in general can be accomplished in a variety of ways. Overall objectives and approaches identified include the:

– promotion of safer sex (including abstinence, delayed sexual initiation and the consistent use of condoms);

[26] http://www.unaids.org/publications/documents/care/general/JC637-GlobalFramew-E.pdf

- encouragement of risk reduction in drug use (including use of clean injecting equipment);
- detection and early treatment of other sexually transmitted infections;
- use of voluntary and confidential counselling and testing;
- prevention of HIV transmission from infected mothers to their infants;
- prevention of HIV transmission through infected blood and blood products; and
- prevention of HIV transmission within the health care setting.

Such reductions in risk can be brought about by a variety of means. These include:

- information, education and communication (IEC) and behaviour change communication (BCC) strategies;
- schools-led education;
- skills building education;
- peer education; and
- outreach work with young people in difficult circumstances.

While some of these means will be suited to meeting the needs of young people in general, others are more attuned to the circumstances of those who, for different reasons, are especially vulnerable. These latter approaches include peer-led education and outreach approaches in sex work and drug use, as well as among homeless young people, street dwellers, migrants and refugees. The use of formal and informal networks to communicate safer sex and harm minimization messages among especially vulnerable groups of young people is also important.

Action to reduce vulnerability

Young people's vulnerability to HIV/AIDS can be reduced in many ways. Among possible approaches are, through:

- social networks and peer relations that model and promote norms for safer behaviour;
- increasing family and peer trust and support;
- the development of schools as more inclusive, gender sensitive and protective environments;
- ensuring access to commodities (e.g. condoms and clean injecting equipment) that have been shown to have a demonstrable effect in preventing HIV infection;

- the provision of health services in ways and at times that young people find appropriate;
- economic and political action that promotes positive educational, employment and health opportunities;
- legal provision that guarantees young people's right to the full range of information and resources to protect themselves (and their partners) against infection;
- systemic efforts to combat stigma, discrimination and denial;
- the reduction of economic and gender disparities that fuel the epidemic; and
- efforts to build supportive social norms and social inclusion.

Reductions in vulnerability can be brought about by:

- legal, political and economic action and reform;
- the development and implementation of healthy public policy;
- social and community mobilization;
- the provision of rights based education for empowerment;
- the re-orientation of existing service provision; and
- social network development to cultivate a sense of trust and shared responsibility at grassroots level.

Once again, these actions may be taken across a variety of contexts to meet a wide range of young people's needs. More specifically, however, it will be important to focus upon those forms of policy and legal change that bring about reductions in young people's vulnerability to HIV/AIDS through the provision of employment, education and health services; that tackle gender disparities and inequalities, and that build norms of trust and social reciprocity in severely disadvantaged circumstances.

Action to mitigate impact

Finally, the impact of HIV/AIDS on young people as a whole, and on especially vulnerable young people in particular, can be alleviated in a variety of ways. Among the principal means of doing this are:

- efforts to reduce the financial and social impact of the epidemic on individuals, families and communities;
- action to enhance the access of those orphaned as a result of HIV/AIDS to health, nutrition and education;
- promotion of livelihood and vocational education for young people;
- improved access to care, social support, voluntary and confidential counselling and testing, and anti-retroviral therapy;

- improved access to services to prevent the mother-to-child transmission of HIV; and
- increased access to legal services and human rights protection.

Reductions in the impact of the HIV/AIDS pandemic can be brought about by:

- strengthening national and local systems of governance;
- developing sound economic and social programmes;
- support for more effective HIV/AIDS programming;
- action to increase access to essential commodities (including anti-retroviral drugs);
- improving the capacity of community organisations to carry out their work;
- enhancing the role of schools and other forms of educational provision so that they can offer broad-based support; and
- increasing community and external investments in health, social services, education and agriculture, among other means.

Impact reduction measures of relevance to especially vulnerable young people include all of the above, but special emphasis needs to be given to actions that promote equity and reduce inequality. These include efforts to improve (or rebuild) access to health and social services in contexts of particular need; actions to strengthen vulnerable young people's access to employment and education; and actions that provide health, education and employment in ways especially suited to the alleviation of impact in serious and complex emergencies.

Conclusions

The goal of this review has been to take stock of what has been learned about effective approaches to promoting HIV/AIDS prevention and care among young people in general, and especially vulnerable young people in particular. Two decades experience shows there is no instant recipe for success. Instead, 'combination' approaches, in which action is taken on several fronts simultaneously, are important. Beyond this, experience shows that young people themselves should be centrally involved in needs assessment, planning and programme development. Without their wisdom, insight and experience, programmes are unlikely to achieve realistic targets and/or adopt suitable approaches. Concern for rights, and the determination to address gender inequalities is also important, for if we fail to recognise the structural factors determining vulnerability and risk, other actions will be ineffective and may even do harm.

In the same way that efforts to promote prevention and care should be multi-faceted and linked, so should be the field across which we aim to make a difference. Tackling individual risk without addressing broader societal vulnerability will not work. And dealing with risk and vulnerability, while failing to recognise the impact of the epidemic on the systems and structures (the health service, education, civil society) that can be utilised for prevention and care, can only be short-sighted. Action on all three fronts – risk reduction, vulnerability reduction and impact alleviation – is therefore a prerequisite for success.

Yet, as other publications and activities from the Safe Passages to Adulthood programme have demonstrated, actions on HIV/AIDS need to be linked to more broad-based efforts to promote young people's sexual and reproductive health. For, the principal route through which HIV is transmitted globally is that through which pregnancy takes place, and concomitant sexually transmitted infections enhance the likelihood that HIV will be transmitted from an infected partner to an uninfected one. Ultimately, promoting young people's sexual health calls for a more integrated and joined up approach – and facilitating young people's involvement in HIV/AIDS prevention and care calls for a respect for young people's varied circumstances and needs. Now in the third decade of HIV/AIDS, let us learn the lessons of the past, and work together to apply some of the principles outlined here.

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Appendix Two

Other publications from the Safe Passages to Adulthood Programme

Knowledge Synthesis series

Working with young men to promote sexual and reproductive health
http://www.socstats.soton.ac.uk/cshr/SafePassagesyoungmen.html
ISBN 0 85432 781 9

The role of education in promoting sexual and reproductive health
http://www.socstats.soton.ac.uk/cshr/SafePassageseducation.html
ISBN 0 85432 782 7

Preventing HIV/AIDS and promoting sexual health among especially vulnerable young people
http://www.socstats.soton.ac.uk/cshr/SafePassagesvulnerable.html
ISBN 0 85432 783 5

Promoting young people's sexual and reproductive health: Stigma, discrimination and human rights
http://www.socstats.soton.ac.uk/SafePassagesstigma.html
ISBN 0 85432 806 8

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Dynamic contextual analysis of young people's sexual health
http://www.socstats.soton.ac.uk/cshr/SafePassagesDCA1.html
ISBN 0 85432 779 7

Learning from what young people say…about sex, relationships and health
http://www.socstats.soton.ac.uk/cshr/SafePassageswhatypsay.html
ISBN 0 85432 780 0

All available to download free from http://www.socstats.soton.ac.uk/cshr/safepassages.htm or write to:

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