ADOLESCENTS UNDER THE RADAR

IN THE ASIA-PACIFIC AIDS RESPONSE

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Youth LEAD

YOUTH VOICES COUNT

ADOLESCENTS UNDER THE RADAR IN THE ASIA-PACIFIC AIDS RESPONSE

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FOREWORD

When AIDS first appeared 30 years ago, the world was at a loss. No one knew how to respond to this crisis. Three decades and many trips to the drawing board later, we know a lot about the HIV epidemic. We have highly skilled people, and effective medicines and tools to respond to the epidemic. We have gained the upper hand against HIV. We are tantalizingly close to eliminating mother-to-child transmission of HIV, and can now envisage ending the AIDS epidemic as a public health threat by 2030. This makes it unacceptable that a generation of adolescents has been overlooked in the global HIV response.

In Asia and the Pacific – as worldwide – adolescents have been largely neglected as a distinct group in focused efforts to prevent HIV transmission and prolong the life of people living with the virus. The result is rising infections among 10-19 year-olds at risk of HIV and an increase in the number of AIDS-related deaths. These are preventable deaths. As parents, teachers and leaders – as societies – we ask that children in their second decade of life assume ever-growing responsibilities as they approach adulthood. And yet we have responsibilities towards them – to ensure their right to health care, to education, to protection, and to development. Failure to prioritize adolescents in the HIV response leads to injustice at many levels.

Experience and a strong track record of success are powerful assets we can harness to right this wrong. We also need innovation. A sharp focus on adolescents will require new investment, new action from the highest levels of government, and new ways of reaching adolescents at risk of and living with HIV. We need to really listen to those we seek to help. Only adolescents themselves can provide a reality check on the most effective HIV programmes and policies for them and their peers. Their participation – or lack of – will make or break any comprehensive HIV initiative.

This report highlights the HIV crisis for vulnerable adolescents in Asia and the Pacific and what we can do to give them the support they desperately need. If we fail to do this, the world will not get to where it wants to be: ending the AIDS epidemic by 2030.

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ACRONYMS

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
CRC	Convention on the Rights of the Child
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
IHBSS	Integrated HIV biological and serologic surveillance
LGBT	Lesbian, gay, bisexual or transgender
MSM	Men who have sex with men
NGO	Non-government organization
NSP	Needle and syringe programme
OST	Opioid substitution therapy
PPTCT	Prevention of parent-to-child transmission (of HIV)
PWID	People who inject drugs
SOGI/E	Sexual orientation and gender identity/expression
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SRH	Sexual and reproductive health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
YKP	Young key populations

DEFINITION OF KEY TERMS

Adolescents: People aged 10-19 years.

Children: People aged 0-17 years.

Youth: People aged 15-24 years.

Young people: People aged 10-24 years.

Adolescents selling sex: Refers to people under 18 years of age who are exploited in the sex industry. Under international law they are considered to be sexually exploited children and any sexual act undertaken with them in this context is considered to be an act of violence.

Harm reduction: A comprehensive package of evidence-informed services for people who use drugs, consisting of:

1. Needle and syringe programmes,
2. Drug dependence treatment, including opioid substitution therapy,
3. HIV testing and counselling,
4. Antiretroviral therapy,
5. Prevention and treatment of sexually transmitted infections,
6. Condom programmes for people who use drugs and their sexual partners,
7. Targeted information, education and communication for people who use drugs and their sexual partners,
8. Diagnosis and treatment of, and vaccination for, viral hepatitis,
9. Prevention, diagnosis and treatment of tuberculosis, and
10. Overdose prevention and access to naloxone.

HIV incidence: The number of new HIV cases in a fixed time period divided by the number of people at risk. The formula for incidence rate is: Number of onsets/Number at risk during a given time period x 100.

HIV prevalence: Number of people with a characteristic or behaviour – in this case those who are HIV-positive – at a given time divided by the number of people who could possibly have this characteristic, attribute or behaviour. Prevalence is normally measured in a sample, for instance the number of people who are HIV-positive over the total number of people in the sample.

Men who have sex with men: Refers to all men who engage in sexual and/or romantic relations with other men regardless of their sexual orientation. The term 'young MSM' includes adolescents.

Opioid substitution therapy: Substitution therapy is the administration under medical supervision of a prescribed psychoactive substance, pharmacologically related to the one producing dependence to people with substance dependence, for achieving defined treatment aims. Medicines used in substitution therapy can be prescribed either in decreasing doses over short periods of time (usually less than one month) for treatment of withdrawal or for detoxification, or in relatively stable doses over a long period of time (usually more than six months) for substitution maintenance therapy, which allows stabilization of brain functions and prevention of craving and withdrawal. The term 'substitution therapy' is often used as an equivalent to 'substitution maintenance therapy'. At present the only form of therapy that is available is for people who are dependent on opioids and is therefore referred to as 'opioid substitution therapy'.[1]

People who inject drugs: Refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. The term 'young people who inject drugs' includes adolescents. This definition of injecting drug use does not include people who self-inject medicines for medical purposes, referred to as 'therapeutic injection', nor individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or for improving athletic performance.

Trafficking: Defined as the recruitment and movement of persons, through force and other forms of coercion, abduction, fraud, deception, and abuse of power for the purpose of exploitation. For persons under 18 years, the recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered "trafficking in persons" even if this does not involve any of the means set forth above. For a full definition see The United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Article 3.

Transgender: An umbrella term for all people whose internal sense of their gender (their gender identity) is different from the sex they were assigned at birth. A transgender woman is someone born male who identifies as female and a transgender male, someone born female who identifies as male. Recognition as transgender is not based on sex reassignment surgery. Most countries in Asia and the Pacific have their own terms to refer to culturally specific sub-populations that include feminized men, third gender and/or male-to-female and female-to-male transgender people. The term 'young transgender people' includes adolescents.

Sex workers: Sex workers include female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work may vary in the degree to which it is 'formal' or organized.[2]

Young key populations: People between the ages of 10 and 24 years who are most likely to be exposed to HIV or to transmit it. This report focuses on adolescents belonging to four young key populations: Those who are sexually exploited by (under 18) or engaged in sex work (18 and over), men who have sex with men, people who inject drugs, and transgender people. Central to the report are adolescents living with HIV who acquired it through mother-to-child transmission or during adolescence. Adolescents who are vulnerable to HIV include those in detention centres and other closed settings, orphans, street children, migrants, mobile workers and people with disabilities. Many adolescents will relate to more than one key population. *Note that adolescents at higher risk for HIV and young key populations are used interchangeably in this report.*

Young people selling sex: These refer to people aged 10–24 years. They therefore include both adolescents aged 10-17 years defined as sexually exploited under the Convention on the Rights of the Child and young people aged 18-24 years. This report uses age categories currently employed by the United Nations and the World Health Organization (WHO), it is acknowledged that the rate of physical and emotional maturation of young people varies widely within each category. The United Nations Convention on the Rights of the Child - CRC recognizes the concept of the evolving capacities of the child, stating in Article 5 that direction and guidance, provided by parents or others with responsibility for the child, must take into account the capacities of the child to exercise rights on his or her own behalf.[3]

The United Nations Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child (1989) (CRC) is the global treaty guiding the protection of human rights for people under 18 years of age.[4] One of its key principles is that the best interests of the child should guide all actions concerning children (Article 3). The CRC also recognizes the concept of the evolving capacities of the child (Article 5). The CRC guarantees the rights to non-discrimination (Article 2), life, survival and development (Article 6), social security (Article 26) and an adequate standard of living (Article 27), among other rights. Article 24 stresses "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for treatment of illness and rehabilitation of health". For an expanded summary please see pp. 26-27: http://www.who.int/hiv/pub/toolkits/en/ [5]

Sexual exploitation of children

All forms of involvement of those under the age of 18 years in selling sex, and other forms of sexual exploitation or abuse, contravene Articles 12, 19 and 34 of the CRC and international human-rights law, and governments have a legal obligation to protect those under 18 from such exploitation. Under the CRC people under 18 also have rights to life and health, which are contravened when they are excluded from effective HIV prevention and life-saving treatment, care and support services. The Committee on the Convention of the Rights of the Child has highlighted that young people who sell sex need services that address their risk of HIV and other sexually transmitted infections (STIs), unwanted pregnancies, unsafe abortions, violence and psychological distress. The Committee also emphasizes their right to physical and psychological recovery and social reintegration in an environment that fosters health, self-respect and dignity.[6]

Note about data

This report features some of the latest data reported by countries to the UNAIDS/WHO/UNICEF Global AIDS Response Reporting (GARPR) and published on the AIDS info online database (http://www.uaidsinfoonline.org/devinfo/libraries/aspx/Home.aspx). These data are derived from national HIV or behavioural surveillance surveys and have limitations. Most of these surveillance surveys are not nationally representative, as they are collected from capital cities or a few geographic locations that have concentrated key populations. Some countries report aggregated prevalence and some report separately. In addition, the indicators, data collection methodologies, and age disaggregation levels are not always standardized across countries, and sometimes even within a country.For this reason, the country data essentially provide a snapshot of the situation for young key populations in the region and are not meant to serve as the basis for comparative analysis.

1. INTRODUCTION

Adolescence is a time of wondrous transformation. It is also a time of experimentation with sex and drugs, with potentially grave consequences for the spread of HIV. In Asia and the Pacific, one in seven new infections in 2014 occurred in 15-19 year olds. The region in 2014 accounted for almost one quarter of global new HIV infections among adolescents (aged 10-19).[1] Even as impressive inroads are made against entrenched epidemics in the region, many countries, including Thailand, Indonesia, Pakistan and the Philippines, are witnessing growing HIV infection rates among the most vulnerable adolescent populations.

Adolescents neglected in the HIV response

The number of adolescents aged 10-19 officially estimated to be living with HIV in Asia and the Pacific has trended upwards over the past decade, reaching 220,000 in 2014.[2] This trend is likely to persist unless budgets and priorities quickly adapt to reflect realities. Individuals in the second decade of life are more vulnerable to acquiring HIV than adults and harder to care for once transmission has occurred for many reasons – biological, social, psychological and legal.[3] Yet they are a much less powerful constituency, with often a poor visibility and a weak voice. To date they have been a neglected component of national HIV testing, treatment, care and support strategies. This inequity needs to be redressed – urgently.

Adolescent AIDS-related deaths on the rise

In Asia and the Pacific, it is likely that fewer than one third of all HIV-positive adolescents receive life-prolonging antiretroviral therapy (ART).[4] Late diagnosis of HIV and a delayed start to often-inadequate treatment, or a lack of diagnosis and treatment altogether, have fuelled rising fatalities. AIDS-related deaths of 10-19 year olds in the region increased by 110 per cent between 2005 and 2014.[5] In contrast, AIDS-related adult deaths fell by 28 per cent over the same period.[6]

Adolescents at higher risk among the most marginalized

Adolescents most at risk of exposure to HIV in Asia and the Pacific are the young key populations, namely young men who have sex with men (MSM), young people selling sex, young people who inject drugs (PWID) and young transgender people. The fastest-growing epidemics in the region – especially in big cities – are among young MSM and PWID.

Adolescents from these key populations are at greater risk of acquiring HIV than their older peers – themselves often on the back burner of the HIV response – while being even more underserved. They are also among the most marginalized – often rejected by their families and ignored by health, education and other services. However their social and economic circumstances might differ, these are compounded by the emotional insecurities of adolescence, such as the expectation to conform to gender roles, low self-esteem, understanding their sexuality, and having sex not just for pleasure but because of peer pressure. Young people also commonly believe that they themselves are not likely to run into danger even while perceiving that others engaging in the same risky behaviours are at risk.

A punishing legal environment and severe taboos around same-sex relations, injecting drug use and selling sex tend to drive these behaviours underground, reinforcing the exclusion of adolescents and perpetuating the infection cycle. Adolescents under 18 who sell sex or are otherwise defined as sexually exploited tend to be the most unseen, unheard and unhelped group. Hidden under the matrix of laws that criminalize the sexual exploitation of children, they are frequently placed in detention centres and involuntary shelters, and report being harassed, sexually assaulted, raped and violated by the very people who are meant to protect them – police and law enforcement personnel.[7]

Entrenched stigma and oppressive laws hinder progress

Deep-rooted stigma and discrimination – personal and institutionalized – exact a heavy toll on adolescents, hindering many from going to health clinics for HIV testing and HIV-related services. If they do take an HIV test, they may not pick up the results. Or they may hide their HIV status and refrain from seeking treatment. Or they may begin treatment and then drop out. The Convention on the Rights of the Child stipulates that all children have the right to protection against ill health, which includes the right to information, skills and services to prevent and treat HIV and other sexually transmitted infections. Access to health services, according to the CRC, should be based firmly on the principles of individual voluntary consent, assent and confidentiality.[8] In many Asia-Pacific countries, however, adolescents under 18 years are deemed to be too young to give their consent, and national laws and policies supposed to protect their best interests effectively do the opposite – barring them from testing and other services without parental or spousal consent.

Discriminatory attitudes in schools against young people living with HIV are still common. Indeed, because of stigma, spread by inappropriate fears and myths about transmission, some educational institutions continue to prevent children who are HIV-positive – and those who are affected by HIV – from attending. This, even as a majority of schools in the region report that school-based HIV education has been successfully implemented.

High levels of unprotected sex

Adolescents from key populations are not consistent users of condoms, which are highly effective barriers against HIV transmission. Common reasons for unprotected sex include forced or coerced sex,[9] condoms not being available or too costly to buy, lack of knowledge about HIV, trusting that a partner is 'healthy', and drug or alcohol use. The belief that condoms diminish sexual pleasure is also a factor. For those selling sex, the incentive to make more money by agreeing not to use a condom can be a deterrent, while some clients refuse to wear one. Procuring condoms and condom-compatible lubricants that help prevent HIV transmission during anal sex can be especially difficult for adolescent migrants, detainees and those who are trafficked.

Data gaps hamstring action

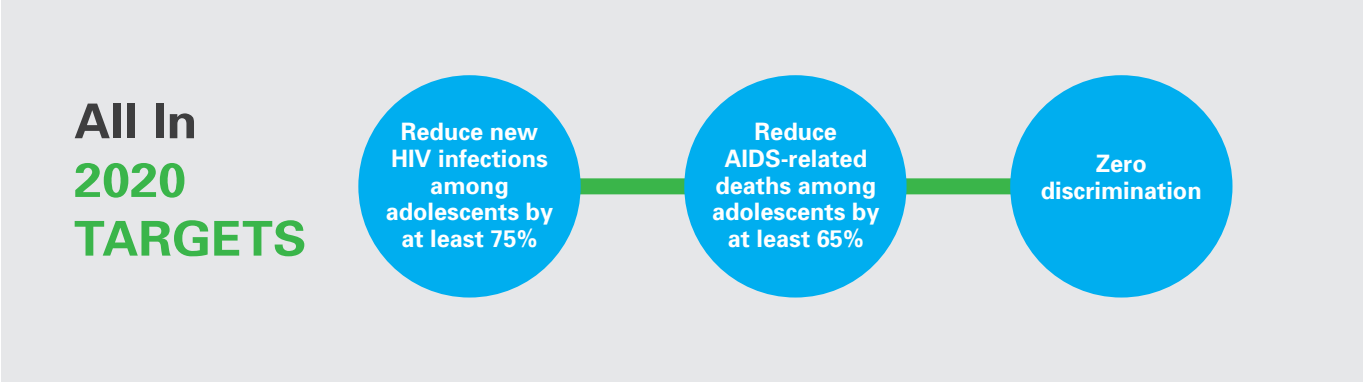
Although we know which adolescent populations are at highest risk of HIV infection, we don't have a firm grasp on the HIV prevalence of these populations, nor indeed of the extent of their risk behaviours or their whereabouts. The reason is scarce data. Every country in the region collects routine HIV sentinel surveillance data, with most countries including criteria for people aged 15-19. In practice, however, data for those under 18 are often hard to obtain because of ethical and parental consent issues. Where there are data on 15-19 year olds, they tend to be aggregated into under 25 or 15+ age cohorts and rarely analysed as a distinct group. The scarcity of intelligence on adolescents has contributed to their absence from policies and programmes designed for youth in general. This is particularly the case for young transgender women who are often categorized as MSM. Accurate, disaggregated data are needed for focused, comprehensive programming for adolescents. Closing the data gap therefore is crucial.

New global targets for ending HIV in adolescents

Aggressive ramping up of the adolescent HIV response in Asia and the Pacific is vital to achieving an end to the worldwide AIDS epidemic as a public health threat by 2030. UNAIDS, UNICEF and a broad coalition of partners are promoting **"All In"**, a movement started in 2015 that aims to address the neglect of adolescents in the global AIDS response. **All In** has a concrete agenda to fast-track data generation, action and results for adolescents. Two specific targets have been set for 2020:

- A minimum 75 per cent reduction in new HIV infections (from 2010 levels) among adolescents at higher risk of HIV
- Minimum 65 per cent reduction in AIDS-related deaths among adolescents at higher risk of HIV.

All In is a time-bound plan for a seismic shift. And it requires a whole new investment mind-set.



Smart Investments in proven strategies

While programmes that have stemmed the tide of HIV in adults have a strategic place on the adolescent agenda, it would be wrong to apply a one-size-fits-all investment approach. For the greatest leverage, investment to curb HIV infection in adolescents and prevent AIDS needs to be nuanced and targeted to strategies that meet their specific needs, realities and vulnerabilities. In Asia and the Pacific, three key strategies for adolescents from key populations, rooted in the Investment Framework for the global HIV response,[10] are recommended:

- Scaling up high-impact Interventions focusing on condom and lubricant promotion, harm reduction services, testing and counselling, and treatment, care and support.

- Turning political commitment on HIV into action, removing legal barriers to testing, treatment and harm reduction services, upholding human rights, promoting community-based and community-led services (critical enablers), and fortifying protection and education systems (development synergies).

- Generating strategic information, research and analysis on adolescents at higher risk of HIV infection, including disaggregation of data by age, gender and risk behaviours.

What works for adolescents

Some elements of these strategies are already in place and producing results. Where applied, for example, high-impact interventions for young key populations are reducing new HIV infections, prevalence and mortality rates.

Successful approaches that are helping to protect the physical and mental health of adolescents at risk of or living with HIV in the region (and for which there exist some, albeit limited, data) include:

- Distribution of free condoms and condom-compatible lubricants to young people.
- Needle and syringe programmes (NSPs) and opioid substitution therapy (OST) that are free, voluntary, available and accessible to adolescents.
- Comprehensive sexuality and HIV prevention education in schools.
- Reduced age at which adolescents can take an HIV test without parental consent.
- Available adolescent-sensitive and community-led sexual and reproductive services, including HIV testing and counselling, and treatment.
- HIV testing, counselling and related services for young people that are local, confidential, quick, non-judgemental and free.
- Peer outreach to adolescents at higher risk of HIV, providing them with information about HIV and support to access prevention, treatment and care services.
- Use of smart phone technology and social media platforms to raise awareness about HIV.
- Advocacy by youth activist networks to transform social norms and include young key populations in decision-making.
- Peer support networks that provide on-the-ground practical help for those at risk of and living with HIV.

This is by no means a full list. Rather, the comprehensive set of recommendations at the end of this report – anchored within the three key strategies – can be interpreted as a road map to establishing exactly 'what works' to prevent, diagnose and treat HIV in adolescents in Asia and the Pacific (see the section **'Moving forward to zero'**).

Adolescent participation is pivotal

While far from standing alone as essential, community and peer-led actions to safeguard the health of adolescents living with HIV or from key populations nevertheless merit special mention. The participation of adolescents in shaping relevant policies and programmes for their own generation is central to ending the AIDS epidemic. After all, they know their needs better than anyone else.

Costs of continuing the funding status quo

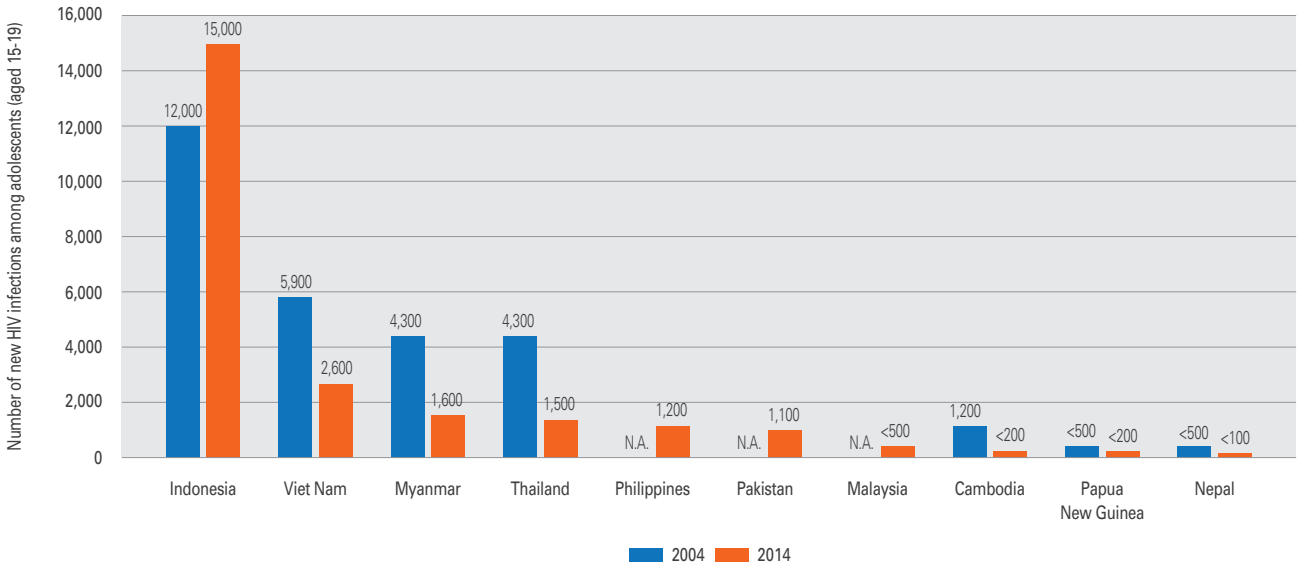
To reach the **All in** targets for adolescents, a rallying of resources is needed. Based on Investment Framework modelling, UNICEF and the Futures Institute estimate that in 2016, roughly US$759 million are required for a comprehensive adolescent HIV response in Asia and the Pacific. By 2020, budgetary needs are expected to increase to US$1.025 billion and decline only slightly each year over the ensuing decade.[11] The alternative – maintaining the resource status quo – will be costly, measurable in thousands of new adolescent infections and AIDS-related deaths by 2020.[12] Compelling evidence – as this report aims to provide – is on the side of expanded and expedited investments in multidisciplinary strategies to ratchet up the HIV response in adolescents as a step to an AIDS-free Asia and Pacific.

2. HIV AND ADOLESCENTS IN ASIA AND THE PACIFIC: OVERVIEW

More than half of the world's 1.2 billion adolescents live in Asia and the Pacific. Just four countries in the region – India, China, Indonesia and Pakistan – have a combined adolescent population of 500 million. While the vast majority of people under the age of 20 are at low risk for HIV, there are pockets where prevalence is extremely high – in double digits among some key populations in Hanoi, Jakarta, Bangkok, Chiang Mai, Mumbai and other urban areas. Large national populations mean that HIV hotspots in otherwise low epidemic settings can comprise sizeable numbers of people.

Between 2000 and 2014, the global annual rate of new HIV infections among adolescents aged 15-19 fell quite substantially, mainly because of the decline in new cases in eastern and southern Africa (from almost 200,000 to 100,000).[1] However, since 2004, the annual number of new HIV cases among adolescents in Asia and the Pacific has declined only slightly for the region as a whole. In 2014, an estimated 50,000 adolescents aged 15-19 in the region became HIV-positive (see Figure 1), accounting for almost 15 per cent of all new cases in Asia and the Pacific.[2] In the Philippines alone, new HIV infections among 15-19 year olds rose from an estimated 800 in 2010 to 1,210 in 2014 and 1,403 in 2015.[3]

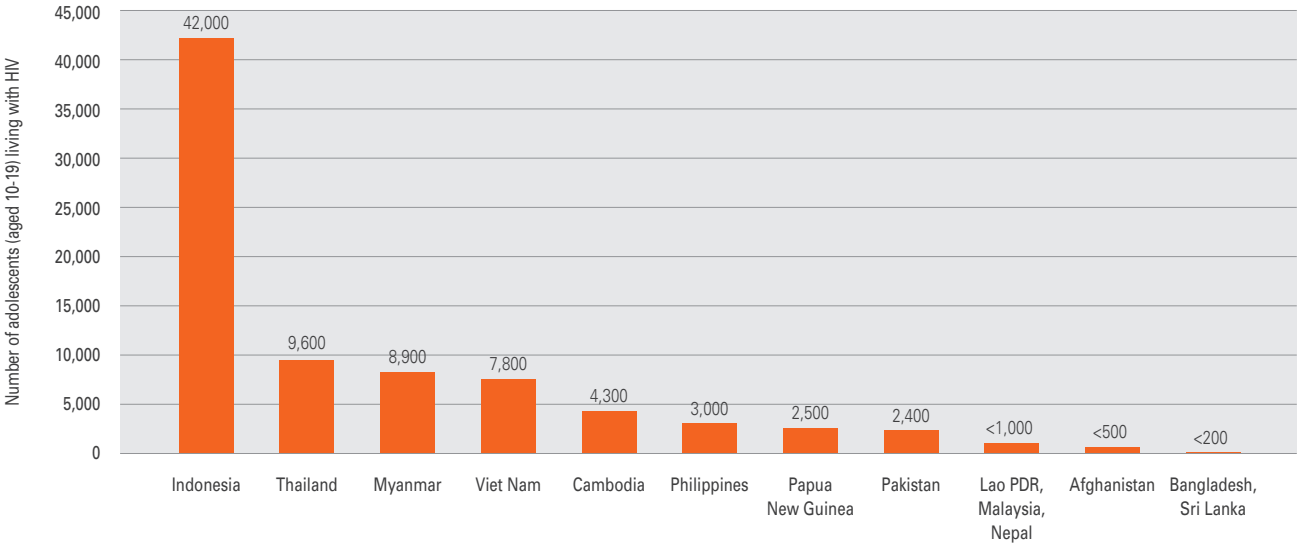
Figure 1: Estimated number of new HIV infections among adolescents (aged 15-19), Asia-Pacific, 2004 and 2014[4]



Note: Data for China and India are not available for both years. Data for the Philippines, Pakistan and Malaysia are not available for 2004.
Source: UNAIDS 2014 HIV estimates (July 2015).

In 2014, 220,000 adolescents (aged 10-19) were estimated to be living with HIV in Asia and the Pacific. The HIV burden among adolescents falls heaviest on 10 countries, namely India, Indonesia, Thailand, Myanmar, Viet Nam, China, Cambodia, the Philippines, Papua New Guinea and Pakistan, which together account for 98 per cent of adolescents (aged 10-19) living with HIV in the region. Among countries where data are available, the Philippines and Papua New Guinea have a significant proportion of adolescents living with HIV, accounting for almost 10 per cent of people living with HIV in the country.[5]

Figure 2: Estimated number of adolescents (aged 10-19) living with HIV, Asia-Pacific, 2014



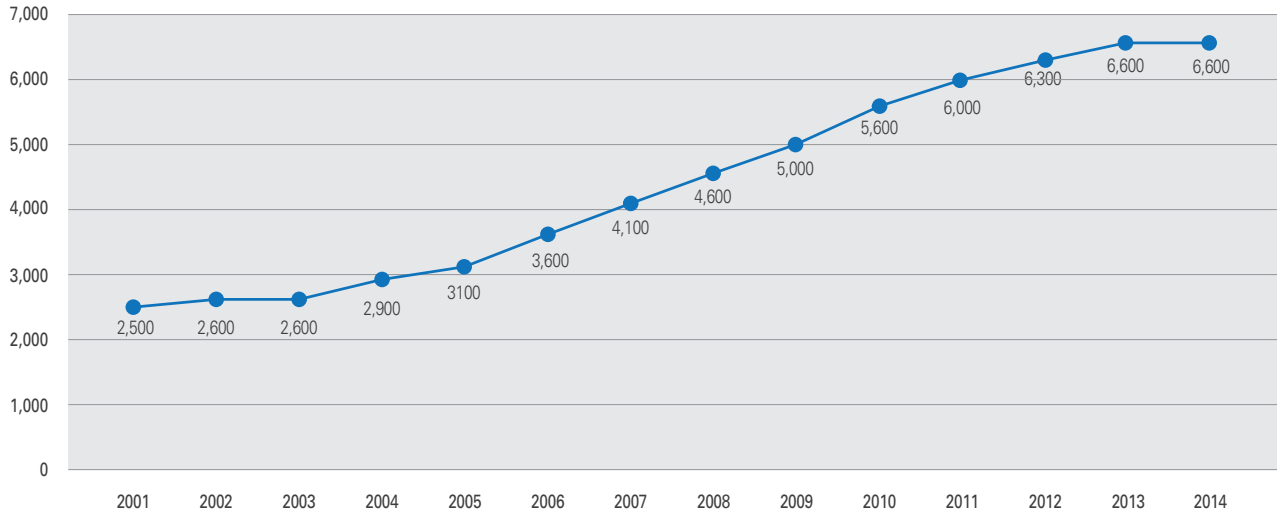
Note: Data for Bhutan, China, Fiji, India, Maldives and Mongolia are not available. For Lao PDR, Malaysia, and Nepal, each country has <1000 adolescents (aged 10-19) living with HIV. For Bangladesh and Sri Lanka, each country has <200 adolescents (aged 10-19) living with HIV.
Source: UNAIDS 2014 HIV estimates (July 2015).

A growing death burden

While more adults than ever are accessing antiretroviral therapy and maintaining their health, coverage rates for HIV-positive adolescents are lagging behind,[6] with serious ramifications for survival. In Asia and the Pacific, many adolescents who acquired HIV through mother-to-child transmission were diagnosed and treated too late, or were never diagnosed or treated at all, enabling progression of the disease through childhood.[7] Some adolescents who began treatment as young children were unable to make the transition from paediatric to adult treatment while others have dropped out of the 'care continuum' at different stages. Some of those who acquired HIV during adolescence are also not being tested or treated quickly enough to suppress viral loads.

In South Asia, AIDS-related deaths among 10-19 year olds have almost quadrupled, from around 1,500 in 2001 to 5,300 in 2014. In East Asia and the Pacific, deaths among this age cohort increased from 1,000 to 1,300 over the same period.[8]

Figure 3: Estimated number of AIDS-related deaths among adolescents (aged 10-19), Asia-Pacific, 2001-2014



Source: UNAIDS 2014 HIV estimates (July 2015)

Risky behaviours begin in adolescence

High-risk HIV behaviours begin in adolescence – a period of immense and often turbulent physical, psychological, emotional, sexual and social change. It is a time when boundaries are pushed back, independence is exerted, and societal norms, including around sexuality and gender, are both questioned and reinforced. Experimentation involving unprotected sex and injecting drugs is not always – or perhaps is rarely – accompanied by an awareness of the health consequences that may result, especially in the absence of sexuality and HIV education in and out of school. Even where there is awareness, the sense of immortality and the I'm-not-at-risk-but-others-may-be perception that are common to youth as well as the need for instant gratification can downplay the recognition of any apparent perils. It is important to acknowledge that an adolescent's ability to make choices is in keeping with the normal brain development process, which typically ends around 25 years of age.[9]

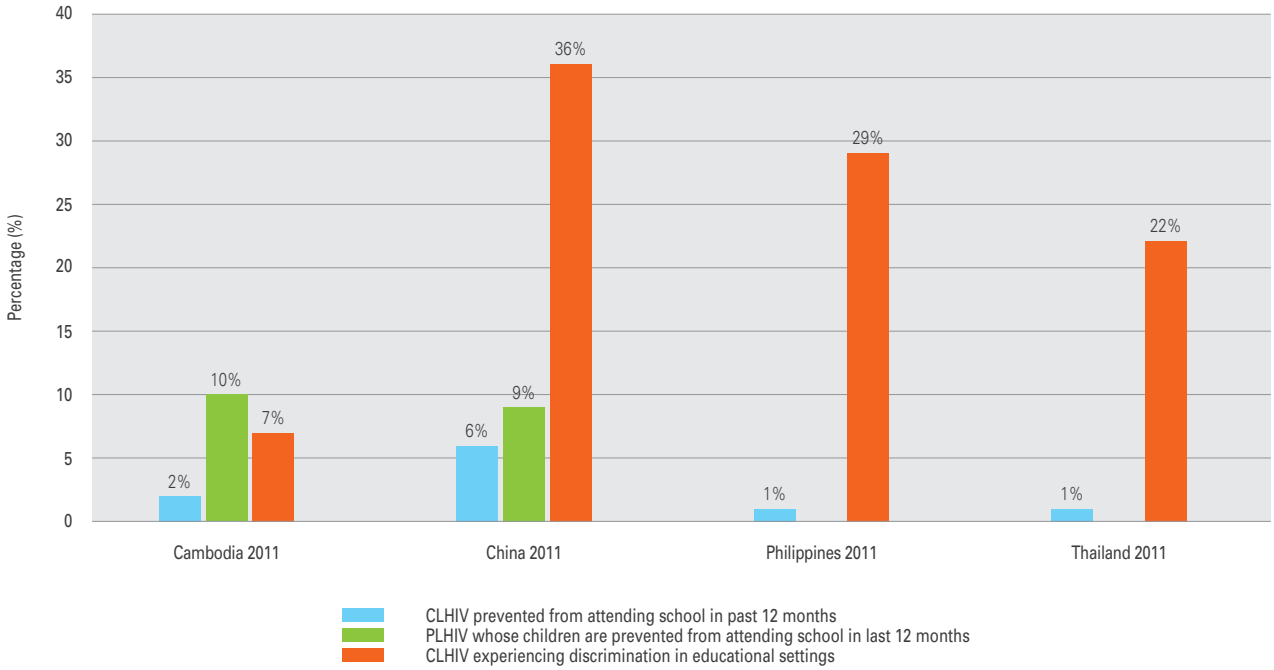
Other issues pertinent to adolescence, such as low self-esteem and confidence, a lack of power and even the desire to emulate one's peers, can increase the risk of HIV infection. So can rejection by the family because of behaviours that are widely condemned (e.g. same-sex relations and injecting drug use). Moreover, adolescents are especially vulnerable to acquiring HIV because of their young age, which puts them at a disadvantage because of their early exposure to risk. This may be particularly the case if they are having sex with older people from key populations. It is a statistical probability that over time, an adolescent or young MSM is more likely to join the pool of individuals who are HIV-positive (the 'prevalence pool) – bearing in mind that the majority of those contributing to high HIV prevalence in the region are 25 and older. Once they have acquired HIV, adolescents and young people also have a greater potential of transmitting it to others.[10] This is because HIV risk behaviour is generally highest among young people and lessens as individuals form long-term relationships.

Adolescence can be a period of immensely positive and exciting transformation, providing excellent opportunities to reinforce sound health, nutrition and learning practices for a lifetime. However, adolescents at higher risk of and those living with HIV in Asia and the Pacific often fall outside the reach of these opportunities. They tend to be marginalized from the mainstream and face punitive environments associated with same-sex relations, injecting drug use and selling sex. They are also subject to rampant stigma and discrimination in and out of school.

Stigma and discrimination in schools

Schools arguably rank with family as among the most influential environments for young people, their protective role for children commonly enshrined in laws, if not constitutions. Yet even today, the stigma attached to HIV is such that young people living with and affected by HIV are not only frequently subjected to discriminatory behaviour in school, but in some cases are prevented from going to school altogether, even though in theory they have the same right of admission and access to education as every other child. In China, the Philippines and Thailand (among others), discriminatory behaviour in educational settings remains rife (see Figure 4). In China, for example, over one third of children living with HIV experienced discrimination in the classroom, and 9 per cent of the children of people living with HIV were prevented from going to school in the last 12 months.[11] The fact that China has guidelines on HIV prevention education in schools, and addresses HIV in the primary and secondary school curriculum[12] suggests a large disconnect between what is being taught under school policy and ingrained attitudes and fears about HIV.

Figure 4: Discrimination against children living with and affected by HIV in school settings, East Asia and the Pacific, 2011 [13]



Note: Data for "% of PLHIV whose children prevented from attending school in the last 12 month" are not available for the Philippines and Thailand for 2011.
Source: People Living with HIV Stigma Index: Asia Pacific Regional Analysis, UNAIDS (2011).

3. EPIDEMICS AMONG ADOLESCENTS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YOUNG MEN WHO HAVE SEX WITH MEN

Cities are major infection hubs

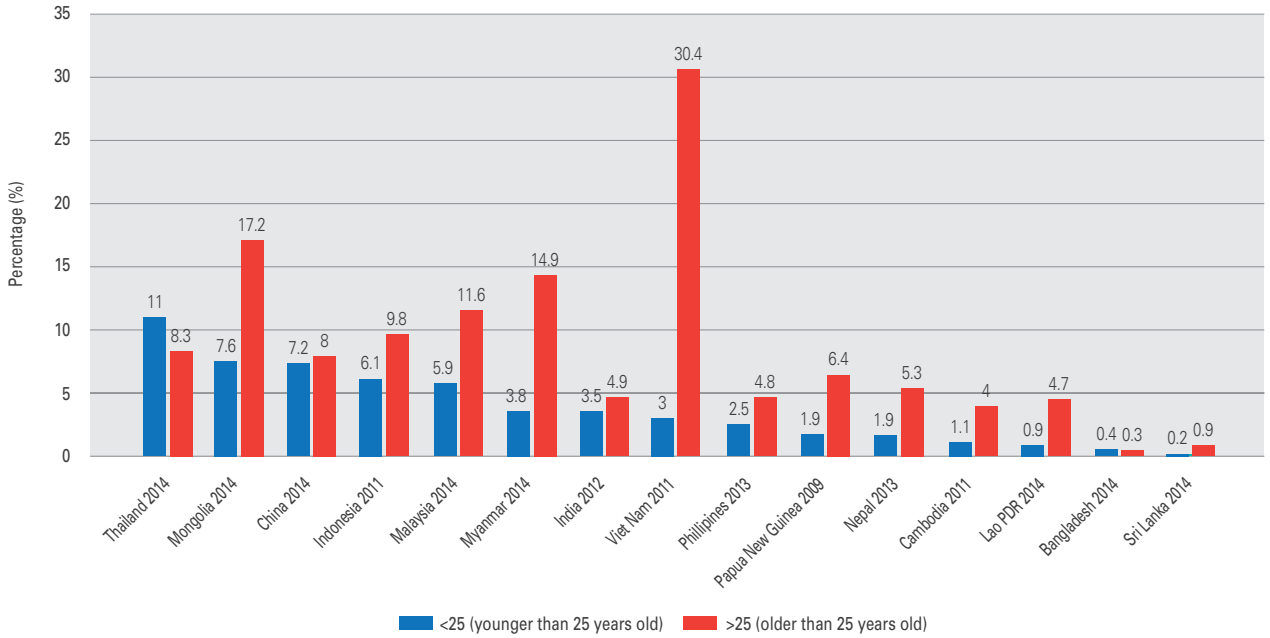
Estimates for the regional number of MSM range from 10.5 million to 27 million – a substantial population.[1] In the Philippines, MSM are estimated to make up 3 per cent of the population (730,917), with 15-19 year olds estimated at one fifth of MSM aged between 15 and 49.[2] Many MSM acquire HIV when they are young. The failure to reach this group with relevant risk information and provide focused support is unleashing some 'told-you-so' consequences.

"Five years ago, the Commission on AIDS in Asia predicted that if men who have sex with men did not become a greater focus of HIV prevention efforts, this population would bear nearly half of all new infections by 2020 and represent the largest share of new infections among key populations at higher risk. Five years later, overall trends of new HIV infection hint that the Commission's prediction is becoming a reality." So said UNAIDS in its 2013 report on HIV and AIDS in Asia and the Pacific.[3]

Thailand – which has successfully tackled a generalized HIV epidemic – is one of at least five countries in the region with concentrated epidemics among MSM under 25 (defined as national prevalence of more than 5 per cent). The others are China, Indonesia, Malaysia and Mongolia (see Figure 5). Even so, in many cases high national prevalence masks even higher capital city prevalence.

In Thailand, HIV prevalence among all MSM was estimated at 7.1 per cent in 2012, but it was more than triple that – 24.4 per cent – in Bangkok.[4] The incidence of HIV (rate of new infections) among young MSM is rising, while falling among older men (who nevertheless may have higher HIV prevalence, having already acquired HIV). In a Bangkok cohort study of 4,762 young MSM (2006-2011), the probability of those aged 18-21 acquiring HIV over a five-year period was over 30 per cent, the highest among all age groups.[5] This same study found that the rate of new infection was 12.2 per 100 persons among 15-21 year-old MSM, nearly double the rate seen among all ages combined (6.3 per 100 persons).[6]

Figure 5: HIV prevalence among MSM (<25 and >25), Asia-Pacific, 2009-2014



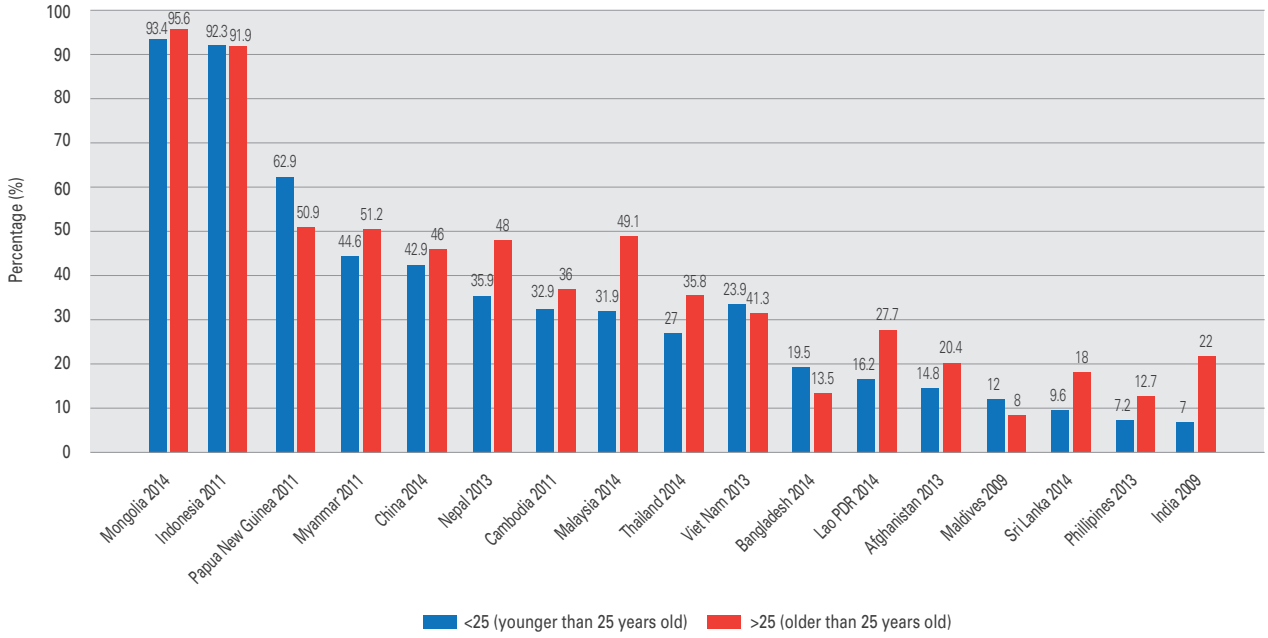
Note: Data refer to countries where data are available in Asia Pacific. Data may not reflect national figures, but represent locations included in sample. Years are indicated as available in AIDS Info online and do not necessarily reflect the year of survey. Data for MSM <25 in India are from 2012, and data for MSM >25 in India are from 2013.
Source: AIDS Info online: http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx; October 2015. Query "1.14 MSM: HIV prevalence", <25 yrs and >25 yrs.

Bangkok's intensifying HIV epidemic among young MSM is largely a result of extensive sexual risk-taking, a higher number of partners, overall increased biological vulnerability through unprotected anal sex with an HIV positive partner, low uptake of HIV testing, and an earlier age of first sex – frequently in the low to mid-teens.[7] All of these phenomena are common to other cities in and outside of Thailand. The explosion of smart phone gay dating apps has expanded the options for casual spontaneous sex as never before – mobile app users in the same vicinity (if not the same street) can locate each other and arrange an immediate sexual encounter with a few screen touches.

In high-prevalence areas in the region, up to 20 per cent of MSM buy sex from male sex workers,[8] many of whom appear to be adolescents. In Pakistan, for example, 41.5 per cent of 1,205 male sex workers who were interviewed in six cities for a third round of surveillance were aged 15-19 and over a third were 20-24.[9] Among MSM, selling sex is often associated with an increased likelihood of being younger, unemployed, having less education, using drugs, engaging in high-risk sexual practices and being raped, compared to MSM who do not sell sex.[10] Selling sex can lead to higher rates of infection among young MSM[11] (although prevalence data for adolescents are largely lacking). Information from Pakistan (2011) showed 0.7 per cent of 15-19 year-old males selling sex surveyed tested positive for HIV,[12] while 2010 data from Papua New Guinea showed 15 per cent were HIV-positive.[13]

In Mongolia and Indonesia, over 92 per cent of MSM aged under 25 surveyed reported having tested for HIV in the previous year and receiving the results (see Figure 6). In Papua New Guinea, over 60 per cent of respondents aged under 25 reported likewise. However, in many countries of the region, including China, Thailand and Malaysia, well over half of MSM under 25 who were surveyed (2014 data) reported not knowing their HIV status. For adolescents, available data suggest that in some places awareness of HIV status is extremely low. In the Philippines, roughly 95 per cent of 15-19-year-old MSM reported never having been tested for HIV, compared with around 85 per cent of MSM aged 20-24 and three quarters of MSM aged 25 and above.[14]

Figure 6: MSM (<25 and >25) who received an HIV test and knew their result, Asia-Pacific, 2009-2014



Note: Data refer to countries where data are available in Asia-Pacific. Data may not reflect national figures, but represent locations included in sample. Years are indicated as available in AIDS Info online and do not necessarily reflect the year of survey.
Source: AIDS Info online: http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx; October 2015. Query '1.13 MSM: HIV Testing', <25 yrs

Initials: JA, aged 28, the Philippines
Young key population: MSM

I was very vulnerable to HIV before I even turned 18. Those were years when I was exploring my sexuality and trying to find ways to handle the pressure from school and high expectations from home. I also suffer from chronic depression, particularly when my romantic relationship fails. Because of this, I was having unprotected penetrative sex with different boys who I barely knew and who I met through social media on the Internet.

As I grew older, my awareness about HIV increased. My behaviour changed a bit (i.e. having less sex and fewer sexual partners). But because of my chronic depression, I sometimes still fall back to my old ways. I received formal HIV prevention education when I was 15. It was very biological in nature and since it was conducted in school, it felt awkward with the teacher. The informal education I got when I was 23 and working was much better. I was given this information when I went for my first HIV counselling and blood test. I was really scared, because while I was briefed about the process, I was afraid of the injection and knowing my status. I was scared of the implications of being HIV-positive in my relationship with my parents and friends. Back then, I thought HIV was a death sentence and that I would probably soon die from it. The peer counsellor who assisted me, however, was very approachable and hospitable. She answered a lot of my questions and concerns about HIV.

A lot of testing centres in my country are places where sex workers regularly go. It can be difficult to get tested because when you queue there, people will ask for your identity card, assuming that you are a sex worker, which is very uncomfortable. If mental health-related services were available, then it probably would have helped lower my risk of getting HIV. I think it's so important to have an environment where young people from key populations can talk about their personal issues without judgment and prejudice; a space where there are not only peers but also professionals who can also attend to the needs of young people.

YOUNG PEOPLE SELLING SEX

Across the region sex is sold in numerous ways and places and for reasons running the gamut from informed occupational choice at one end, to intense poverty, needing to support the family, violence and trafficking at the other. The activity is in constant flux, continually integrating new technologies into its modus operandi (e.g. mobile phones apps, texting, emails, chats, videocam, social networking sites and web advertising). For adolescents of all genders, as with their older peers, the nature of selling sex varies: from the sexual acts performed (such as penetrative and receptive anal sex and oral sex); the location where sex is sold (e.g. on the street or in hotels, brothels, bars, industrial areas or beaches); and the ways of working (such as informal, individual or organized). Adolescents are more likely to be freelance (working individually), with common contact sites including streets and bus stands, shops, restaurants and bars.[15]

Early start to selling sex

Survey data from Asia and the Pacific reveal that a high percentage of women who sell sex do so for the first time as adolescents, with many beginning in their early teens. In India, 40 per cent of the estimated 3 million females in the sex industry are under 18, with 17 per cent under 15 according to one study.[16] In Thailand, one third of females selling sex in massage parlours and brothels began before they were 18.[17] The median age of females selling sex in the Maldives and Papua New Guinea is 17-19.[18]

Children who are involved in selling sex are considered by the universally ratified (in Asia and the Pacific) Convention on the Rights of the Child to be sexually exploited.[19] The CRC regards such children as victims of sexual violence who are not to be treated as offenders and prosecuted. Although governments have a legal obligation to prevent the sexual exploitation of children,[20] laws, policies and police practices are not always implemented in a manner that effectively prevents exploitation, protects survivors and brings perpetrators to account.

Serious HIV inroads

Adolescent females who sell sex are extremely vulnerable to HIV and a host of other sexually transmitted infections and sexual and reproductive health problems, including unplanned pregnancy. They are more prone to violence than their older peers,[21] less capable of negotiating condom use, more likely to use drugs and alcohol, and less likely to test. Adolescents who are trafficked face some of the slimmest odds of escaping HIV. They commonly have little or no control over their sexual lives, have restricted mobility, low access to preventive health services,[22] and are at high risk of sexual violence, including rape, as a means of eroding their sense of self-worth or coercing them into sexual exploitation.[23] A survey in Mumbai, for example, found that almost 1 in 4 trafficked females tested HIV-positive[24] as did 38 per cent of females trafficked for sexual exploitation in a Nepalese study.[25]

There is considerable variation across the region in HIV prevalence among sex workers aged under 25. Papua New Guinea has the highest reported prevalence among countries where data are available, and China the lowest (see Figure 7).


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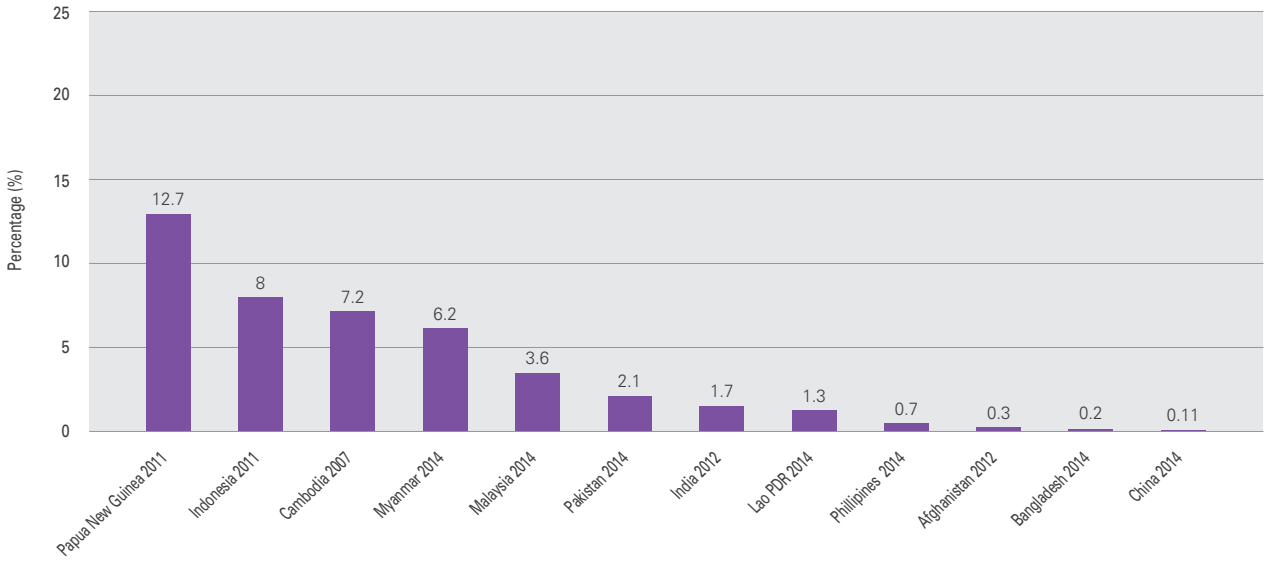
Figure 7: HIV prevalence among sex workers (under 25), Asia-Pacific, 2007-2014

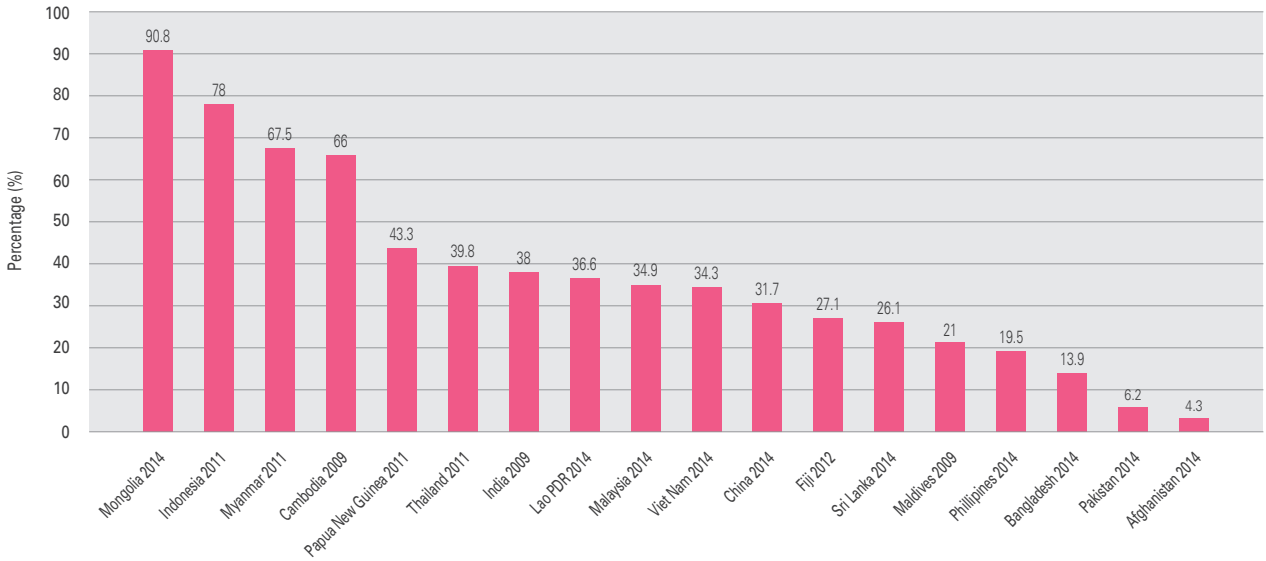


Note: Data refer to countries where data are available in Asia-Pacific. Data may not reflect national figures, but represent locations included in sample. Years are indicated as available in AIDS Info online and do not necessarily reflect the year of survey.
Source: AIDS Info online: http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx; October 2015. Query '1.10 Sex Workers: HIV prevalence', <25 yrs.

In hotspot urban areas, HIV prevalence can be many times the national prevalence. In one example, 48 per cent of 18-24-year old sex workers in Mumbai were found to be HIV-positive as were 30 per cent of sex workers in Thane-based brothels (2009-2010).[26] In general, female sex workers in Asia and the Pacific are 29 times more likely to be living with HIV compared with all women of reproductive age, according to a global systematic review in low and middle-income countries.[27]

The younger the age of women selling sex, the less they tend to know about HIV, based on comprehensive knowledge questions. The news is not terribly encouraging either on awareness of HIV status. The latest available data (2014) show that Mongolia has the highest percentage of sex workers aged under 25 who report having had an HIV test in the past year and knowing the result (see Figure 8). Only around one third of sex workers in China, Thailand, Viet Nam and Lao PDR report likewise.

Figure 8: Sex workers (under 25) who received an HIV test and knew their result, Asia-Pacific, 2009-2014



Note: Data refer to countries where data are available in Asia Pacific. Data may not reflect national figures, but represent locations included in sample. Years are indicated as available in AIDS Info online and do not necessarily reflect the year of survey.
Source: AIDS Info online: http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx; October 2015. Query '1.9 Sex Workers: HIV Testing', <25 yrs.

Efforts to prevent HIV in sex workers are multiplying in the region (some with notable success) and general prevention efforts among youth continue. However, adolescents who sell sex tend to fall between the cracks of both these responses. Health services - including testing and treatment for sexually transmitted infections – often are not given legal protection to cover those under 18 and neglect to refer them to appropriate child welfare services. Child welfare services, for their part, are often overstretched and under-funded, and their collaboration with HIV prevention and treatment programmes is often missing.

YOUNG PEOPLE WHO INJECT DRUGS

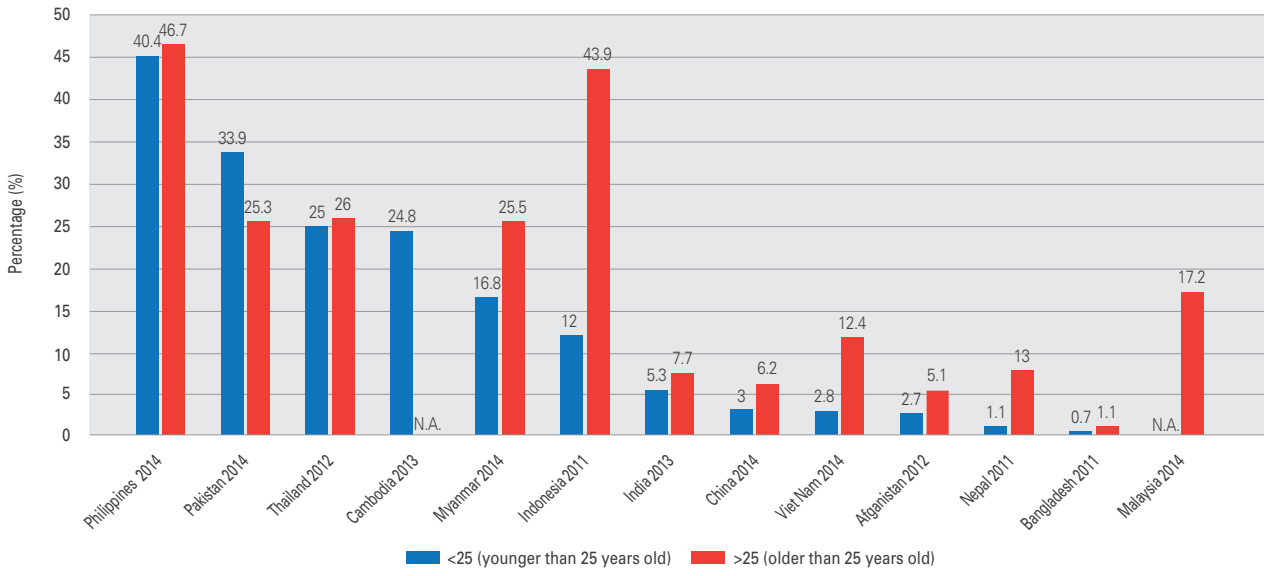
There are an estimated 3-5 million PWID in Asia and the Pacific,[28] a majority of whom started injecting in their late teens and early twenties, according to surveys. The use of non-sterile injecting equipment is one of the most efficient ways of transmitting HIV, putting PWID at the top rung of the risk ladder.

The Philippines and Pakistan report by far the highest HIV prevalence among young PWID in the region (see Figure 9) with some of the lowest rates of sterile injecting equipment use (Figure 14) and condom use at last sex (Figure 12). Pakistan is also the only country that reports higher HIV prevalence among PWID aged under 25 than for those who are older (33.9 per cent vs. 25.3 per cent, respectively).[29] While China's prevalence for younger PWID is reported at 3 per cent, the country has the highest number of young people who inject drugs, storing up a potential HIV time bomb vis-à-vis young users.[30]

Some countries (Thailand, Indonesia and Myanmar) report 70 per cent plus rates in the use of sterile equipment in addition to double digit HIV prevalence among young PWID. Indeed, HIV prevalence among PWID aged under 25 is much higher, proportionately, than among the same age cohort of sex workers and MSM in a majority of countries where such data are available.

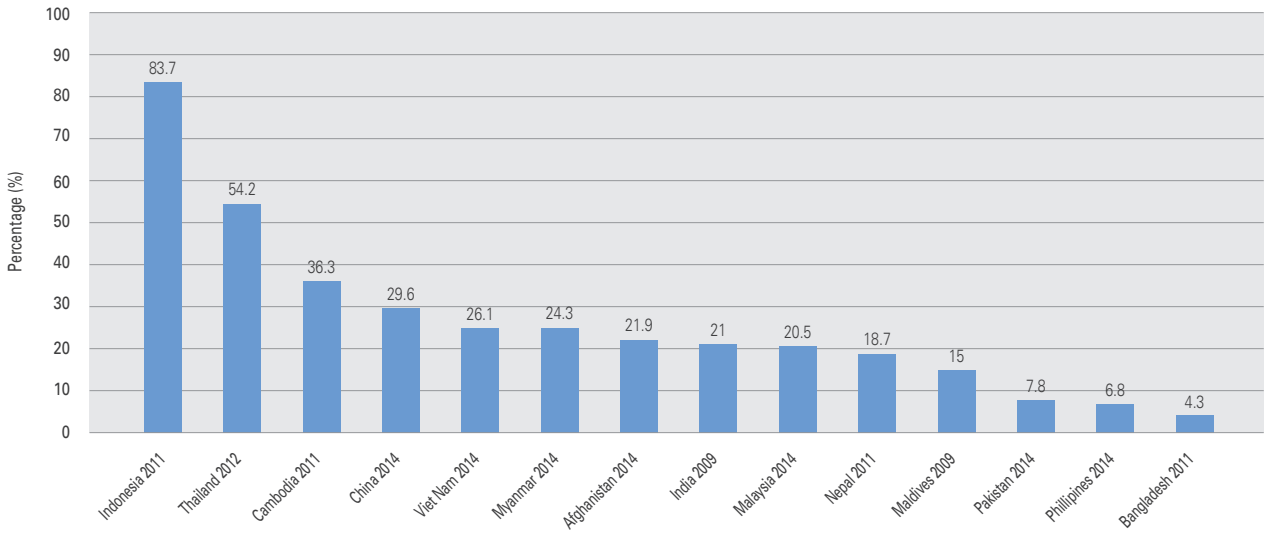
One factor that could contribute to high HIV prevalence is the greater frequency of unprotected sex reported among PWID in many countries (see section on **condom use** in 'High-impact interventions'). Another factor to consider is that PWID may engage in other risky behaviours, thereby increasing their risk of exposure to HIV. It is not uncommon to find a young injecting drug user selling sex for money for drugs or in exchange for drugs. Moreover, in many countries, a majority of PWID are apparently unaware of their HIV status (see Figure 10), which increases the chances of transmission to others. In the Philippines and Pakistan, according to the available data sets, fewer than 10 per cent of those under 25 reported having taken an HIV test in the past 12 months and knowing the result.

Figure 9: HIV prevalence among people who inject drugs (<25 and >25), Asia-Pacific, 2011-2014



Note: Data refer to countries where data are available in Asia-Pacific. Data may not reflect national figures, but represent locations included in sample. Years are indicated as available in AIDS Info online and do not necessarily reflect the year of survey. Data for PWID >25 in Thailand are from 2014. Data for PWID >25 in Cambodia and PWID <25 in Malaysia are not available.
Source: AIDS Info online: http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx; October 2015. Query '2.5 People who inject drugs: HIV prevalence', <25 yrs and >25 yrs.

Figure 10: People (under 25) who inject drugs who received an HIV test and knew their result, Asia-Pacific, 2009-2014



Note: Data refer to countries where data are available in Asia-Pacific. Data may not reflect national figures, but represent locations included in sample. Years are indicated as available in AIDS Info online and do not necessarily reflect the year of survey.

Source: AIDS Info online: http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx; October 2015. Query '2.4 People who inject drugs: HIV testing', <25 yrs.

Initials: SA, aged 24, Indonesia
Young key population: Female sex worker and PWID

Before I was 18 I was injecting drugs using non-sterile equipment. At that time I had already heard about HIV infection through dirty injecting equipment. But when I was in withdrawal it was hard to wait for outreach workers to get to me or to look for sterile equipment so I just cleaned the needles I had with water, and if possible, bleaching liquid. I think it's easier to find this than a sterile needle. You can buy it in the mini-market and you don't have to worry about the police. When I was older I always made sure the equipment that I used was sterile or I didn't use it at all, because I knew that bleaching liquid would protect you from HIV but not from HCV.

I did receive a bit of formal HIV education from school, but mostly I learned from organizations that focus on HIV. I am much more comfortable with support and education from peers in the community, because they are friendly and don't judge. I first tested in 2011. I was uncomfortable, not only about the result but also because everyone in the waiting room in the hospital looked at me when I said, "I've come for HIV testing".

I've suffered a lot from stigma, because being a young person, a woman and using drugs is really bad from the point of view of my social culture and the norms in my country. The stigma is not just from family and college friends but also from health providers. Once, I went to a hospital to get buprenorphine (substitution therapy) but the administrator and nurse there were very unfriendly. They put me through a lengthy administrative process, counselling and urine tests and in the end said they couldn't give me that drug because they were out of stock. But they didn't give me any alternative solutions. Because my university would tell me to leave if they found out I use drugs, I don't get sterile needles or opioid substitution therapy from primary health services but prefer to go through my friends who also work as outreach workers.

Drug users are still criminalized in Indonesia. If they are arrested by the police they are thrown into jail and cannot access rehabilitation programmes. The new narcotics law mentions rehabilitation for people who use drugs but new regulations on national health coverage (universal health coverage) don't cover those who use drugs.

To lower risks for young people, you have to provide a safe environment. By that I mean support from family and friends, friendly and easy-to-access health and harm reduction services and support from educational institutions. They have to remove their policy of expelling people who use drugs and law enforcement must decriminalize people who use drugs and refer them to rehabilitation centres.

In theory, reaching young PWID with prevention information and services should not be impractical. From the information obtained, many PWID in the region are reportedly male, cluster in big cities, near drug smuggling routes or in regions where opiates are cultivated, and move within social networks that enable them to obtain drugs and sustain their habits. However, although coverage of harm reduction services in Asia and the Pacific has steadily increased, programmes for young PWID are still not common. Thus, many may find it difficult to obtain sterile injecting equipment and opioid substitution therapy such as methadone, and access HIV testing, counselling and treatment. Age restrictions or requirements for parental consent also make harm reduction services less accessible to young PWID.[31] Moreover, increasing numbers of them in the region are using methamphetamine and pharmaceutical drugs (e.g. benzodiazepines), which are not covered by OST.[32]

YOUNG TRANSGENDER PEOPLE

The number of transgender people in Asia and the Pacific is "possibly" 9–9.5 million, although existing research is scattered and limited to transgender women.[33] Pakistan and Thailand appear to have the largest transgender female populations as a percentage of birth-assigned males, suggested at 0.7 per cent[34] and 0.6 per cent[35] respectively.

The extremely limited data on young transgender people in the region frustrates attempts to pin down HIV prevalence and curtails our understanding of the size of the HIV burden they face and behavioural issues. What little data there are focus on urban transgender women – especially those selling sex – omitting rural populations and transgender men. What we do know is that because transgender women very often engage in receptive anal intercourse (commonly to affirm their feminine identity),[36] they are at especially high risk for HIV and other sexually transmitted infections.

Among rare disaggregated data, an Indonesian survey (2007-2009) showed HIV prevalence to be 5.4 per cent among 15-19-year-old transgender adolescents selling sex and 14.2 per cent among their 20-24-year-old counterparts.[37] In Pakistan, 10 per cent of 15-19-year-old *hijra* selling sex were found to have HIV (2008), compared with 7.5 per cent of their 20-24-year-old peers.[38] More recent estimations that are not age-specific reveal that nearly one quarter of transgender people surveyed (2010) in Papua New Guinea had HIV, as did 15 per cent in Larkana, Pakistan (2011).[39] Other sources cite HIV infection rates among transgender women as high as 42 per cent in Mumbai and 49 per cent in New Delhi.[40]

In general, transgender females selling sex are four times more likely to be HIV-positive than non-transgender female sex workers, with those who are young facing higher risks than their older counterparts, according to a global systematic review.[41]

Broad-based discrimination

Stigma and prejudice are major problems for transgender people, and are rooted in a range of beliefs (either traditional or modern, depending on the culture concerned) about sexuality and gender norms and nonconformity.[42] "The stigma and prejudice appear to put large numbers of this key population onto a slope (a 'stigma-sickness slope'), prompting patterns of discrimination, harassment and abuse (verbal, sexual and physical)" in every setting, including in the provision of health services. In many countries the daily experience of social stigma and prejudice, is "so consistent and marked as to nudge many transgender people towards the social, economic and legal margins of society, and damage their psychological health and well-being."[43]

Stigma and discrimination can be particularly brutal for transgender adolescents struggling to develop a sense of self amid pressures to conform to gender and sexual identity norms. Some are rejected by their families and thrown out of home. Others flee home because they are shunned and/or sexually assaulted by family members or the community.[44] It must be stressed that many adolescents do not self-identify as transgender early on, but are rather gender non-conforming adolescents. They face stigma because they do not conform with traditional understandings and expressions of what it means to be male or female rather than because of any gender identity they feel they have.

In studies of discrimination, bullying and violence in schools throughout the region, including in Australia[45] and Thailand,[46] transgender and non-conforming adolescents and youth appear to be disproportionately affected. School rules relating to school uniforms and haircuts, and gender-segregated sanitary facilities and student accommodation in residential schools have also been reported to be a barrier for transgender students to continue their education, or limit their selection of schools and universities.[47] Others may be expelled for not adhering to school guidelines.[48, 49] These challenges in education have implications for employment and career opportunities, with lifelong economic impacts and consequences for social benefits – for example, access to pensions and social security.

Squeezed into selling sex

Rampant discrimination and job exclusion push many transgender people into commercial or transactional sex.[50] Almost all the 1,150 young transgender females (*waria*) surveyed in Java, Indonesia, for example (2011), worked in the sex industry.[51] A study of 400 transgender youth in Bangladesh in 2011 found that one third were aged 15-19 and for half, selling sex was their main income.[52] Yet the pay is not the sole reason for engagement in sex work. "Aside from money, a transgender woman may find that sex work makes possible membership of a (hopefully supportive) transgender community, daily (or nightly) re-affirmation of her gender identity and her sense of attractiveness to men, and the prospect of a long term relationship with a customer (including perhaps foreign customers and the prospects of life in another country with better living standards and legal gender status recognition)."[53]

While recognition as a transgender person is weighted with risk, not being recognized as a distinct gender can also have serious ramifications. In Asia and the Pacific, transgender people are often categorized as MSM or are reported as a subpopulation within that behavioural group. Few countries in the region report national statistics for their transgender female populations – as distinct from MSM or from individuals who do not identify as male or female – leading to these groups being "invisibilised".[54] Terminology can contribute to the problem. In the Philippines, for example, there is only one term, '*bakla*' in the local Tagalog language, to describe MSM, effeminate men and transgender women. Data from transgender women identified as '*bakla*' are thus typically subsumed under the MSM category.[55]

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Initials: MR, aged 24, Dhaka, Bangladesh
Young key population: Transgender

I only went to school until grade 3. My parents separated and got married to other people. So I had to live with my uncle, who worked at the Indonesian Embassy in Dhaka. My uncle took me out of school and placed me in a madrasa (Islamic school) because it was free. He didn't want to pay for my education. I couldn't stay for more than a year though as the environment was not friendly and I would get beaten up by the teachers. I knew I was attracted to men and used to experiment with 'thigh sex' with older men. My uncle used to take me to the Indonesian embassy and the guard there one time asked me for penetrative sex. He entered me without using any lubricant or protection. I bled a lot. I was afraid. Between the ages of 10 and 12, I think I was raped two more times, once by an injecting drug user. Similar experiences followed. My hijra identity came later.

My aunt wasn't providing much food and I would run away from home a lot and go to parks. There, I met *hijras* and sex workers. They knew who and what I was before I knew myself. A young MSM at the park told me about the NGO Bandhu and the singing and dancing performed at their centre. I went to see it and had so much fun. I wouldn't have missed my weekly visits to the NGO for anything. That was a turning point for me as I was really alone. The NGO became my family. It changed my life for the better in every way.

I started plucking my eyebrows and dying my hair. I learnt and accepted my identity more. I started earning from 'night work'. I got courage and confidence. When my uncle kicked me out because of my 'difference', the other hijras took me in. If I had stayed with my uncle, my life would've been controlled and dominated. I'd have been their slave and wouldn't have had an education. I probably would've been raped more and more. I found a guru with whom I'm still attached. We have to stay with our community as when we get harassed by police or attacked by people, our gurus protect us. My guru taught me how to protect myself physically from violence. But it was Bandhu that educated me about safe sex and condom use. Now, I can't imagine sex without a condom or lube, whether with clients or my boyfriend. My clients are mostly truck drivers and rickshaw pullers.

There were days when I would have sex 10-15 times with different clients, but how could I have bought that many condoms without free ones from NGOs when I was trying to make a living? There needs to be more centres providing HIV services. There are only three in Dhaka that I know of and this is not nearly enough. The remote places are even worse. The government should inform people about these services. It should also educate doctors and medical personnel, or at least let them know about such centres for referrals.

Change has to come from families first. The government can help. When the HIV epidemic was made public, the government did educate people. General education works. It reaches a large audience. The government runs many family planning campaigns here in Bangladesh, like "two kids are enough," and "male and female children are equal." They should do the same for diversity: "Whoever your children are, they should be accepted and loved," not kicked out and forced to go into 'night work'. If I'd have had the support of my family, I wouldn't have taken such risks. I now do safe 'night work' by choice and to make extra cash. I have the power to negotiate.

4. SMART INVESTMENTS IN ADOLESCENTS

There are good reasons why a focused response for adolescents at higher risk of HIV needs a customized investment blueprint, keeping in mind the **All In** 2020 targets for reducing new infections and AIDS-related deaths. For one thing, HIV programming for adolescents requires a stronger emphasis than for adults on strategies (critical enablers and development synergies) that create a space conducive to the success of high-impact interventions. While stigma and discrimination around HIV are certainly not age-specific, they may be particularly damaging to adolescents at higher risk of exposure because of their young age and disempowering legal, policy and social environments that throw up barriers to prevention and treatment services.

Upping the budget

What are the resources needed to reach the **All In** targets for adolescents? Based on Investment Framework modelling, The Futures Institute and UNICEF calculate that in East Asia and the Pacific, an estimated US$748.6 million will be required for the adolescent response in 2016 (against US$680 million needed in 2015), rising to around US$1 billion in 2020.[1] Between 2020 and 2030, an estimated US$950 million per year will be required for strengthening access to and delivery of programmes to achieve an end to the AIDS epidemic as a public health threat to adolescents. For South Asia, estimated funding requirements to achieve the **All In** goals for adolescents at higher risk of HIV are expected to increase from US$10.4 million in 2016 to around US$18.4 million in 2020.[2]

In the budget breakdown, approximately two-thirds of the resources are pinpointed for high-impact actions, including condom promotion, testing and counselling, and treatment, care and support for young key populations. Between one-quarter and one-third of targeted investment is earmarked for critical enablers and development synergies. All told, between 2015-2030 (inclusive), the budget estimated for the adolescent response in Asia and the Pacific is US$14.8 billion.[3]

The calculations have been made and the deduction is clear: A rapid scale-up of funding for adolescents at higher risk of HIV in Asia and the Pacific is needed to avert tens of thousands of new HIV infections by 2020. A continuation of the status quo, by contrast, will result in hardly any decline in the number of new infections, nor in AIDS-related deaths.

5. HIGH-IMPACT INTERVENTIONS

Where applied, high-impact interventions for young key populations are reducing new HIV infections, prevalence and mortality rates with great efficiency. But coverage is still much too low in the region. To reach the 2020 targets for adolescents, high-impact programming needs to be rapidly scaled up, while making the most of existing services and infrastructure.

It also needs to take into account heavyweight influences dictating behaviours.[1] Young MSM and transgender people, for example, are likely to hide their same-sex attraction or gender non-conforming expressions from their family and community until they are more independent and better able to cope with strict cultural and societal pressures. They are thus unlikely to seek HIV-related services.[2] All the HIV knowledge in the world will not lead to behaviour change unless adolescents can relate risks to their own circumstances and perceptions, hence the importance of communication based on real risk perceptions. Understanding not only coverage rates but also what services are taken up by whom and why – and why not – is the key to planning specific, results-oriented programming for adolescents.

Based on the epidemiology of transmission, high-impact interventions for adolescents at higher risk of HIV in Asia and the Pacific should prioritize four areas:

- Condom use with condom-compatible lubricants
- Harm reduction services
- HIV testing and counselling
- HIV treatment and care

These strategies must involve adolescents in programme design, rollout and monitoring. The challenges in universalizing these first-line defences serve only to emphasize how instrumental they are.

CONDOM USE

Condoms have a pretty impeccable track record of thwarting infection, which is why they get top billing in any HIV prevention campaign. Yet their reported use among adolescents at higher risk of HIV infection is low – according to the evidence. Knowing that condoms – along with condom-compatible lubricants for anal sex – prevent HIV transmission does not necessarily mean they will be used, or used consistently. A low perception of risk, including trust in and the belief that a partner is 'disease-free', is one important determinant of condom use among young key populations.[3] Other factors negatively associated with condom use include young age, coerced sex (for those over 18), lower education, being isolated from school and family, self-stigma and drug and alcohol use.[4] Heightened sexual pleasure is also a factor, given the perception that condoms reduce physical sensation.

For young people who sell sex, a common barrier to condom use is the unwillingness of some clients to use condoms.[5] The cost of condoms may also be prohibitive, particularly for 'freelance' adolescents with a high number of daily clients. Girls under 18 who sell sex or are otherwise defined as sexually exploited or trafficked or who are illegal migrants face especially big obstacles in negotiating condom use as well as procuring condoms from public places such as pharmacies and health clinics.

Self-stigma

Stigmatizing attitudes towards and discrimination against those who engage in same-sex behaviour or who are gender non-conforming can all too easily damage individual self-worth and lead to self-stigmatization. Self-stigma is linked to HIV risk behaviour.[6] Feelings of depression, anxiety, isolation, anger and self-loathing may find outlets in self-harming acts, including compulsive and reckless unprotected sex. Research shows that men who accept their sexual orientation are more psychologically healthy, have higher self-esteem, are more likely to disclose their HIV status with casual sex partners and are less likely to engage in sexual risk-taking.[7] In a Thai study, higher self-esteem was linked to higher condom use at last sex among young transgender people, as was the higher likelihood of HIV testing among sex workers.[8]

Trust issues

The yearning for respect, trust in a partner and intimacy can alter risk perception and deter condom use, particularly in the context of widespread stigma. In many cases, young MSM acquire HIV in what they regard as monogamous relationships that entail fidelity and trust.[9] If a sexual encounter holds the promise of affection, acceptance and affirmation, insisting on a condom may slip down the rung of priorities. Condoms may even be perceived as undermining intimacy and conversely, unprotected sex may be seen as a sign of trust and desire for a loving relationship. Young people at higher risk of HIV infection who are in relationships with older partners are more likely to have unprotected sex than those with partners of the same age, and are more likely to be HIV-positive.[10]

In a 2010 survey in Cambodia, just 1 in 3 girls (aged 10-19 years) at high risk for HIV said a condom was used at last sex with a 'sweetheart'.[11] While unprotected sex may be a sign of trust, insisting on a condom might be interpreted as a sign of suspicion or even a veiled allegation about infidelity: It's a loaded request.

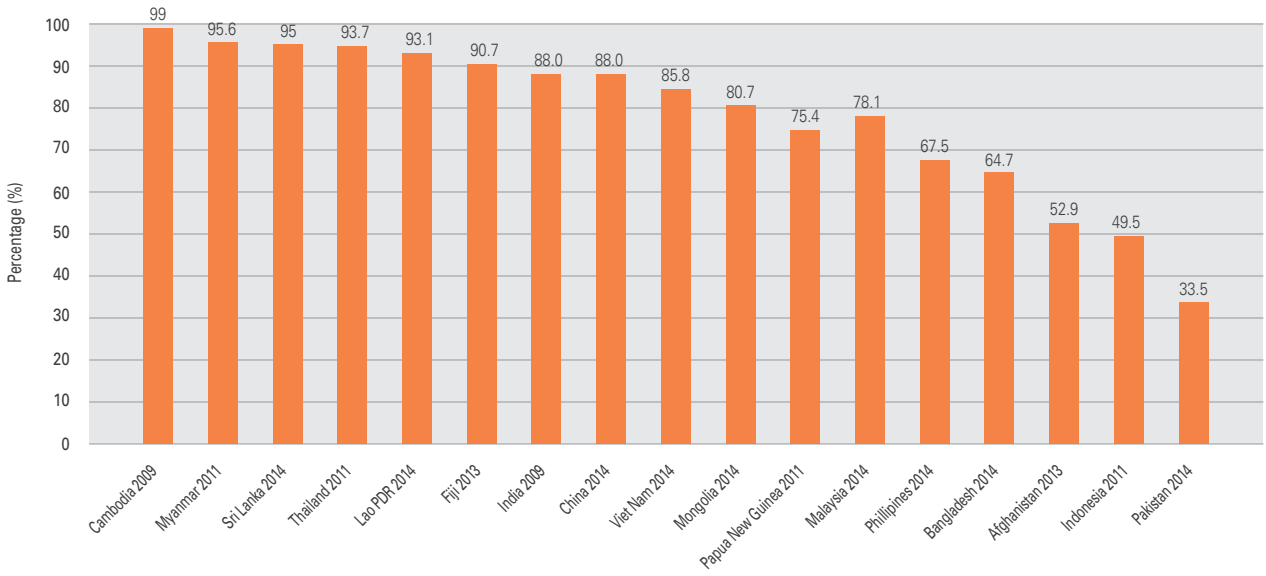
Drugs and alcohol

Quite obviously, being inebriated or 'high' does not aid clear, rational decision-making, so it is no surprise that concerns about protected sex tend to recede when people combine sex with drugs or alcohol. Psycho stimulants (such as methamphetamine, ecstasy and alcohol) reduce self-awareness and increase the odds that condoms will not be used, or will be used infrequently and incorrectly. Surveys in Thailand have linked drug taking (especially of amphetamine-type stimulants) and increased sexual risk taking among men having sex with men. In a study of MSM (mostly aged 18-24) in Chiang Mai, HIV prevalence was 20 per cent among methamphetamine users compared with 12 per cent among those who did not use the drug.[12] The use of amphetamine-type stimulants during sex appears to be a growing phenomenon in the region, and calls for further research on the implications for safer sex efforts.

Young people who sell sex

Reported condom use among young people under 25 selling sex in the region is high (see Figure 11). It is fairly universal in Cambodia (2009 data) and above 90 per cent in Myanmar, Sri Lanka, Thailand, Lao PDR and Fiji. However, the picture is not so positive for the younger age cohort. In surveys, little more than half of women aged 15-19 selling sex reported condom use the last time they had paid sex. Consistent condom use appears to be even rarer. In the Philippines, for example, just one third of 14-17 year-old girls selling sex said clients always used a condom.[13] A study in Lao PDR found that younger and less experienced adolescents selling sex were more likely to report being intimidated into not using condoms.[14] In one survey in the Philippines, girls who had been trafficked were 12 times more likely not to negotiate condom use.[15]

Figure 11: Young people (under 25) selling sex who used a condom at last sex, Asia-Pacific, 2009-2014



Note: Data refer to countries where data are available in Asia-Pacific. Data may not reflect national figures, but represent locations included in sample. Years are indicated as available in AIDS Info online and do not necessarily reflect the year of survey.
Source: AIDS Info online: http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx; October 2015. Query '1.8 Sex workers: Condom Use', <25 yrs

Trumping safety

The circumstances of adolescents selling sex tend to be so debilitating that other factors often trump the perceived need to insist on a condom, even where HIV awareness is high. The opportunity to earn more is a powerful incentive to forego condom use, especially if the client is a 'regular' or looks 'healthy'. Studies show that a surprising degree of HIV risk assessment involves trying to deduce a client's HIV status from his appearance. A survey in China exploring condom use among young female sex workers found that many believed regular partners and clients who claimed they did not have HIV, at least partly because they wanted to cultivate trust with men who might be future husbands.[16]

A review of surveys in the Philippines found that around 1 in 4 female sex workers (most of them aged 18-24) who had sold sex in the previous six months did not even try to negotiate condom use with venue clients. The reasons included: sex without a condom paid more; they had been coerced into selling sex and had no say in the matter; or they were intoxicated at the time.[17] It must be stressed that coerced sex is not conducive to protected sex. In addition to mental anguish and humiliation, coerced sex can cause physical trauma (such as tearing and lacerations in both girls and boys) that can aid transmission of HIV and other sexually transmitted infections.

Selling sex and going steady

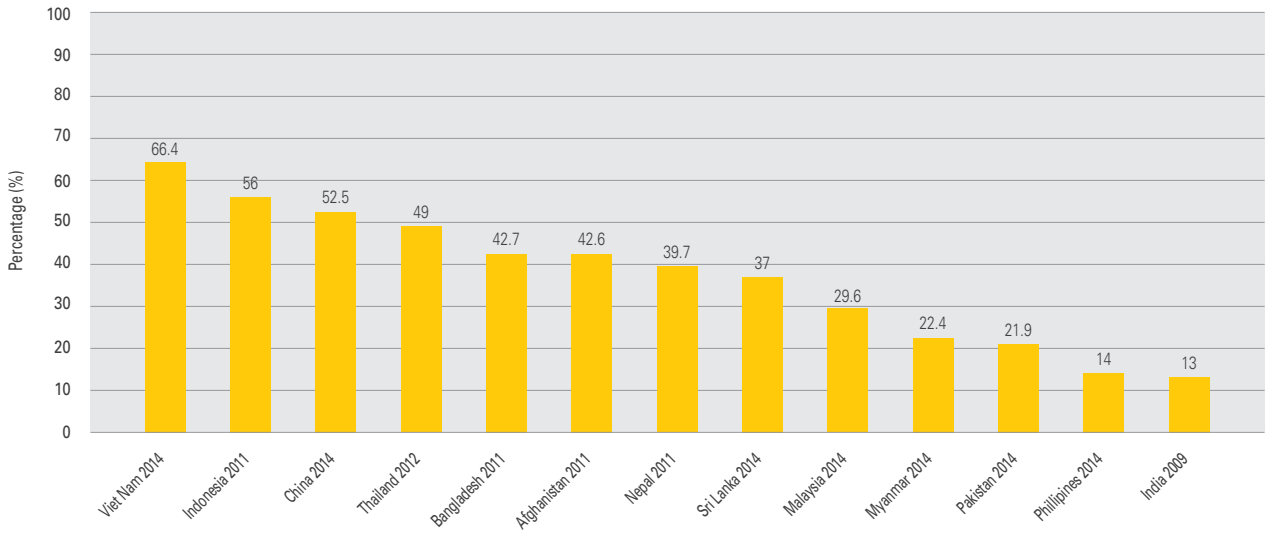
Many adolescent females who sell sex in Asia and the Pacific are living with partners or are in what they regard as steady relationships. In the Philippines, for example, 44 per cent of 'registered' adolescents aged 15-17 selling sex and 28 per cent of their 'freelance' peers reported living with a partner (2009).[18] In Indonesia (2007-2009), 10 per cent of 15-19-year-old females selling sex said they were married.[19] The fact that significant numbers of these young people are in intimate-partner relationships (marriage and otherwise) has implications not only for the onward transmission of HIV if they acquire it, but also for strategies to promote consistent protected sex in all sexual relationships.

Young people who inject drugs

Available data on condom use by young PWID are concerning. In most countries, fewer than half of the under 25 year olds surveyed reported wearing a condom at last sex and in a handful of countries, fewer than one quarter. Among these are the Philippines and Pakistan, both grappling with worsening HIV epidemics among young PWID. Just 14 per cent of young PWID surveyed in the Philippines reported wearing a condom at last sex, as did 22 per cent in Pakistan (see Figure 12).

Considerations of sexual pleasure, cost and a lack of awareness about HIV may conspire against condom use. Added to these is the reality that concern for protected sex often vanishes with drug use – the 'if you are high you do not care about using a condom' phenomenon.[20]

Figure 12: People who inject drugs (under 25) using a condom at last sex, Asia-Pacific, 2009 – 2014



Note: Data refer to countries where data are available in Asia-Pacific. Data may not reflect national figures, but represent locations included in sample. Years are indicated as available in AIDS Info online and do not necessarily reflect the year of survey.
Source: AIDS Info online: http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx; October 2015. Query '2.2 People who inject drugs: Condom Use', <25 yrs..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Young transgender people

The picture appears to be no better among young transgender women, with adolescents less likely to use condoms and apply condom-compatible lubricants consistently than their older peers.[21] It should be emphasized that much of the limited data available regarding transgender women and condoms relate to those selling sex.[22] In one survey in Pakistan, fewer than 2 per cent of *hijra* selling sex reported using condoms at last commercial sex. Research among older *hijra* sex workers (median age 24 years) showed that 83 per cent had never asked a client to use a condom.[23] Given the perils of unprotected anal sex, a weak condom culture poses a huge challenge to HIV prevention efforts among young transgender people.

Snapshot 1: Condom use among transgender people under 25 [24]

- Thailand: More than 50% of 15-24 year olds did not use condoms consistently in the previous 3 months. Those aged 15-19 are least likely to have used one. In Chiang Mai, 55% of those with an average age of 22 did not use condoms consistently in the last six months with casual partners. 74% did not use condoms with regular partners.
- *Waria* selling sex in Indonesia: 61% of 15-19 year olds used condoms at last commercial sex vs. 65% of 20-24 year olds.
- *Hijra* selling sex in Pakistan: 1.8% of 15-19 year olds used condoms at last commercial sex vs. 9.3% of 20-24 year olds.

Sexual violence against and abuse of transgender people along with rampant stigma and discrimination add to the condom conundrum. Even so, other factors that are less obvious are possibly more intractable. Attempts to use condoms and lubricants consistently are often undermined by financial pressures, especially for individuals seeking to fund hormonal medications or sexual reassignment surgery. In this case, a higher fee for not using a condom can be very tempting. In addition, many young transgender people avoid carrying condoms and lubricants for fear that the police will interpret them as evidence of sex work, whether or not they actually sell sex.[25]

Young men who have sex with men

Condom use during anal sex among young MSM appears to have risen substantially across the board in recent years (see Figure 13). In Nepal, 91 per cent of MSM aged under 25 who were surveyed reported wearing a condom, while the figure was 85 per cent in Thailand. In several countries, however, the rise was from a very low base. Fewer than half of MSM aged under 25 reported using a condom at last anal sex in Bangladesh, the Philippines, India, Sri Lanka and Lao PDR and a mere 17 per cent in Afghanistan. Only a minority of adolescents seems to consistently use condoms. For example, in a study in Bangkok, Chiang Mai and Phuket, almost half of 15-19 year olds surveyed reported inconsistent condom use during anal sex.[26] There is also evidence that many young MSM are not aware of the importance of condom-compatible lubricants (to help prevent condoms from slipping and breaking) in HIV prevention.[27]


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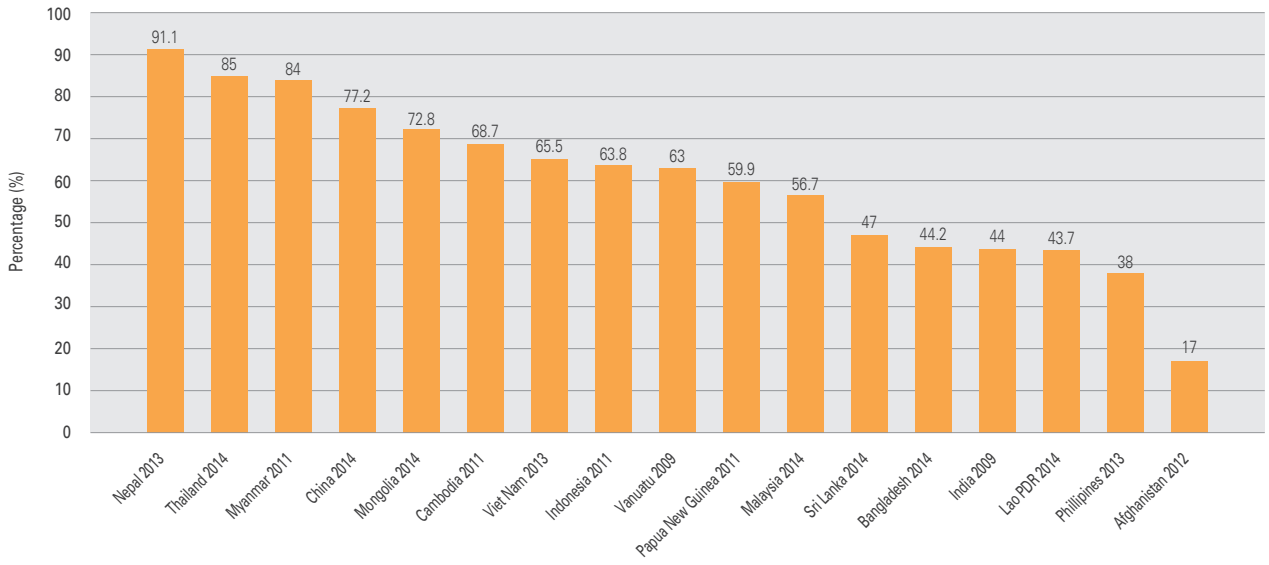
Figure 13: MSM (under 25) using a condom at last sex, Asia-Pacific, 2009-2014



Note: Data refer to countries where data are available in Asia-Pacific. Data may not reflect national figures, but represent locations included in sample. Years are indicated as available in AIDS Info online and do not necessarily reflect the year of survey.
Source: AIDS Info online: http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx; October 2015. Query '1.12 MSM: Condom Use', <25 yrs

Promoting protected sex

Promoting consistent condom use along with condom-compatible lubricants is integral to prevention efforts focused on *all* adolescents at higher risk of HIV infection. Studies show that having access to condom promotion, free HIV counselling and testing and peer education are linked with lower levels of unprotected sex.[28] Robust efforts are also needed to address the many interlocking issues that can imperil condom use, including self-stigma, the dynamics of trust in a relationship, and drug and alcohol abuse.

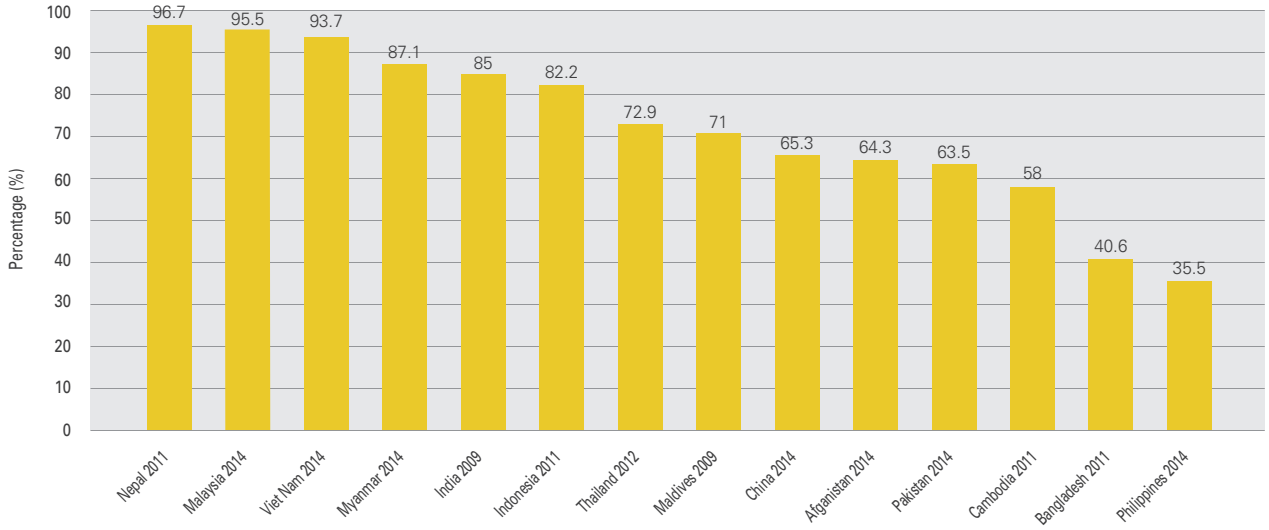
HARM REDUCTION

Coverage expanding but still low in Asia and the Pacific

Making it safer for people who inject drugs by providing sterile equipment is a relatively easy and inexpensive strategy for HIV prevention – one proven to be highly effective. Seventeen countries in Asia provide some form of NSP, a number hat appears to have remained stable since 2012.[29] Between 2012 and 2014, two countries reported a decline in NSP services: Bangladesh and Viet Nam, where the average number of needles and syringes provided to PWID dropped from 180 in 2012 to 98 in 2014.[30]

Where NSPs are in place, avoiding contaminated injection equipment can be relatively straightforward – at least compared with the layered complications that undermine the consistent use of condoms during sex.

Figure 14: People who inject drugs (under 25) reporting use of sterile injecting equipment the last time they injected, Asia-Pacific, 2008-2014



Note: Data refer to countries where data are available in Asia-Pacific. Data may not reflect national figures, but represent locations included in sample. Years are indicated as available in AIDS Info online and do not necessarily reflect the year of survey.
Source: AIDS Info online: http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx; October 2015. Query '2.3 People who inject drugs: Safe injecting practice', <25 yrs.

In most Asia-Pacific countries, more than two thirds of the PWID aged under 25 surveyed reported using sterile injecting equipment (see Figure 14). Adolescents who inject drugs, in particular, are more likely to do so in groups and develop rituals associated with injecting that expose them to sharing equipment. They might not necessarily – at least initially – see themselves as 'injecting drug users' and tend to be more isolated from support networks. As a result, they often know little about the links between HIV and injecting drug use or about ways to inject safely. Also, young women may frequently use the same needles as their male partners.[31] For some, the cost and difficulty of buying sufficient quantities of syringes from pharmacies makes re-use or sharing the only option.

Where harm reduction services are available to adolescents, they almost always have to operate against a backdrop of criminalization and punishment of drug use, particularly opioids. Even when young PWID can access NSPs, some are too mistrustful to take advantage of the service, are too uncomfortable being around older PWID, or too afraid to be caught with drug paraphernalia by the police out of fear of conviction or being sent to compulsory centres to undergo forced treatment and rehabilitation. 'Zero tolerance' drug approaches stop people from seeking services that provide sterile equipment and other assistance.

Opioid substitution therapy

Several countries have continued to expand OST services. In India, for example, the number of sites offering OST doubled to 145 between 2012 and 2014.[32] Even so, OST remains a fringe activity in Asia and the Pacific, where coverage was just 7 per cent of those dependent on opioids in 2013.[33] While NGOs may be in a more flexible position to run NSPs, the medical and clinical constraints surrounding OST mean that the public sector tends to be the main provider of this service.

'Opening Doors' to harm reduction in Asia [34]

'Opening Doors' is a project aimed at increasing access to harm reduction services for people aged 10-25 who inject drugs and those who are at risk of doing so. Young PWID have been part of the consultation process in the three places the project has been implemented: Bangkok, Kunming (China) and Kathmandu. In Kunming, where the main drug of concern is heroin, the focus has been on 'youth-friendly' methadone maintenance therapy, alongside other activities such as counselling groups, employment assistance and home visits. An evaluation undertaken by Youth Vision in Nepal in 2010 suggested a significant increase in young people signing up for harm reduction services. Among these, it reported improved mental health, less involvement with crime, a reduction in sharing syringes and increased condom use. The projects have helped to establish new partnerships between the health, education, vocational training and employment sectors, building greater capacity for youth-focused harm reduction.

Legal age restrictions remain a major barrier to OST for adolescents in the region (see **'Legal constraints to harm reduction for adolescents'** in the section on 'Critical enablers'). As a result, it is often difficult or impossible for adolescents to wean off drugs with, for example, methadone (the most common opioid substitute in Asia). Stigma is also an impediment. Many young PWID in the region deny they are dependent on drugs and need harm reduction services.[35] Those who do enter clinics may face judgemental staff, putting them off repeat visits. Moreover, few countries report the existence of OST and other harm reduction services in response to the growing use of amphetamine-type substances, which in some countries far exceeds opiate use.[36]

TESTING AND COUNSELLING

Taking an HIV test and getting the result is a vital step to protecting the health of adolescents. Not only does it allow those who have HIV to know their status, seek ART, and stop onward transmission of HIV to others, it is also a critical entry point to providing protection information and education when a result is negative.

Low risk perception governs test taking

In general, only a minority of young people at higher risk of exposure test for HIV. In most countries, well under half of survey respondents reported taking an HIV test and knowing the result (see Figures 6, 8 and 10). For young transgender women, this is also very likely the case. Data (2010) from Thailand suggest that around 21 per cent of transgender women took an HIV test over a 12-month period.[37] The pivotal reason perhaps is the perception that the risk of acquiring HIV is low. Not knowing where to get tested, not having money for testing, not having a nearby testing facility, worries about stigma and confidentiality, the fear of testing positive and a perceived lack of support also weigh into the equation.[38] What factors seem to encourage HIV testing? Being older, employed, living away from home, having social support, having family members aware of one's sexuality/gender identity, and knowing that effective HIV treatment, care and support are available.

Shunning the results

Taking a test but not collecting the result is a grave missed opportunity for those who are both HIV-positive and negative. Perhaps not surprisingly, failure to pick up results seems to correlate with a higher chance of having HIV. In a 2008-2009 Chiang Mai study among mostly young MSM, HIV prevalence was roughly the same irrespective of whether the person had taken an HIV test. However, the boys and young men who said they had taken a test but failed to return for the results were nearly twice as likely to be HIV-positive than those who had never taken a test.[39] "It takes too much time" and "the testing place is too far away" are reasons often cited for not picking up the results. Digging deeper, it is likely that an immobilizing fear of being seropositive is at work among young key populations.

Parental consent barriers

The ramifications of parental consent requirements for HIV testing in those under 18 should not be underestimated. Given the sensitivity of an HIV result – and its implications about sexual activity or injecting drug use in adolescents – parental consent can be a strong disincentive for under 18s to test and know their HIV status. Rigid age limitations on independent consent to testing – imposed by many Asia-Pacific countries – run counter to the concept of children's evolving capacities and their right to participate in decisions regarding their own treatment, wellbeing and best interests. In view of this, a more flexible approach to HIV testing for adolescents is gaining ground in the region (see **The right to test: reviewing age of legal consent laws** in the section on 'Critical enablers').

Testing 'musts'

Testing for adolescents should be convenient, safe and free, and conducted at clinics or other fixed locations or at mobile sites. It should also adhere to the '5Cs': consent for testing, confidentiality, counselling, correct test results and connections to appropriate care and prevention services.

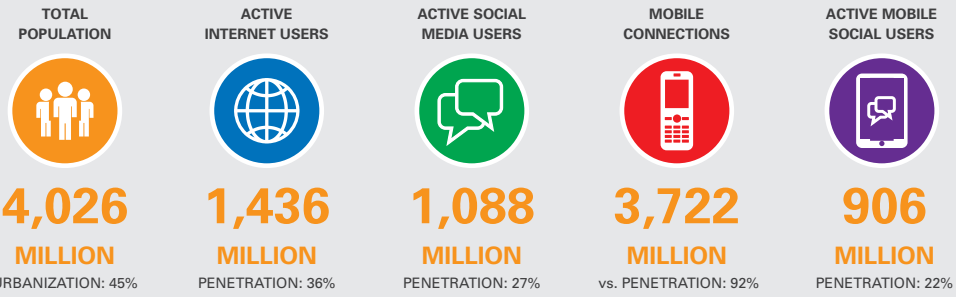
Self-testing

One innovation that has the potential to popularize testing for adolescents is the HIV self-test kit. Home kits are already available in several Asian countries and territories (e.g. Malaysia, China, Hong Kong SAR and Singapore). This method has many benefits – confidentiality, immediacy of test result, no need to travel, non-invasiveness – while also involving many policy and programme considerations, including cost and permissible age of purchase. Most essentially, as UNAIDS makes clear, "any positive result must be confirmed by a healthcare worker,"[40] with all that implies for linkage to counselling, treatment and care services.

Harnessing technology to promote HIV testing

Harnessing technology to the cause of HIV testing is possible with today's ultra 'connected' youth – most of whom in Asia and the Pacific are growing up with mobile or smart phones as part of their lives. Popular smart phone dating apps in the region such as Jack'd, Blued and Grindr, while enabling a generation of MSM to meet sexual partners easily, could also be educative. Public health experts hope that such apps will become vital conduits promoting sexual health, including HIV messaging and testing.[41] It is starting to happen in Asia. Thailand, for example, is using social media such as Facebook, Line and Camfrog to reach MSM with information on prevention and HIV testing.[42] On World AIDS Day 2014, UNAIDS and UNICEF worked with Chinese gay dating app Blued to add a red ribbon next to every user's profile picture. The ribbons linked to information about HIV and details of the user's nearest voluntary testing centre.

Snapshot of key digital statistical indicators, Asia-Pacific, March 2015



Source: wearesocial.sg

Smart phone connectivity and Internet interactivity offer intriguing possibilities for making testing and other HIV-related services youth friendly. One possibility might be the creation of a user-generated online rating system of health care providers. Clinics, for example, could be rated by those who have sought their services for their quality of care, attitudes and friendliness towards young key populations.

ANTIRETROVIRAL TREATMENT

Adult access to ART has massively expanded in Asia and the Pacific. Around 1.8 million people in the region were receiving ART at the end of 2014 (up from 70,000 in 2003) – a coverage rate of 36 per cent.[43] For those who stick to their regime, ART can lead to a healthy and fulfilling life. Progress has been especially robust in China, India, Papua New Guinea and Viet Nam, while Cambodia and Thailand have consolidated their already high ART coverage. Adolescents are falling through the net, however. What data there are suggest that fewer than one third of 15-19 year olds living with HIV could be receiving life-saving treatments – with AIDS-related illnesses and deaths on the rise as a result.[44]

Unique challenges

In Asia and the Pacific, adolescents who acquired HIV through their mother at birth and those who acquired it during adolescence face similar daunting challenges: a lack of quality counselling for treatment, effective support and follow-up plans, the need for adult consent for ART, and the difficulty with disclosure and adhering to uninterrupted treatment regimens. Adolescents who became HIV-positive at birth face additional physical challenges in that transmission happened before their immune systems were developed and in many cases they received sub-optimal ART. In addition, they must grapple with moving from complete dependence on their guardians to assuming responsibility for their own health regimes and navigating the transition from paediatric to adult care. This is an especially fragile point of the care continuum from initial diagnosis to daily uninterrupted ART.

Important insights about the attitudes, experiences and coping mechanisms of adolescents living with HIV emerged from a 2013 study by the Asia Pacific Network of People Living with HIV, called *Lost in Transitions: Current issues faced by adolescents living with HIV in Asia Pacific*.[45] The research, the first of its kind in the region, argues that adolescents living with HIV are a neglected component of national and regional treatment, care and support strategies. It highlights five pressing issues affecting the physical and psychological health of adolescents – both those who acquired HIV perinatally and in the second decade of life:

- Disclosure of their HIV status, especially to friends;
- Navigating healthcare systems given that adolescent-specific care is rare and most adolescents living with HIV transition from paediatric care directly into adult care;
- Dealing with life-long treatment, including physical manifestations, long-term clinical impact, affordability of 2nd and 3rd line ART medicines and adhering to their medication during the emotionally turbulent period of adolescence;
- Sexuality and sexual and reproductive health services (SRH) as adolescents become sexually active and need support in this area; and
- The social environment, including education, job training and opportunities and access to social protection.

Investment in comprehensive, community-based, adolescent-sensitive quality treatment and care services is part of the solution to these complexities. These should emphasize specific approaches to meet the needs of the three broad groups of adolescents living with HIV:[46] 1) adolescents who acquired HIV through parent-to-child transmission, who were diagnosed early, and started on ART, 2) adolescents who acquired HIV through parent-to-child transmission, who were not diagnosed or started on ART, 3) adolescents who acquired HIV through unprotected sex or injecting drug use during adolescence.

It is essential to make it easier for adolescents to start treatment once they have been diagnosed with HIV to prevent delayed debut of ART. Adolescents already on ART need help to make a safe and effective transition from paediatric to adult services and with adherence to ART and retention in care.[47] Related to this is the need to focus on health worker training. In surveys, young MSM and transgender people most frequently cite stigmatization and hostility at clinics and other healthcare places as paramount reasons for not seeking HIV-related services. The training of healthcare providers should include respect of confidentiality and how to earn the trust of the patient. In addition to primary HIV treatment and care, training should also embrace mental health issues, including depression, anxiety and low self-esteem among young key populations.[48] Transgender people need sexual and reproductive health (SRH) services that cater specifically to their needs, given that sexual healthcare services are focused on women – and more recently – MSM communities.[49]

Prevention of parent-to-child transmission of HIV (PPTCT)

There is a cogent case to be made for scaling up SRH services for young key populations, including HIV-positive adolescents, to prevent unplanned pregnancy. There is also a need to provide prevention-of-parent-to-child transmission services for pregnant adolescents as part of a broader expansion of antenatal care for adolescents. While the number of HIV-positive pregnant adolescents is comparatively small – crude calculations suggest there are around 5,500 in the region[50] – PPTCT interventions have a proven track record of dramatically reducing HIV transmission rates, and are a sexual and reproductive health right. HIV-positive pregnant adolescents – where they manage to access PPTCT services – all too commonly confront health workers who are judgemental, and who may subject them to violations of their sexual and reproductive rights, including forced sterilization.[51] More training is needed to make SRH and PPTCT services within the maternal and child health sector more sensitive to the needs of young key populations and HIV-positive adolescents.

Prevention innovations

Bio-medical approaches have been garnering more attention as part of the global HIV response, with some recent breakthroughs on prevention. One such is PrEP (pre-exposure prophylaxis), approved for use in the United States in 2012. A daily dose of PrEP taken by people who are HIV-negative can prevent infection during sex with an HIV-positive partner or through drug injection. PrEP's efficacy (if taken as prescribed) has been proven for MSM, while drug trials among transgender people are continuing in many parts of the world. Given the low uptake of HIV testing among young MSM, it is expected that PrEP will reinforce the need for HIV testing among this key population.

To date, adolescents generally, and those at higher risk of HIV infection specifically, have not been included in studies of biomedical and combination prevention due to regulatory and parental permission-related issues.[52] The WHO strongly recommends that oral PrEP be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination prevention approaches (substantial risk of HIV infection is provisionally defined as HIV incidence >3 per 100 person-years in the absence of PrEP).[53] The WHO, UNICEF and other partners are discussing the possibility of pioneering PrEP specifically for adolescents. Global and regional consultations have already begun, to ensure that governments and civil society organizations are well informed about PrEP and to examine context-specific realities for its roll out. In Thailand, demonstration projects focusing on older adolescents at higher risk are being planned in partnership with the government and civil society organizations.

Complacency concerns

Fears that widespread dependency on prophylactics such as PrEP will lead to more risky behaviours, especially lower condom use, and end up spiking new infections are provoking heated debate in some circles. Others counter that such fears are unfounded. In Asia and the Pacific, to guard against complacency in the wake of the increasing availability of ART, information and messaging about HIV (including condom use and harm reduction) and treatment services for adolescents must also include the need for strict adherence to regimes and encourage ongoing prevention behaviours.

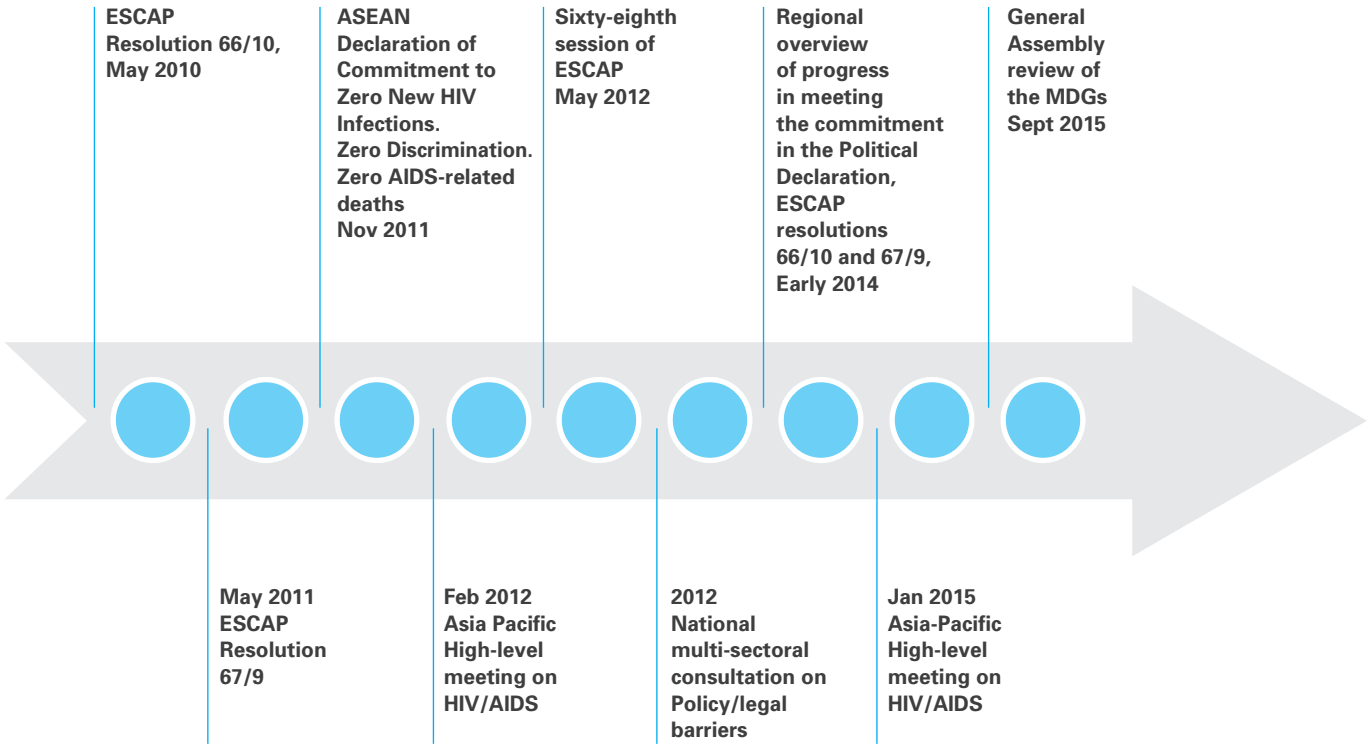
6. CRITICAL ENABLERS

The extent to which investments in high-impact interventions for adolescents yield fruit will depend on a variety of factors that lie beyond the control of health specialists, or indeed any single sector. Critical enablers increase the likelihood of successful programming by addressing many of these factors – political, rights-based and social – very often at the root of adolescent vulnerability. Budgeting for high-impact interventions without also prioritizing the critical enablers is leaving the job half done. One needs the other – if an irreversible drop in new infections and keeping HIV-positive adolescents alive and healthy are the goals.

POLITICAL COMMITMENT

The Asia-Pacific region has repeatedly voiced its commitment to ending the AIDS epidemic as a public health threat. All countries, for example, have signed various regional and international resolutions calling for more action against HIV. However, in many cases, deeds have not kept pace with words. Take, for example, National AIDS Strategic Plans, a barometer of a country's political engagement to tackling HIV. If young key populations are missing from these plans, they are probably unable to access high-impact HIV interventions and are falling through the cracks.

Figure 15: Key resolutions on HIV and AIDS signed by Asia-Pacific governments



Shut out of national HIV strategic plans [1]

The Asia-Pacific scorecard on national strategic plans is weak – insofar as inclusion of adolescents at higher risk of HIV is concerned. A recent UNESCO review of national strategic plans in 19 countries found that only slightly more than one third (seven) include young key populations in their country's situation analysis, primarily referring to children or young people living with HIV. Strategic information about young key populations, particularly behavioural data, is generally lacking, and plans for future research are either absent or sketchy. Rarely are adolescent PWID and young MSM singled out for outreach efforts and risk reduction communication or even – the Philippines apart – identified as populations at greater risk of exposure to HIV.

Snapshot 2: The Philippines' National Strategic Plan [2]

The Philippine national strategic plan (2011-2016) includes young key populations in a number of interventions, such as needle and syringe exchange, risk reduction communications, STI prevention and treatment, and ART for children and young people living with HIV. Specifically, it:

- Includes strategic information for young key populations – mainly MSM, girls and young women who sell sex and PWID as well as street-associated children.
- Includes a target of reaching 60-80 per cent of young key populations with specific HIV services.
- Calls for monitoring and reforming laws that hinder the HIV response among young people and young key populations specifically.
- Specifies a need to train health workers in approaches that are appropriate to young key populations.
- Discusses the need to boost education and child protection for children and young people who are most at risk of or vulnerable to HIV.

When programmes do focus on young people, they tend to highlight general risk reduction information and education, occasionally along with condom distribution. The case for eradicating stigma and discrimination around HIV and AIDS is made in reference to all people living with HIV. Given the demographics of the epidemics in Asia and the Pacific, leaving young key populations out of an HIV epidemiological analysis is a major omission, with serious ramifications for HIV budgets and programming for those in the second decade of life. Encouragingly, the January 2015 Asia-Pacific Intergovernmental meeting on HIV and AIDS heard how, with the increasing number of infections among young key populations, there is "the need to ensure that programmes are tailored to their specific needs."[3]

A RIGHTS-BASED APPROACH

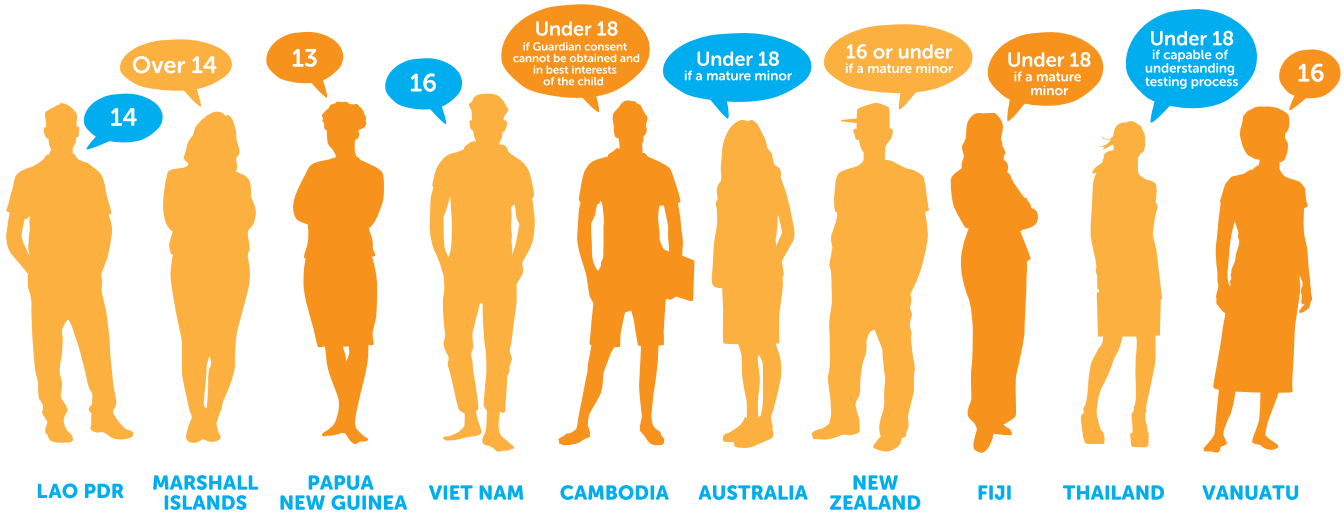
Promoting and protecting human rights are vital to the HIV response for adolescents in Asia and the Pacific, where HIV is spread through behaviours that are either criminalized or highly stigmatized. A rights-based approach to HIV prevention must include eliminating punitive laws that close the door to HIV services, providing access to independent channels of legal recourse for adolescents, improving the law enforcement practices of public security officers and police, and changing harmful social and cultural norms.[4]

Reviewing the age of independent testing

The WHO has recommended that health authorities revisit policies on age of consent for independent HIV testing, to enshrine the right of adolescents to make choices about their own health and well-being based on the 'evolving capacities' of the child.[5] Thailand has recently made this move. In December 2014, the country's Medical Council removed the 18 years of age restriction for having an HIV blood test without parental permission. Importantly, it is encouraging health workers to counsel those younger than 18 so that they fully understand what an HIV test is and its implications.

Including Bangladesh, 11 countries in Asia and the Pacific now have HIV testing laws in place that recognize the evolving capacities of adolescents under 18 to make independent decisions regarding their own health (see Figure 16).

Figure 16: Age of legal capacity to consent independently to an HIV test, Asia-Pacific [6]



Chipping away at the legislative status quo

The tide is gradually turning against some forms of punitive legislation. Eight countries in the region had enacted omnibus national HIV laws by 2012, all of which include some protection against HIV-related discrimination, although they tend to be unevenly enforced and inapplicable to children under 18. Even where punitive laws seldom lead to arrest and prosecution, their existence feeds stigma and social marginalization, legitimizes discrimination, and drives young key populations away from health services and essentials such as condoms and sterile syringes. Repressive legal environments also feed harassment by law enforcement officials, which can disrupt the provision of high-impact HIV interventions.

Figure 17: Punitive laws hindering the HIV response, Asia-Pacific, October 2014 [7]

● Has punitive law
● Contradictory information
● Does not have punitive law
● Not illegal (generally not prohibited but exceptions apply)
● No information available

		MEN WHO HAVE SEX WITH MEN	SEX WORKERS		PEOPLE WHO USE DRUGS		PEOPLE LIVING WITH HIV	
		Reported to criminalize same-sex sexual activities between consenting adult males	Reported to criminalize sex work in private	Reported to criminalize soliciting	Reported to maintain compulsory detention centres for people who use drugs	Reported to impose the death penalty for drug-related offences	Reported to maintain some form of restriction on entry, stay and residence on the basis of HIV status	Reported to specifically criminalize HIV transmission or exposure
South and South-West Asia	Afghanistan	●	●	●	●	●	●	●
	Bangladesh	●	●	●	●	●	●	●
	Bhutan	●	●	●	●	●	●	●
	India	●	●	●	●	●	●	●
	Maldives	●	●	●	●	●	●	●
	Nepal	●	●	●	●	●	●	●
	Pakistan	●	●	●	●	●	●	●
	Sri Lanka	●	●	●	●	●	●	●
East and North-East Asia	China	●	●	●	●	●	●	●
	Japan	●	●	●	●	●	●	●
	Mongolia	●	●	●	●	●	●	●
	People's Democratic Republic of Korea	●	●	●	●	●	●	●
	Republic of Korea	●	●	●	●	●	●	●
South-East Asia	Brunei Darussalam	●	●	●	●	●	●	●
	Cambodia	●	●	●	●	●	●	●
	Indonesia	●	●	●	●	●	●	●
	Lao People's Democratic Republic	●	●	●	●	●	●	●
	Malaysia	●	●	●	●	●	●	●
	Myanmar	●	●	●	●	●	●	●
	Philippines	●	●	●	●	●	●	●
	Singapore	●	●	●	●	●	●	●
	Thailand	●	●	●	●	●	●	●
	Timor-Leste	●	●	●	●	●	●	●
	Viet Nam	●	●	●	●	●	●	●
Pacific	Australia	●	●	●	●	●	●	●
	Fiji	●	●	●	●	●	●	●
	Kiribati	●	●	●	●	●	●	●
	Marshall Islands	●	●	●	●	●	●	●
	Micronesia, Federated States of	●	●	●	●	●	●	●
	Nauru	●	●	●	●	●	●	●
	New Zealand	●	●	●	●	●	●	●
	Palau	●	●	●	●	●	●	●
	Papua New Guinea	●	●	●	●	●	●	●
	Samoa	●	●	●	●	●	●	●
	Solomon Islands	●	●	●	●	●	●	●
	Tonga	●	●	●	●	●	●	●
	Tuvalu	●	●	●	●	●	●	●
	Vanuatu	●	●	●	●	●	●	●
	Totals (of 38 Member States)	**18**	**18**	**33**	**11**	**15**	**10**	**10**

Same-sex relations are still widely criminalized

Sexual relations between consenting men who have sex with men are still criminalized in 18 countries in the region.[8] In some jurisdictions where same-sex relations are not illegal, the age of consent for homosexual sex is higher than for heterosexual sex.[9] This makes young MSM who are above the age of criminal responsibility more vulnerable to arrest for their sexual behaviour than their older peers who are having heterosexual sex.

Young MSM may also be targeted by the police for arrest, extortion or violence, including sexual abuse, sometimes in the guise of enforcing laws against 'public nuisance' or obscenity.[10] Even in countries where homosexual sex is not illegal, the threat of exposure gives police tremendous power over young MSM, many of whom have no awareness of their legal rights.

Young transgender women face a double whammy legally speaking – in many jurisdictions denied legal recognition of their gender and penalized by legislation criminalizing same-sex behaviour. Two countries – Malaysia and Tonga – have laws that specifically criminalize cross-dressing or female impersonation (although Tonga does not actually enforce this law).[11] Although Article 2 of the CRC calls upon countries to protect children from any form of discrimination, it does not in itself provide a safeguard against discrimination of adolescent MSM and transgender people, as sexual orientation and gender identity are not specifically mentioned as statuses needing protection.

Examples of progressive change include Fiji's decriminalization of sex between men in 2010 and Hong Kong SAR's establishment of legal equality for homosexual men under criminal law.[12] Meanwhile, more countries have moved to recognize the rights of transgender people. Some examples:

- In 2014, the Supreme Court of India issued a landmark judgment directing the Government of India to recognize transgender people as a third gender and to formulate special health and welfare programmes to support their needs.
- Nepal's new constitution endorsed in September 2015 provides explicit protections for lesbian, gay, bisexual and transgender (LBGT) people. Among the constitution's provisions: members of sexual and gender minorities have rights to benefit from state services, discrimination against them by the state is prohibited, and they have the right to have their preferred gender displayed on their identity cards.
- In Pakistan, the National Database and Registration Authority has added a third gender column to national identity cards for transgender people, giving them the right to register to vote.
- In 2013, Bangladesh added a third gender identity category on all official documents, including passports.
- The Governments of Cambodia and Papua New Guinea have developed national policy documents that specifically address the need for an enabling legal environment for HIV responses for MSM and transgender people.[13]

Prohibitions on sex work

The vast majority of countries in Asia and the Pacific criminalize some aspect of sex work such as soliciting or operating a brothel, although sex work conducted in private is either not illegal or not criminalized in nearly half. In some countries, a punitive approach to sex work is entrenched by national constitutions (e.g. Bangladesh, Cambodia and Pakistan).

Protective laws: Unintended consequences

Laws designed to protect adolescents from prostitution (as per CRC obligations) can, paradoxically, end up making them more, not less vulnerable if they are not understood by all parties – rights holders and duty bearers – or are used by police indiscriminately. This happened with young people in Cambodia, according to its National AIDS Authority, after the introduction of anti-trafficking legislation in 2008.[14] Similarly, in China, a crackdown on children who were exploited by the sex industry was reported to have worsened their marginalization and triggered increased migration, as well as impeding health workers from providing continuous HIV services, according to a recent study.[15]

Anti-trafficking campaigns can sometimes encourage rescue and reintegration operations that can also lead to rights violations, including mandatory HIV testing and forced detention for long periods in rehabilitation homes or shelters, where adolescents may lack access to basic healthcare and where they are vulnerable to abuse. To avoid arrest, detention or 'rescue', children who sell sex may go underground, work freelance and avoid all social services, all of which deepens their vulnerability to violence and other forms of harm.

It is also common for police to use public order offences to arrest sex workers and "confiscation of condoms by police as evidence of illegal conduct and justification for harassment and extortion is a widespread problem."[16] There has, however, been some progress in reforming laws. For example, in 2012, Viet Nam amended laws to end administrative detention of sex workers, although sex work remains illegal.

Working towards decriminalization of sex work and community empowerment

"HIV interventions with sex workers have tended to primarily focus on condom promotion and testing for HIV and STIs, and too often have failed to address the power relationships that create HIV vulnerability....Sex worker organizations in India and Thailand have demonstrated the effectiveness of adopting an empowerment approach, based on community mobilization, peer-based health promotion, self-regulation, active engagement on law enforcement issues and participation in dialogue about law and policy reform. Similarly, sex worker organizations in Cambodia, China, Hong Kong SAR, and Indonesia are actively engaged in advocating for law reform and improvements to law enforcement practices."[17]

Legal constraints to harm reduction for adolescents

All countries in the region criminalize drug use. Sixteen countries (including China, India and Indonesia) provide for the death penalty for drug-related offences and 11 incarcerate people who use drugs in compulsory detention centres. Given such contexts, young people who use drugs, and in particular people who inject drugs, go to great lengths to avoid detection and arrest by the authorities. This includes shunning government-provided health and other social services. Concerned about this, the UN Committee on the Rights of the Child has taken a more forceful stance, explicitly recommending (in 2012) appropriate harm reduction services for those under 18 in the context of the right to health and as part of a wider holistic development agenda.[18] The UN position is that, "Children who are dependent on drugs should benefit from rights-based and evidence-informed programs to facilitate their recovery and reintegration into families and communities."[19]

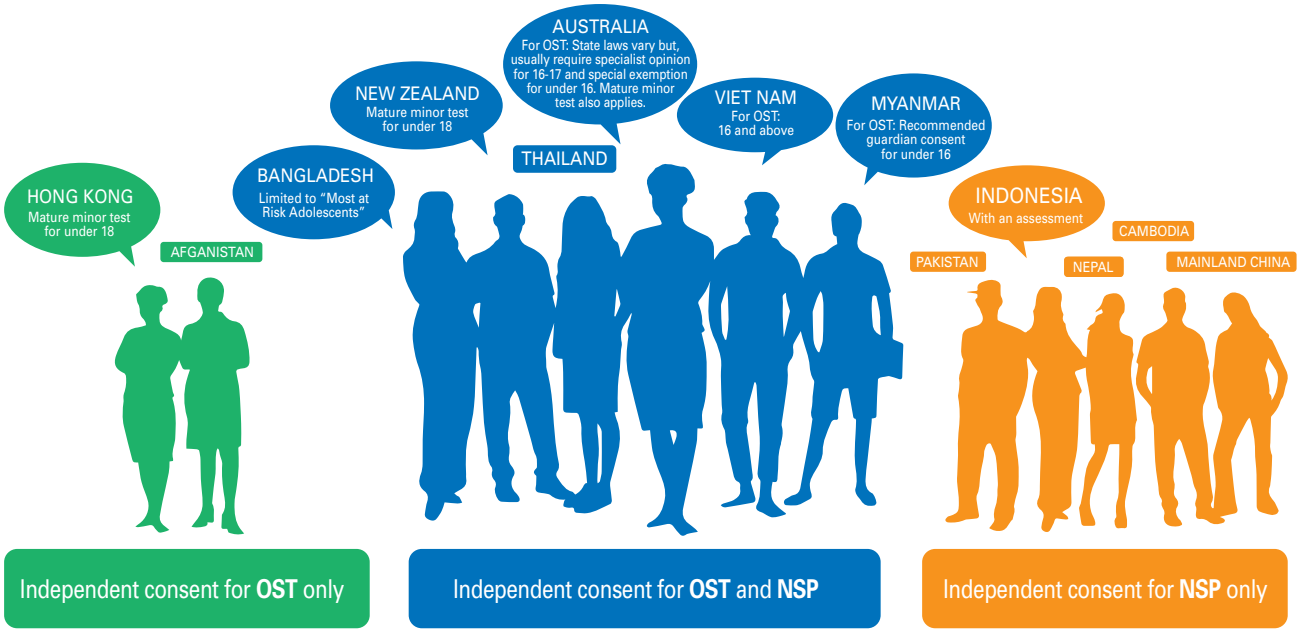
Danger zones: Mandatory detention centres

Roughly 10-20 per cent of the regional prison population are young people, many of whom are jailed on drug-related offences.[20] Not only are young detainees and prisoners more prone to be victims of violence and abuse in closed settings, which can heighten their risk of acquiring HIV, but they also have little to no access to HIV information, condoms, treatment and care, sterile needles, or sexual and reproductive health services.[21] Sexual harassment of young PWID is also common, and they sometimes have sex in exchange for cigarettes or drugs.

Nevertheless, legal age restrictions are still a barrier to harm reduction services in some countries. For example, in Nepal and Pakistan, harm reduction projects can work only with those aged 18 and above. This is of particular concern in Pakistan where the debut age of PWID is reported to be falling.[22] Moreover, in Pakistan OST is largely unavailable.[23]

Thirteen countries are known to have laws and policies enabling independent consent for young people to access needle and syringe programmes and/or opioid substitution therapy programmes (see Figure 18). In India, revised government guidelines on OST published in 2014 allow opioid substitution therapy for adolescents under 18 on a case-by-case basis, although signed consent is still required from a family member or guardian.[24] Adolescents are also included in the WHO's new recommendation that communities likely to experience drug overdose situations be given access to and information on how to administer the opioid antagonist naloxone. Worldwide, drug overdose is the leading cause of death among PWID.[25]

Figure 18: Countries enabling independent consent for young people to access harm reduction services, Asia-Pacific [26]



COMMUNITY SERVICES FOCUSING ON ADOLESCENTS

To reach a critical mass, services for adolescents should not only be acceptable. They need to be easy to access, located in (safe) places in affected communities, and run during hours that are convenient to their clients. They should also be free of charge or affordable, and integrated where possible into other programmes such as drop-in centres. Harsh, punitive legal environments mean that young key populations tend to distrust formal state authorities – especially the police – and government-run services. In Asia and the Pacific, many medical and other functions (except treatment) for young people are also provided by NGOs – sometimes on a large scale.

Active community participation and peer outreach are prerequisites for successful prevention and treatment programmes. Community in a concentrated HIV epidemic includes not only the place where an individual may live, but more importantly, the community to which they belong and with whom they share a certain lifestyle and ethos. An adolescent boy or man who has same-sex relations may still live at home and consider himself part of the local community while also belonging to his own congregation of like-minded MSM. Young key populations need to weigh in on what constitute the best community prevention, testing and treatment strategies – including education. The power of peers to effect change is hard to exaggerate. In Kyson Nghean, a poor remote area of Viet Nam, needle sharing fell by 97 per cent and young PWID were three times more likely to use condoms after interventions by a group of peer educator networks.[27]

Overlapping risk behaviours require combined services

Combining services for adolescents through 'one-stop shops' makes sense. This means bringing together, for example, family planning, STI and HPV screening, HIV testing and counselling, and mental health services. It also means providing items such as condoms, condom-compatible lubricants, contraceptives and sterile syringes. Given that risk behaviours very often overlap, adolescents who sell sex may also need hepatitis testing, needle and syringe provision and addiction treatment. Where health services cannot be combined or integrated, there should be strong links between them that enable referrals to address co-morbidities.

Greater mobility equals less access to services

Adolescent females who sell sex tend to move around a lot more than older sex workers, partly to avoid being harassed by the police. But those evasive tactics also make it harder to reach these girls with HIV-related services. Adolescents and young people (average age 18 years) selling sex in Kunming (China) were significantly less likely to have received peer education, outreach services, free condoms or an HIV test compared with their older counterparts.[28] In a Philippine study, almost all (97 per cent) of the adolescents under 18 who were selling sex at cruising sites had never had an HIV test.[29]

Peer empowerment through networking

Community projects that are designed and run by networks of young people are making things happen *right now*, whether it is boosting demand for HIV services or delving into research on self-stigma and vulnerability. Some examples:

- **Youth Voices Count** (http://youthvoicescount.org/) is a network of over 50 young MSM and transgender people from 19 countries in Asia and the Pacific. Working in communities, they are potent rights advocates for their peers as well as hands-on helpers who support young people to get testing and treatment.

- **Youth LEAD** (http://youth-lead.org/), working with young people aged 14-25 who are directly affected by HIV or at risk of infection, has sat down at the table with law and policy makers locally, regionally and internationally, to voice the concerns of its constituents and advocate for change. The network, active in 17 Asia-Pacific countries, has built up leadership, knowledge and skills among its own ranks and boosted service uptake and participation of adolescents in HIV programme planning, implementation and monitoring.

- The **Purple Sky Network** (http://www.purplesky.asia/v2/) is an umbrella group of organizations, experts, professionals and volunteers working on HIV and AIDS for MSM and transgender people in the Greater Mekong sub-region.

- **APN+** (http://www.apnplus.org), with 30 country members, gives a collective voice to people living with HIV in the region.

Empowerment through theatre in the Philippines

UNICEF and Tanghalang Pilipino, one of the Philippines' premiere theatre organizations, run Theatre for Development. This project aims to raise awareness of and transform attitudes towards people living with HIV, particularly young people. The performers take workshops on acting and sexuality, and tackle issues around HIV that are personal to them and their young peers, actively engaging with the audience. A recen ly produced play, Melanie, about how a community reacts in the wake of a friend's death due to AIDS-related complications, was cited by BroadwayWorld as one of the most unforgettable plays of 2013. The play has toured in different parts of the Philippines, and its innovative methodology is being adapted by various organizations.

In January 2015, youth activists from across the region gathered in Bangkok for the Asia-Pacific Governmental Meeting on HIV and AIDS. On the sidelines of this event, some of them shared their insights, and what they would like governments to do to support young people at risk of or living with HIV. These are written up in a blog: http://unicefeapro.blogspot.com/2015/01/young-agents-for-change-eliminating-hiv.html

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7. DEVELOPMENT SYNERGIES

Investment in holistic development may not have an immediate payoff, but like the invisible underground foundations of a building it is crucial to support the structure that goes on top. Strong social and child protection programmes and high rates of primary and secondary school enrolment and completion generate knowledge, lower health risks and are powerful barriers against the spread of HIV.

SOCIAL PROTECTION

Why adolescents sell sex

Many adolescents and young people sell sex to support their families – or themselves – and escape poverty. Being able to send money regularly back home engenders pride and potentially earns them esteem, even though many who sell sex may never divulge exactly how they earn their income. Research in Thailand suggests that for many transgender sex workers, sending back remittances fulfils a powerful sense of obligation, often linked to the Buddhist concept of *karma*.[1] However, the determination to earn more money can lead to more risk taking, such as not wearing condoms in exchange for higher payment.

Cash transfers

Social protection schemes have an important role to play in reducing the vulnerability of young people to HIV and in improving their circumstances overall. Cash transfers in particular have recently gained ground as a key tool in the HIV-sensitive social protection kit. Cash transfers tend to be more accessible for children and families affected by HIV and AIDS than for adolescents who sell sex or PWID living on the streets who often survive outside the sphere of family care and protection.[2] Nevertheless, adolescents may be able to access some forms of child welfare support, from universal programmes such as free school lunches to special targeted programmes like scholarships for poor students, allowances for orphans, or outreach to children living on the streets.

The results of a 2009-2010 study in South Africa on the impact of cash transfers and care on high-risk behaviours in adolescents[3] could be pertinent for the Asia-Pacific context. The study of 3,515 adolescents aged 10-18 over a one-year period found that combined economic support and care halved the incidence of HIV risk behaviour among girls and boys. The economic support consisted mainly of unconditional government cash transfers, school feeding and food gardens. Psychosocial support included positive parenting and teacher social support. Cash plus care had the greatest impact on adolescents at higher risk of HIV, reducing the incidence of school drop out, child abuse, conduct problems, psychological distress and drug or alcohol use. In statistical terms, follow-up HIV risk behaviour fell from 41 per cent to 15 per cent among girls and from 42 per cent to 17 per cent among boys.[4]

Overall, social protection schemes must be sensitive to adolescents, with the flexibility to intervene early and meet age and gender-specific needs.

CHILD PROTECTION

Protection from violence, abuse and exploitation

Protecting adolescents from violence, abuse and exploitation is not just a human rights imperative. It is critical to preventing risky behaviours from manifesting immediately – or later in life. Addressing violence and abuse early on in the context of HIV programmes could well mean the difference between condom use negotiated – or not.

Sexual violence is prolific in Asia and the Pacific

A recent study of over 10,000 men in six countries – Bangladesh, Cambodia, China, Indonesia, Sri Lanka and Papua New Guinea – found that a quarter of them had committed rape.[5] In Vanuatu, almost two thirds of sexually active females (aged 15-24) among 367 vulnerable youth surveyed in 2009 said they had experienced forced sex.[6]

Unfortunately, while there is ample evidence of violence and abuse perpetrated against adolescents at higher risk of HIV, there are very few, if any, examples of efforts to address these issues in current prevention strategies for these groups. What needs to happen to end such violence is large scale, beginning with closer collaboration between child protection, law enforcement, juvenile justice, social welfare and HIV and health services. More resources are certainly required, as well as specific guidance given to these sectors for dealing with adolescents who have experienced violence and abuse.

Sexual abuse, including a forced first experience of sexual intercourse, is all too common in the region, especially in the Pacific, which has some of the highest global rates of sexual violence against girls and women. There is a strong link between early sexual abuse and sex work at young ages. Most people under the age of 18 who sell sex in the region operate in circumstances that expose them to the constant risk of physical and sexual violence. In low-income countries, boys are actually more susceptible to child sexual abuse than girls, according to recent research by UNICEF.[7]

The violence vulnerability scale

A hierarchy of sorts exists in the sex industry. The youngest females selling sex often work at the lowest rungs (usually on the street, in parks, at beaches or in other public places), where they earn the least and tend to have the most clients. They are also more likely to be 'freelancers' – which can be a more dangerous way of working if they lack the protection that pimps and managers sometimes provide.[8] They face especially high risks of violence, abuse and harassment compared with those who work in brothels and bars, for example, where bribes and other favours can shield them from predation by the police and clients and where managers can support condom use policies.[9] Transgender adolescents – selling sex or not – often have little or no recourse to the police if they are the victims of harassment or violence. In fact, they are commonly subject to abuse, extortion, beatings or rape by the police themselves. In some Asian countries, sexual violence laws do not criminalize sexual assault on transgender individuals.[10]

Figure 19: Sexual violence among young key populations, Asia-Pacific [11]

A brief stocktaking of sexual violence among young key populations in Asia Pacific			
Bangladesh (2012)	>50% street-based, >40% hotel based and 36% brothel-based	Young people 10-24 years selling sex	44% forced into having sex within the 12 months prior to the survey. All reported this had happened on average 2 to 4 times during that same period
	47%	Transgender persons <25 who sell sex	Coerced into sex at least once in the previous year
	25%	MSM/MSW aged 10-24 years	Forced into having sex in the last 12 months
Port Moresby, Papua New Guinea (2010)	71%	Young people 10-24 years selling sex	Forced into sex in the previous three months – perpetrator was a client in 63% of these cases
Kiribati (2012)	5%	Young people 10-24 years selling sex	Forced into having sex
Solomon Islands (2012)	11%	Young people 10-24 years selling sex	Forced into having sex
Philippines (2009)	44% in Angeles, 45% in Baguio, 49% Tuguegarao and 50% in Quezon	Young people 10-24 years selling sex	First sexual encounter with a man had been forced
Pakistan (2008)	49%	*Hijra* aged 20-24 who sell sex	Police or clients physically abused them or forced them into sex in the previous year
Pakistan (2011)	54%	*Hijra* younger than 20 who sell sex	Forced into having sex at some point
Thailand (2011)	25%	Adolescents who sell sex	Reported physical or sexual violence in the previous week (compared with 18% of those aged 18-30 years)

Street children beyond the protective pale

No one knows for sure how many street children there are in Asia and the Pacific, but some country estimates are staggering. Bangladesh has an estimated 400,000 children living on the streets, nearly 10 per cent of whom have been forced into selling sex to survive.[12] A survey of seven districts in Pakistan that 'mapped' some 97,000 adolescents found that 17 per cent of them sold sex, either intermittently or as their main source of income.[13]

Children living on the streets are often the victims of collapsed households and family breakdowns, or are fleeing violence and abuse. Many face multiple, intertwined hardships (social, psychological and economic) and may be locked in a spiral of drug use and forced or transactional sex – all of which compound their risk of acquiring HIV. Survival is often the motive for selling or trading sex, and often in exchange for very basic necessities, such as food and shelter. Whereas systems can fail any child, young people who live on the streets tend to be the most alienated and outcast of the lot. Because they are rarely researched, their realities are not properly understood and they remain well outside of any protective response fold.

EDUCATION

Quality education is a fast track to increasing awareness, reducing vulnerability to HIV, and providing the young with lifelong options. The biggest challenge is to get more adolescents from key populations to enrol and stay in school. What proportion they make up of the total out-of-school adolescent population is not known, although studies (see below) indicate that many adolescents from key populations exit education early. While school enrolment levels have significantly improved in South Asia, they still remain low in some areas, especially for girls, and most markedly at secondary level.

Aborted schooling heightens vulnerability

Some individuals within young key populations have little formal education. For example, fewer than one third of 15-19-year-old adolescents in Indonesia surveyed between 2007-2009 who sold sex had completed high school and above.[14] In Afghanistan, more than half (58 per cent) of PWID under 25 said they had no formal schooling at all.[15] In Pakistan, 42 per cent of 15-19-year-old *hijra* who sold sex were found to be illiterate in a 2011 survey,[16] while in Indonesia (2007-2009), fewer than half (44 per cent) of young *waria* involved in the sex industry had finished high school.[17]

Ensuring that all adolescents go to school – and stay in school – is a critical part of the education sector response to HIV. Also essential are the provision of content and curricula that build knowledge and skills for protective behaviour and combat stigma and discrimination around HIV. Teacher training that addresses issues around HIV realistically, including sexual and gender preferences and school policies that ensure zero tolerance of violence, abuse, bullying and discrimination against children living with or affected by HIV are a must. Schools should enforce strict confidentiality regarding disclosure of a student's HIV status, while working towards becoming 'HIV-friendly' through a holistic approach that promotes a caring, supportive and inclusive environment.[18]

COMPREHENSIVE SEXUALITY AND HIV EDUCATION IN SCHOOLS

Adolescents have the right to quality, non-judgemental and unbiased information to safeguard their sexual and reproductive health. Comprehensive sexuality education (CSE) has a demonstrated impact on improving knowledge, self-esteem, changing attitudes, gender and social norms and building self-efficacy among adolescents. CSE has been shown to result in delayed sexual debut, more frequent condom use, fewer sexual partners and significantly reduced sexual risk-taking among those who are sexually active.[19, 20] International standards and guidance recommend that sexuality education[21] starts early in childhood and progresses through adolescence and adulthood, building knowledge and skills through a carefully phased process over time, like any other subject in the curriculum. Teaching CSE (embracing communication, relationships, decision making, gender equality and SRH and HIV) in schools from an early age provides a golden opportunity to reach children before they become sexually active. It also reaches those adolescents at higher risk of HIV who do not enrol in, or who drop out of, secondary school.

The Asia-Pacific region has a favourable policy environment for the implementation of HIV education, with most countries integrating broader sexuality education into national HIV strategies.[22] But in country reports, fewer than half (43 per cent) indicate having integrated sexuality education at primary level, while 22 out of 28 countries reported doing so at secondary level.[23] Moreover, few curricula in the region are comprehensive. For example, most curricula rarely acknowledge the specific SRH needs and rights of young people living with HIV, young people with disabilities, or young gay, lesbian and transgender people, especially as they reach puberty. Effective CSE has to be both inclusive and non-stigmatizing, addressing sexual and gender-based violence and promoting gender equality, as well as ensuring the needs and rights (to education, privacy, fulfilling relationships and SRH) of all young people, including those living with HIV.[24]

Creative approaches have been developed, often in partnership with young people themselves, to reach marginalized young people who are out of school using new media and technologies, peer education and community-based approaches. Other interventions to enable adolescents to return to school through 'second chance' or related programmes can be a bridge for those who may drop out to advance their education and can improve employment outcomes.

Nepal: Teaching sexual orientation and gender identity in schools

The Ministry of Education in Nepal has recently integrated sexual orientation and gender identity/expression (SOGI/E) into its official curriculum for grades 6-9. One of the government's partners, the Blue Diamond Society (BDS), has delivered training to teachers and school administrators on incorporating SOGI/E into the school syllabus. With a team of experts, BDS developed a training manual and a toolkit, along with a booklet of frequently asked questions.[25] The toolkit,[26] which provides basic information about sexuality and gender issues, has been used in teacher training workshops in many regions in Nepal, with support from the World Bank. Almost 800 teachers to date have received training on implementing SOGI/E in school.

Those participating in the programme have committed to ensuring that the school environment is friendly and respectful towards lesbian, gay, bisexual, transgender and intersex (LGBTI) students. This includes designation of 'other' as a gender option on forms, providing a flexible dress code and appropriate restrooms on school premises. [27, 28]

Thailand: Insight into school bullying because of sexual orientation and gender identity [29]

In 2013, Thailand's Mahidol University, Plan International and UNESCO undertook the country's first systematic study of bullying and violence on the basis of sexual orientation and gender identity. The research involved the collection of quantitative and qualitative data from over 2,500 students, administrators and teachers in secondary schools (grades 7-12) in five provinces across Thailand. The study provides an unprecedented look into bullying against students who identify as, or are perceived to be, lesbian, gay, bisexual or transgender in Thai schools and its toxic effects on victims, from absenteeism, to depression and even attempted suicide.

More than half (56 per cent) of LGBT students in the Thai study reported having been bullied within the past month because of their sexual orientation and gender identity (SOGI), while 25 per cent of those that did not self-identify as LGBT also had been bullied because they had been seen to be LGBT. This confirms other research suggesting that it is the perception of same-sex attraction or of transgender identity that puts people at risk. Nearly one quarter (23 per cent) of those bullied because of their perceived sexual orientation or gender identity/expression were depressed, with nearly 7 per cent having attempted suicide in the past year. Around two thirds of students who had experienced anti-LGBT bullying said they did not report these incidents or even talk about them with anyone. Twenty three per cent of those that did not react said that this was because "nothing would happen even if someone were told."

In response to the findings, Plan International Thailand and UNESCO Bangkok mobilized funding for a three-year programme to strengthen the capacity of the Thai education system to prevent and respond to school-related gender-based violence, including bullying on the basis of SOGI. The programme will strengthen interventions in 12 schools in Chiang Mai and Bangkok through initiatives in curriculum, teacher training, awareness-raising, counselling and peer support in schools. The programme aims to test models and embed programmes and practices within the curriculum and daily life of the participating schools rather than being 'add-on' features. It will provide important lessons learned for other schools in Thailand and the Asia-Pacific region.[30]

8. BRIDGING THE DATA GAPS

Intelligence is vital in order to turn the HIV epidemic around and reach the 2020 targets on infection and mortality reductions. The good news is that all countries in the region gather routine HIV sentinel surveillance data and many conduct other surveys, such as behaviour surveillance surveys. Regrettably though, adolescents are too often absent from data collection. One third of the 31 country HIV surveillance systems in Asia and the Pacific in 2011 did not include people aged 17 and younger. Even where those under 18 are surveyed, data samples are often too small to be informative, not disaggregated by age and not analysed separately. Fewer than half of the 38 countries in the Asia and Pacific region reported key indicators (HIV prevalence and testing, condom use, access to prevention programmes and safe injecting practises [PWID only]) for key populations under the age of 25 in the Global AIDS Response Progress Report of 2012.

The chief reasons why data on adolescents are missing are:

- Surveys and research usually do not include criteria for the 10-14 age group.
- Conservative attitudes and the belief in some countries that inclusion of adolescents is not possible simply because it has never been done.
- Worries about ethical clearance, particularly for adolescents under 18, to participate in research studies.
- Young key populations often do not go to programme sites used to gather behavioural surveillance data.
- Widespread criminalization of risk behaviours makes it difficult to include them in mapping and research.
- Adolescents selling sex and street children at higher risk of HIV exposure are often hidden, difficult to reach and potentially unwilling to participate in research.
- Adolescents who sell sex may lie about their age to avoid detection (and to be allowed access to sexual and reproductive health services).

The recent guidance published by four UN agencies, *Young Key Populations at Higher Risk of HIV in Asia and the Pacific – Making the Case with Strategic Information* (http://www.unicef.org/eapro/12205_3607.html) – urges the consistent inclusion of persons aged 10-14, 15-19 and 20-24 in HIV surveillance activities and surveys, and the systematic and consistent disaggregation of those data for the 15-19 and 20-24 age groups.[1]

Innovation in data generation

Big data for a better grasp

Technology can help to bridge data gaps in ways that were fiction not long ago. Collecting instant information about adolescents to inform HIV prevention and detection is increasingly feasible, and not just in the process of conducting official surveys and the like. Consider 'big data' – everything from call detail records to blogs, texts, twitters, chats, images, video and system logs. Big data, machine learning and new analytical tools powered by information en masse, are enabling a better understanding of the rapidly expanding volumes of real-time data as more and more adolescents go mobile and get online. At its core, big data is about predictions and making correlations that were never possible before with smaller data sets, and the identification of proxy indicators where data are scarce or unavailable.

In a 2012 study, over half a billion tweets were collected online and mined using HIV risk-related keywords (e.g. sexual behaviour and drug use). A significant positive relationship was found between HIV-related tweets, and HIV cases and country prevalence. In the authors' own words, "Results suggest the feasibility of using social networking data as a method for evaluating and detecting HIV risk behaviours and outcomes."[2] It is worth highlighting that Indonesia and India now rank among the top five twitter communities globally, according to one estimate.[3]

Another pioneering way to generate data from hard-to-reach adolescents is web-respondent driven sampling (web-RDS). Web-RDS circumvents some of the common RDS challenges such as the stigma and confidentiality concerns of physically going to a survey office, the small geographic catchment area involved (usually a city or part of a city) and the high operational cost. A rollout of Web-RDS among young MSM in Viet Nam in 2011 generated 676 respondents with an average age of 22, four fifths of whom were from Hanoi and Ho Chi Minh City, with an education higher than the average. Twenty initial 'seeds' were able to recruit up to four MSM friends, who then recruited their friends, each one receiving an incentive for every new person brought on board. Participants logged in and answered an eight-question survey, with checks conducted for cheating. Results were similar to other MSM studies. The conclusion? "WebRDS may be a promising method for sampling of Internet-using MSM and other hidden groups."[4]

U-Report for young people

UNICEF is putting its new youth-empowerment tool, U-Report, to work to help achieve the All In targets. U-Report is an SMS and Twitter-enabled tool designed specifically to allow young people to contribute their voices – and information – to issues they care about. It uses RapidPro, UNICEF's open-source software platform for international development. Indonesia is one of the 12 priority countries worldwide where U-Report has been introduced. Plans are in the pipeline to launch it in Pakistan and Bangladesh.

Young people are targeted to join U-Report through local NGOs, youth organizations and faith-based organizations. Traditional media campaigns are also used to advertise the service and encourage young people to sign up. By sending the text message, 'join,' to a toll-free number and answering a few registration questions (e.g. age, gender, region within a country in which they reside), any young person with a mobile phone can become a volunteer 'U-reporter' in their country. Through its ability to connect with young people, U-Report can address data gaps among adolescents (disaggregated by age and sex), and engage with different populations at high risk (adolescents living with HIV and young key population groups) using targeted messaging.


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9. MOVING FORWARD TO ZERO

Recommendations for policies and programmes [1]

We know the strategies that work to halt the spread of HIV and AIDS in adults. These are ground zero for a purposeful response on the adolescent front. But to really deliver, existing initiatives must be customized to match to the needs of adolescents at higher risk of HIV, who are subject to multiple injustices, including stigma, incarceration and violence. Hence, the importance of investing not only in immediate high-impact actions but also in efforts to bring about long-term societal transformations that truly serve the best interests of adolescents.

The following recommendations are directed at the many different actors across the multiple sectors involved in the HIV response. They are focused on adolescents in key populations with the aim of bringing them where they should be – firmly onto the radar screen.

Scale up high-impact interventions as part of a comprehensive health package for young key populations

HIV prevention

- Promote consistent and correct condom use and the use of condom-compatible lubricants among all adolescents at higher risk of HIV.
- Emphasize peer-led and outreach approaches to distribute condoms and lubricants, increase knowledge, develop skills and empower adolescents from key populations to use condoms and lubricants correctly and consistently.
- Educate young key populations about HIV, including the risks of unprotected anal sex, and the links between drug use and unsafe behaviours. Use peer-to-peer contact and multiple communication channels, such as schools, bars, community drop-in centres, and Internet and mobile phone platforms.
- Provide guidelines for HIV testing of adolescents and disclosure in Asia and the Pacific.
- Involve adolescents at higher risk of HIV in creating public health messages to reflect their own perceptions of HIV risk and ground realities, including the pressure to conform to gender roles and issues of self-esteem.
- Involve adolescents at higher risk of HIV in advocacy and decision-making on prevention, testing, treatment and care issues.
- Scale up sexuality and HIV prevention education (including issues of intimacy, trust and gender) at primary and secondary schools and through out-of-school interventions and non-formal education. Ensure teaching is by trained staff.
- Promote community-based adolescent-sensitive 'one-stop' health centres, including HIV and SRH services and screening, diagnosis and treatment for all sexually transmitted infections and co-morbidities.
- Promote access to SRH services for young key populations to prevent unplanned pregnancy.
- Tailor SRH services to meet the specific needs of young transgender women.
- Develop clear communication strategies on the implementation of PrEP for older adolescents and young MSM.

Harm reduction services

- Remove age restrictions for needle and syringe programmes and opioid substitution therapy.
- Provide free sterile injection equipment through needle and syringe programmes at locations that are safe and easy to reach, and operate at convenient times for young PWID.
- Scale up coverage of opioid substitution therapy, using peer initiatives to reach street children and other 'underground' PWID.
- Ensure that adolescent detainees and those in other closed settings have access to sterile injecting equipment.
- Ensure access to naloxone for emergency management of suspected opioid overdose.
- Train healthcare staff to be sensitive to the specific needs of PWID and the vital importance of services that are non-coercive, non-judgemental and non-stigmatizing.

Universal voluntary HIV testing and counselling

- Remove age restrictions on HIV testing and counselling.
- Ensure easily accessible and safe HIV testing sites for adolescents under 18.
- Provide testing based on consent, confidentiality, counselling, correct test results and connections to appropriate, treatment, care and prevention services.
- Ensure referrals are made to child protection services if the adolescent has been abused or is at risk of abuse.
- Provide mobile point-of-care testing and counselling to young key populations to further expand their options.
- Make testing and counselling services free or affordable and ensure they are open at appropriate times for young MSM, PWID, people who sell sex and transgender people.
- Link testing and counselling with other programmes such as youth health services and drop-in centres.
- Counsel adolescents about the potential benefits and risks of disclosure of their HIV status to others and empower and support them to determine if, when, how and to whom to disclose.

HIV treatment and care

- Scale up and improve antiretroviral treatment for HIV-positive adolescents, including free or affordable first, second and third line antiretroviral medicines and cutting edge new treatment when available.
- Provide regular access to diagnostics and monitoring tests for co-infections and co-morbidities.
- Ensure access to SRH services for HIV-positive adolescents and to prevention of parent-to-child transmission services for pregnant adolescents.
- Involve young key populations in the design, operation and monitoring of treatment and care programmes, and ensure services are adolescent-focused.
- Give preference to community-based decentralized care services through mobile outreach and at fixed locations, making the most of existing infrastructure.
- Train healthcare staff to be sensitive to the specific needs of adolescents and young key populations and the vital importance of services that are non-coercive, non-judgemental and non-stigmatizing.
- Provide adolescents with treatment preparedness counselling, including ongoing peer support services to encourage uninterrupted ART adherence.

Champion supportive and protective laws, policies and holistic development for key adolescent populations

Critical enablers

- Include young key populations, and specifically adolescents, in national strategic plans and health and development plans, and ensure earmarked budgets.
- Decriminalize same-sex activity, injecting drug use, sex work and diverse gender identities.
- Review and amend all laws and policies that prevent adolescents from independently accessing HIV-related services and that propagate stigma and discrimination. Ensure all legislation and policies uphold their rights and are truly centred on their best interests.
- Review and amend current policies and laws to remove age barriers to harm reduction services and HIV testing and treatment in line with the 'evolving capacities' of the child.
- In accordance with the CRC, its Optional Protocol and other international human rights standards, all forms of sexual exploitation of children should be criminalized and children who are survivors of sexual exploitation should always be exempt from prosecution and arrest.
- Sensitize police, law enforcement officials and legislative authorities on HIV prevention efforts, anti-trafficking laws and CRC provisions.
- Halt mandatory detention of young people who engage in same-sex relations, inject drugs or sell sex and work for the immediate closure of compulsory detention and 'rehabilitation' centres.
- Change policing procedures so they do not allow confiscation of condoms, needles and syringes for use as evidence of sex work or drug use for criminal charges.

Development synergies

- Advocate a multidimensional approach to social protection of young key populations, involving HIV prevention, social welfare, education and child protection to address overlapping risk behaviours.
- Target social services to adolescents without guardians or 'emancipated' minors (those not under the legal responsibility of parents or guardians).
- Strengthen linkage and referral systems between child protection and social welfare sectors, and SRH and HIV prevention, care and support.
- Work to curb violence against and the abuse of those under 18, including street children, and ensure they have access to legal redress mechanisms.
- Develop procedural guidelines for dealing with children who are sexually exploited and at risk of contracting HIV, to be made available across sectors, including law enforcement, health and juvenile justice.
- Increase enrolment of all adolescents under 18 in school as part of universal quality education drives, aiming for full completion of schooling.
- Ensure schools address prevention of violence (sexual, domestic, gender-based, bullying, etc.) in curricula and have zero tolerance policies on school grounds.

Improve data collection, research and evidence-based analysis on adolescents

- Generate detailed information on adolescents at higher risk of and living with HIV, disaggregating data into 10-14 and 15-19 age cohorts, and by gender, risk behaviours, epidemiology, location, etc.
- Include specific questions for adolescents at higher risk of HIV in sentinel surveillance and other relevant surveys in low and concentrated HIV epidemics.
- Ensure that budgets are set aside for the collection, disaggregation and analysis of fresh data on young key populations.
- Use disaggregated data and research in advocacy to push prioritization of adolescents in the HIV response.
- Explore the potential of 'big data' to inform adolescent HIV prevention and detection through collaboration with development partners (i.e. UN Global Pulse, Asian Development Bank, World Bank) and private partners such as IBM, Mind Benders and Ginger.i.o.

Ensure young key populations have access to universal health coverage that includes HIV-related services

- Prioritize universal health coverage (UHC) for all people as a core element of the post-2015 health goal, adopting UHC strategies appropriate to the local context. Comprehensive interventions and services funded through the public system should be defined, and quality assurance built in.
- Work towards integrating HIV into broader health planning and use a single framework for situation analysis, costing, planning and budgeting for all major health issues.
- Link HIV programmes for adolescents and young people with other health areas, such as tuberculosis, maternal and child health, sexual and reproductive health, drug dependence, non-communicable diseases and mental health.
- Ensure that financial protection schemes cover the full range of HIV interventions and services required by adolescents and young people, such as laboratory tests, transportation costs and nutritional supplements. All out-of-pocket fees for HIV testing, treatment and other health services for children and adolescents should be removed.
- Remove financial and other barriers to enable equitable access to health services for all adolescents and identify new approaches for sustainable financing of comprehensive HIV responses.

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9. MOVING FORWARD TO ZERO

1 The recommendations in this section draw largely from the following documents:
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b) World Health Organization, 'A technical brief: HIV and young people who sell sex', WHO, Geneva, 2015.
c) World Health Organization, 'A technical brief: HIV and young men who have sex with men', WHO, Geneva, 2015.
d) World Health Organization, 'A technical brief: HIV and young people who inject drugs', WHO, Geneva, 2015.
e) World Health Organization, 'A technical brief: HIV and young transgender people', WHO, Geneva, 2015.
f) World Health Organization, *HIV and Adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV – Recommendations for a public health approach and considerations for policy-makers and managers*, WHO, Geneva, 2013.

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