Global consultation on the health services response to the prevention and care of HIV/AIDS among young people

Achieving the global goals: access to services

Technical Report of a WHO Consultation
Montreux, Switzerland, 17-21 March 2003

A WHO technical consultation in collaboration with UNAIDS, UNFPA, and YouthNet

UNAIDS **UNFPA** **WHO** **YouthNet**

Department of Child and Adolescent Health and Development (CAH)
World Health Organization, Geneva

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This report contains the collective views of an international group of experts, and does not necessarily represent the decisions or the stated policy of the World Health Organization or any of the other collaborating partners: UNFPA, UNICEF, UNAIDS and YouthNet.

Executive summary

Young people (10-24 years) are at the centre of the HIV epidemic in terms of transmission, impact, vulnerability and potential for change. The global goals on young people and HIV/AIDS that have now been endorsed in a wide range of fora reflect both the strong public health, human rights and economic reasons for focusing on young people, and also the concern and commitment of governments around the world to direct resources to the prevention and care of HIV/AIDS among adolescents and youth.

In order to contribute to the growing clarity about what needs to be done to achieve these global goals, and to strengthen the collaboration between a range of UN and NGO partners committed to accelerated health sector action, WHO organized a technical consultation on the health services response to HIV/AIDS among young people, in collaboration with UNAIDS, UNFPA, UNICEF, and YouthNet, in Montreux, from 17 to 21 March 2003. The consultation sought to obtain consensus around evidence-based health service interventions for the prevention and care of HIV among young people; effective strategies for delivering these interventions, the essential characteristics of successful programmes; and the strategic partnerships and actions at global and regional levels that will be required to stimulate and support action in countries.

It is now widely accepted that the prevention and care of HIV/AIDS among young people will require a range of interventions from a range of different sectors. The health sector itself will be responsible for a number of different interventions, through a range of health system partners. The consultation brought together UN, NGO and academic partners, and provided the opportunity for these diverse actors to review the evidence for action: what was understood by "evidence", the available evidence about increasing young people's access to priority services, and what could reasonably be inferred or extrapolated from the available evidence from other age groups.

Participants attending the consultation emphasized the important role that the health sector has to play, and stressed that to date there has been inadequate attention and insufficient resources directed to developing and strengthening this. The interventions that are provided through health services need to be seen within the context of other priority activities of the health system, such as collecting, analysing and using the data necessary for programmes, policies, and advocacy, and contributing to and disseminating the evidence base that needs to underpin supportive policies for effective programmes. They also need to be seen within the context of the activities of other sectors, for some of which the health sector will need to play a mobilizing and supportive role.

Based on background papers that were prepared for the meeting and the subsequent discussions, it was agreed that there was evidence for effectiveness for a number of interventions that could be delivered though a range of different service providers. These included information and counselling, to contribute to young people's acquisition of knowledge and skills; condoms for sexually active young people; STI treatment and care; harm reduction

measures to decrease transmission through IDU[1]; and access to HIV testing, care and support. All of these interventions have been demonstrated to have an effective role in reducing HIV transmission and meeting the needs of young people for prevention and care, in a variety of settings. Participants agreed that young people have a right to, and need for equitable access to these interventions, regardless of sex, age, marital status or other socio-culturally-defined variables, and regardless of the prevalence of HIV[2]. Although the precise intervention mix is likely to vary depending on a range of factors including the epidemiology of HIV and the priority target groups (based on behavioural, developmental or socio-economic and demographic characteristics), services for young people should at a minimum comprise some or all of the above interventions.

In addition to agreeing on the core evidence-based health service interventions, the consultation outlined effective strategies for delivering these interventions, that consider the diversity of young people and their needs, different settings, different target groups and different scenarios in terms of the phase of the epidemic and the available infrastructures and resources. These delivery strategies included strengthening existing health facilities, the use of peer and non-peer outreach, social marketing, social franchising, voucher schemes, and greater involvement of the private sector.

The key characteristics required to ensure that services are more responsive to the specific needs of adolescents, or "adolescent friendly", were reviewed and endorsed by participants. Guiding principles for the effective delivery of priority interventions include attention to health system issues, for example giving adequate attention to improving the skills of service providers, and making sure that facilities are accessible to, and used by young people, based on their health seeking behaviours; the meaningful participation of young people, parents and other community members in providing and supporting the services; and giving adequate attention to supervision and supplies as a basis for taking effective interventions to scale. Participants emphasized that when talking about adolescent or youth-friendly services, this was not a call for parallel services, but for the services that are being provided to be more responsive to the specific needs of young people.

The priority health services for the prevention and care of HIV/AIDS among young people need to build on and contribute to other on-going health services for young people directed to their health and development, including sexual and reproductive health. It will be important to link these interventions to efforts to achieve the MDGs on maternal and child mortality, both of which have important implications for adolescents, dual protection, and related problems such as drug and alcohol use and gender-based violence. Because there is a sense of urgency and political commitment to responding to HIV/AIDS in many countries and globally ,including the 3-

1 IDUs (injecting drug users) People who take drugs by injection. A wide definition of IDUs is used to cover people who have injected experimentally or continue to inject occasionally, up to and including heavily dependent drug users who may inject several times each day. IDUs may inject legal or illegal drugs, stimulants (such as amphetamines and cocaine), depressants (such as heroin and benzodiazepines) or other drugs such as steroids. They may inject intramuscularly (into the muscle) or intravenously (into the vein).

[2] High and low prevalence settings were terms used for the working groups; low refers to sero-prevalence in the general population of less than 1%, where there may or may not be concentrated epidemics among specific target populations e.g. sex workers or drug users; high prevalence refers to countries with a generalised epidemic where HIV is over 1% in the general population. Further details on the WHO web site. http://www.who.int/hiv/strategic/surveillance/en/

by-5[3] commitment made by WHO and partners, it is likely to provide an important entry point for developing services for young people, both for the general population of young people and for neglected and particularly vulnerable groups.

If the activities of the range of partners who need to contribute to the prevention and care of HIV/AIDS among young people are to be mobilized and coordinated at national level, it will be important to transform the global goals into more specific and operational national targets. This will not only provide focus for the various partners who need to be involved, but will also help mobilize resources and provide local and national pressure for accelerated action. Such targets can only be determined at country level, but participants were able to develop indicative targets during the consultation, in order to provide a focus for the discussions, and these can be further developed as a basis for accelerated action in countries (Annex 2). Policy makers, planners and programme managers need to ensure that service providers and facilities operating at district and national level are equipped, and have the capacity to deliver effective interventions to reduce new HIV infections among young people, and better respond to the needs of those already HIV infected.

Specific recommendations were made for global and regional activities that would support the implementation of the priority evidence-based interventions outlined during the consultation (prevention and decreasing risk through information and counselling, condoms and harm reduction; and the testing and treatment of STIs and HIV/AIDS). These ranged from advocacy and resource mobilization, through the development of specific programme support tools and capacity development, to the need to support on-going evaluations and operations research. Health and development partners now need to focus their resources around these priority interventions, taking into consideration both the available evidence base and the growing experiences of people charged with developing the health sector response to HIV among young people. Improving overall collaboration and focus among key UN partners and international donors to assist countries accelerate focused action will remain a challenge, and it is hoped that the Montreux consultation will make an important contribution to this, by providing a clear evidence-based focus both for the role of health systems and for the role of individual health service providers.

[3] WHO and partners have committed to ensuring three million HIV infected people will have access to anti-retrorviral therapy by 2005 (September 2003).

Introduction

During the UN General Assembly Special Session on AIDS a number of global goals were endorsed relating to young people and HIV/AIDS. These goals focus on impact; reducing the prevalence of HIV among 15-24 year olds, and coverage; increasing young people's access to key interventions, including services[4], and they are also reflected in the goals that were endorsed during the ICPD +5 and the UN General Assembly Special Session on Children, and in the Millennium Development Goals (MDGs).

Young people remain at the centre of the HIV pandemic, and all UNAIDS cosponsors and international donors are directing greater attention and resources to this population. HIV/AIDS is more than a health problem, and requires a range of interventions through a multi-sectoral response. However, the health system[5] will continue to have a key contribution to make in national efforts to prevent and care for HIV/AIDS among young people.

During the past few years the evidence base for specific health care system[6] interventions[7] directed at HIV has been emerging and evolving, and there is growing clarity about priorities for action that will require efforts from many partners. WHO therefore decided to organize a meeting, in collaboration with UNAIDS, UNFPA, UNICEF, and YouthNet, to develop consensus and mobilization around the priority health care system interventions, with a focus on the provision of services and supplies, as a contribution to accelerated action towards achieving the global goals on young people and HIV/AIDS.

[4] UNGASS declaration 2001 available at: http://www.unaids.org/UNGASS/docs/AIDSDeclaration_en.pdf

[5] Health system is defined by WHO as 'including all the activities whose primary purpose is to promote, restore or maintain health' WHO World Health Report 2000 p 5.

[6] The 'health care system' is the term used to describe the systems and facilities used to deliver promotive, preventive and curative health interventions directed at individuals or populations. World Health Report 2000, p. 6

[7] Health interventions are defined as " any health action; including primitive, preventive, curative or rehabilitative activity where the primary intent is to improve health" World Health Report 2002, p xiv

Background and rationale

There is now wide acceptance that young people are at the heart of the HIV/AIDS pandemic in terms of transmission, impact and potential for change. Available data indicate that more than half of those newly infected with HIV are young people aged 15-24 years, which amounts to 6000 new infections among young people every day, and nearly 12 million of the HIV infected people globally are 15-24 years old, of whom approximately 7.3 million are female[8].

In selected African countries with generalised epidemics, half or more of young people aged 15-19 years have already had sexual intercourse. At the same time, less than half of these same 15-19 year olds are aware of effective ways to prevent HIV infection[9]. In other parts of the world injecting-drug-use is becoming more common among younger cohorts, those least likely to understand the risks of HIV and safe injecting practices[10]. In emerging epidemics it is often the youngest members of specific communities who are at greatest vulnerability to HIV, but who are the least likely to have the knowledge, skills and access to services to protect themselves and their partners[11]. The overall statistics on HIV/AIDS often hide the fact that many adolescents are particularly vulnerable, and that large numbers of injecting drug users, sex workers[12], migrant workers and AIDS orphans are adolescents. In all generalised epidemics young women are disproportionately affected, although in focused epidemics that are driven by injecting drug use (IDU) or men having sex with men (MSM), a greater number of young men are infected.

It is therefore essential for national responses to HIV/AIDS to include an explicit focus on young people, as prevention of HIV transmission in this age group will have an important impact on the epidemic, among particularly vulnerable young people in concentrated and emerging epidemics, in the general population of young people in generalised epidemics. Where there has been sustained focus on ensuring young people have access to knowledge, skills and services to protect themselves, HIV rates among young people have been shown to decline (e.g. Thailand, Uganda, Zambia and Brazil).

The global goals for young people and HIV/AIDS provide focus, vision and accountability. At the same time, the UNAIDS Five Year evaluation provides guidance on key areas for future development, particularly the need for clarity about the roles of co-sponsors and the need to support accelerated action in countries.

Many of the actions needed to develop a sustainable response to the prevention and care of HIV/AIDS among young people will take many years to produce results, and will require a range of sectors and partners to initiate and implement. In the short term however, if the global goals are to be achieved, countries will need to be clear about a

[8] Young people and HIV/AIDS Opportunity in Crisis. UNICEF/WHO 2002
[9] UNICEF/Multiple Indicator Cluster Surveys (MICS), Measure DHS, 1999-2001
[10] *Preventing HIV/AIDS and Promoting Sexual Health among Especially Vulnerable Young People*. Cathy Shaw and Peter Aggleton. WHO/DfID 2002
[11] As above
[12] As above

strategic focus for the health care system, and there will need to be strong consensus among key partners to support the acceleration of a core set of priority interventions, with flexibility for different organizations to contribute according to their capacity and mandates.

In addition to the need for consensus around priority interventions, countries, particularly in resource poor settings, will need to make difficult decisions about resource allocation, between and within sectors. These decisions can only made at national level, and will be affected by the prevailing epidemiological situation, predominant modes of transmission and phase of the epidemic, the evidence base for different interventions, and the capacity of the health care system.

The consultation therefore aimed to develop consensus among key partners about priority, evidence-based health service interventions, and priorities for global level activities to support accelerated action in countries. It specifically sought to establish how different partners might help to increase young people's access to the interventions known to be most effective, focusing on information and counselling; condoms; testing, treatment and care for STIs and HIV; and harm reduction, through trained providers in a variety of settings.

Consultation objectives, outputs and participant expectations

The overall objectives of the consultation were:

1. To define and obtain consensus on an evidence-based set of priority health service interventions for HIV prevention and care among young people.

2. To define, review and obtain consensus on strategies for delivering these priority health service interventions, and the essential characteristics of effective delivery.

3. To identify the strategic partnerships that will be required to support accelerated action of these health service interventions in countries, and outline key areas for collaboration.

The anticipated outputs from the consultation were:

An advocacy publication for wide distribution that outlines the consensus about the priority health service interventions for achieving the global goals on young people and HIV/AIDS: why, what and how.

A meeting report summarizing the consensus about:

a) the priority do-able, evidence-based health service interventions to accelerate action;
b) key strategies and the characteristics of effective delivery of priority interventions;
c) global actions needed to support accelerated action in countries, and clarity about roles and responsibilities;
d) access to the background papers that provide the evidence base for the priority health service interventions, strategies and characteristics of effective delivery.

Fifty people participated in the three and half day consultation (see Annex 3 for a full list of participants). They represented a range of perspectives and expertise, including different organizational backgrounds (UN, government, NGO, academic, public and private services) and technical/operational focus (strategic planning and programme development, service delivery, intervention and operational research, HIV and ASRH programmes, global, regional and country responsibilities).

Participants came with a range of expectations, but all wanted to focus on building clear commitment to concrete plans that were do-able at country level, and based upon consensus about the available evidence base. Participants also felt that consensus on effective strategies for delivering interventions would be useful in order to be clear about how to operationalize interventions in countries. In addition, participants wanted to ensure that accelerated action is underpinned by efforts to measure the success and effectiveness of key interventions through adequate attention to monitoring and evaluation. Giving adequate attention to the heterogeneity of young people was also stressed, including a focus on gender and particularly vulnerable young people. Overall, participants were keen to make the most of the range of expertise represented at the consultation, and learn from each other.

Working methods

There was a range of methods used during the consultation including plenary presentations and discussions, VIPP[13] techniques and group discussion with feedback to plenary that aimed to take advantage of the wide technical and operational experiences of the participants and facilitate their full participation. The agenda was revised daily, based upon feedback and observations from the previous day, in order to ensure that the process was sufficiently flexible to accommodate progress and issues arising in the discussions. The final agenda is attached as Annex 3.

Background papers

The consultation was organized around a set of background papers that had been commissioned specifically for the meeting. These papers examined the evidence for the effectiveness of specific health service interventions at preventing or responding to HIV transmission and infection among young people. In addition they sought to review the evidence and experiences of strategies that had been used to deliver these interventions effectively to young people, including commercial approaches, and identify the characteristics of effective service delivery. The papers summarized the evidence base and provided a basis for prioritizing the interventions, and examining strategies and characteristics of effective delivery as a focus for accelerated action in countries (see Annex 4).

These background papers were presented in plenary and then examined through mobile discussion fora. These allowed participants to provide inputs to all the interventions and strategies covered, or to focus on those most relevant to their areas of experience and interest. For each group a technical discussant/resource person (usually the presenter of the paper) was paired with a rapporteur who elicited comments, additions and points for clarification. This was then presented back to the wider group in plenary for final discussion and review.

Group work was used to allow smaller numbers of people (six to ten) to deal with specific tasks such as prioritizing interventions, developing targets, indicators and action plans. Initially working groups focused on prioritizing interventions in different epidemic settings, based on the major modes of transmission, groups affected, and the evidence of effectiveness of possible interventions, outlining the rationale for their selection in the plenary feed-back.

The task for the next group work was to identify which delivery strategies would be most effective for the interventions previously identified. Participants were then divided into groups based on the priority interventions and were asked to develop specific targets for district level health facilities, that could form the basis for driving the health care systems contribution to achieving the global goals, in high and low prevalence countries. They were also asked to identify priority actions that would need to be taken in countries to reach these targets.

[13] Visualisation in participatory programmes or VIPP. Guide available at http://www.unssc.org/unssc1/html/services/documents/VIPP%20UNICEF%20Bangladesh.pdf

Based on the output of this group work, groups were then asked to propose three or more global level actions that would be important to accelerate action in countries over the subsequent twelve months.

The young people who participated provided additional input in the form of *'20 minutes live in Montreux'*, where Mr H. Hachonda interviewed two of the young participants (Ms M. Rueda and Mr E. Saidy) as to what they saw as the key concerns for young people, and issues to bear in mind during the consultation (summarized in Annex 5).

Evidence of effectiveness and effective delivery

The reviews prepared for the consultation set out to examine the available evidence based upon internationally recognized criteria of "evidence". Evidence, particularly evidence relating to the delivery of interventions, is available in many forms, some of which are more credible than others. Reviewers were expected to evaluate the evidence that they had considered based upon the classification, presented in Box 1.

Box 1: Levels of evidence

Level I. Strong evidence from at least one systematic review of multiple well-designed randomized controlled trials.
Level II. Strong evidence from at least one properly designed randomized controlled trial of appropriate size.
Level III. Evidence from well-designed trials such as non-randomized trials, cohort studies, time series or matched case-controlled studies.
Level IV. Evidence from well-designed non-experimental studies from more than one centre or research group.
Level V. Opinions of respected authorities, based on clinical evidence, descriptive studies or reports of expert committees.

The reviewers were also expected to critically appraise the evidence, including systematically assessing its relevance and applicability in different settings and for different groups of young people. Where the evidence reviewed did not directly focus on young people, reviewers were asked to consider if the findings could be extrapolated to young people.

The primary outcome that was examined in all of the reviews was the incidence of HIV infection among young people. However, behavioural outcomes such as condom use at last sex, reported numbers of partners, and frequency of partner change, or the incidence of other sexually transmitted infections were used as proxy indicators for the likely effect upon HIV transmission. Using HIV incidence as an outcome measure is particularly problematic in low prevalence settings.

Throughout this report, unless otherwise stated references are from the presentations and background papers, which are available at the WHO CAH web site[14].

[14] http://www.who.int/child-adolescent-health/

Main outputs and conclusions of the meeting

The following sections of the report consolidate: (a) a summary of the evidence reviewed during the consultation; (b) the output of the feedback from the mobile discussions on the background papers; and (c) the group work that focused on the following questions:

- What are the priority intervention areas that countries need to focus on in order to achieve the global goals (in high and low prevalence settings)?
- What is known about key strategies for delivering these interventions and the characteristics of effective intervention delivery (in high and low prevalence settings)?
- What targets could be set for the priority intervention areas selected[15]?
- What will be the challenges in reaching these targets?
- What are the conclusions and recommendations for next steps, in terms of country, regional and global actions?

The actual outputs of the group work discussions are summarized in the matrix provided as Annex 2.

Information and counselling

Evidence of the effectiveness of providing information and counselling to young people through health services to prevent HIV infection

Based upon presentation by Ms K. Nojgaard and Mr R. Mabala, UNICEF

Although a background paper on information and counselling had not been finalized before the consultation, presentations by Ms Nojgaard and Mr Mabala, UNICEF, attempted to provide an overview of current knowledge and experiences in relation to this intervention area.

Participants stressed the importance of being clear about the information needs of young people for the prevention and care of HIV/AIDS, the evidence base for the role that information plays in behaviour development and change among young people, and the most effective channels for providing information to specific groups of young people (e.g. peers[16], health service providers, teachers, parents). It is also important to be clear about the contribution that individual health workers and the health system in general can reasonably be expected to play in delivering information to young people

[15] **Note**: in the discussions about targets it was stressed that these were merely indicative – it is clearly **not** possible or even desirable, for national level targets to be defined at a global level, and that within the broad categories defined, i.e. high and low prevalence, there is wide variation in terms of the current situation, resource constraints, etc.

[16] **Peers**. People who are similar to 'oneself'. The peer group for an young person is other young people, for IDU is usually other IDUs, usually peers are of similar age or living in the same neighbourhood. Each peer group has its own unwritten rules and expectations about the sexual and or drug related practices, and about behaviour which is acceptable and unacceptable. Usual accepted behaviours are known as "norms".

for HIV prevention and care, *and* about the range of health services that are available to help them.

There have been several recent reviews that have examined behavioural interventions to reduce HIV risk among adolescents. A comprehensive review of interventions for heterosexual adolescents published in 2000 examined interventions in health facilities, schools and community settings, and suggests that carefully designed theory-based interventions that take into account the characteristics of particular populations and cultures can lead to positive changes in adolescent sexual risk behaviour. Another synthesis of research also emphasized the importance of interventions being theory-based, and of supplementing information with the provision of supplies (usually condoms), and specific instruction and training to practice the behaviours that were being promoted (e.g. using condoms correctly) (Johnson BT, et al, 2003). Studies examining the provision of information to adolescents on other risk behaviours, such as smoking, also confirm that if information is provided in ways that support their autonomy, adolescents are more motivated to address the risk behaviour (Williams, 1999). However, most of these studies are from the US or other developed countries, and include interventions not always feasible in health care facilities, in a single contact, or in resource poor settings.

A review of successful HIV prevention interventions from developing countries does include interventions to provide information based in clinic settings, but notably these were usually linked with other services such as targeted condom promotion, STI treatment or VCT services (Merson, et al, 2000). The review also notes that in general there is a serious lack of evaluated prevention interventions in developing countries for young people.

Participants were clear that it will be important to clarify the terms and accepted working definitions of “information” and “counselling”, and make clear the minimum level of input from providers and services that is required to produce improved knowledge, attitudes and behaviour change. There is a need to identify what capacity is needed within health service facilities to be effective, and provide an indication of successful approaches to helping health care providers deal with difficult issues such as sexuality with younger clients**.**

Counselling is the term usually used to encompass the therapeutic aspects of the medical interview, including anticipatory guidance and discussion between the provider and the adolescent and/or family about how to best address identified health or development problems (Hedberg, et al, 1998). Although there are studies that have attempted to assess the effectiveness of counselling interventions for adolescents relating to unintended pregnancy prevention and unsafe sex, tobacco and alcohol use, in general the evidence base is weak. A review completed in 1998 identified several problems that contribute to this lack of evidence, including the lack of theory-based models for clinical facility-based counselling, problems related to measuring the quality of counselling interventions, and the complexity of other externalities which influence the behavioural outcomes being assessed (Hedberg, et al, 1998). An extensive review of counselling in clinical settings to prevent unintended pregnancy revealed “no robust evidence to determine effective counselling approaches for changing knowledge, attitudes or behaviour” (Moos, et al, 2003). However, developing counselling skills in those who provide information enables them to move beyond “one-way information”

which is important because we know young people need to develop skills to use information provided, together with other life skills[17].

A range of different approaches to delivering information and counselling need to be explored, including information and counselling as a stand alone intervention in health care settings; delivered by a range of providers, methods and modes, and information and counselling linked to the provision of services, for example condom distribution and STI treatment.

Where information and counselling for HIV prevention is provided in health care service settings, young people usually also receive information from other sources, such as media, radio, television, schools and other youth-specific activities and facilities. Therefore any work to develop the evidence base needs to consider the influence of these concurrent interventions that may stimulate interest and demand for services and affect behaviours. It will also be important to establish if there is any evidence that providing good information and counselling generates demand for services in a sustained way, and to what extent the involvement of young people, including young people living with HIV/AIDS, is important to ensure interventions are acceptable and accessible, in terms of developing materials and messages.

Recommendations: Information and counselling as a core element of the health services response for HIV prevention and care among young people

Despite the fact that there had not been an evidence review completed prior to the consultation, there was wide consensus that information and counselling was a crucial intervention, in both high and low prevalence settings. Participants also agreed that:

Information is essential but not adequate for young people to avoid harmful behaviours, maintain protective behaviours, develop new behaviours and take advantage of the services that are available, and that health service providers have an important role to play in ensuring that young people have access to the information that they need.

Information needs to be linked to counselling because while there is no direct evidence to demonstrate effectiveness of counselling, there is evidence that information provided in ways that are empowering and that support young people's development are more effective at inducing sustained behaviour change. The way that the information is provided may be more important than who provides it or where it is provided, and consideration needs to be given to information and/or counselling being provided by people other than doctors or nurses, and through a range of service settings, not only through fixed clinic facilities.

Information and counselling must be integral to health care service provision, and seen as a critical ingredient that health workers need to be able to provide to prevent and care for HIV/AIDS among young people.

[17] Life skills are usually defined as abilities that enable individuals to deal with the demands and challenges of everyday life. They include decision making, problem solving, creative thinking, effective communication, interpersonal relationships, self-awareness, and empathy, coping with emotions and stress

Providers clearly need additional skills for them to be able to provide these client responsive services which include information and counselling, and it will be important to be clear about the minimum level of input from providers and services that is required to produce improved knowledge, attitudes and behaviour change, and the capacities that are needed within health service facilities to be effective, particularly when dealing with difficult and sensitive issues such as sexuality and younger clients.

For the information and counselling provided through health services to be effective, supportive activities in the wider community are needed which legitimize, normalise and de-stigmatize the desired behavioural outcomes.

While all service providers need to be able to provide information and counselling to all young people, in view of the diversity of adolescents it is important for health workers to also be able to adapt their messages so that they are best suited to different target groups (e.g. age, sex, marital status) and settings.

Condoms

Evidence of the effectiveness of condoms for HIV prevention in young people

Based upon presentation by Dr J. Onabanjo and background paper prepared by UNFPA (Dr Onabanjo)

The background paper reviews the evidence for the effectiveness of condoms in preventing HIV among young people, and concludes that male condoms are 90% effective when used consistently and correctly, with higher rates of effectiveness with perfect use[18]. The evidence is less clear about the effectiveness of female condoms at preventing HIV transmission, current evidence indicating that they offer slightly less effective protection against pregnancy and HIV than the male condom. Some studies indicate that having both methods available may lead to a greater overall number of protected sexual acts, through the use of both male and female condoms. Others suggest that female condom availability may merely result in the substitution of male condoms by female condoms.

For several reasons it is difficult to review the evidence on the effectiveness of current condom programming, and to identify the characteristics of effective programmes. First, condom sales or distribution do not reflect consistent and correct use by individuals. Secondly, where sexual behaviour surveys are used to indicate effectiveness it is likely that other efforts to address adolescent sexual and reproductive health, including community based or national based behaviour change interventions, may be partially responsible for the reported positive results. However, there are many examples of successful condom programmes targeting young people that result in increased reported condom use at last sex. In addition, condom-programming interventions often result in reported decreased high-risk sexual behaviour, such as frequency of partner change. Whether this increased use of condoms is sustained and results in decreased incidence of HIV is more difficult to demonstrate. In specific target groups such as sex workers and men who have sex

[18] **Perfect Use**: Perfect use of a condom requires that it be used correctly as per instructions at every act of intercourse and used correctly through out sexual intercourse

with men (MSM), numerous interventions that include condoms have been documented to reduce STI and HIV rates, and lead to safer reported sexual behaviour.

It is clear that *consistent* condom use is necessary for effective protection against pregnancy and HIV/STI, and achieving this depends on:

- ensuring widespread available supplies of acceptable condoms;
- efforts to create demand for condom use by enabling or supportive elements;
- building the skills of young people to successfully negotiate and use condoms.

There are still many myths and misconceptions that may negatively impact condom use, and providing accurate and credible information is still a challenge, something the health system is in a strong position to address in many countries. It is important to be clear about the significant evidence base relating to condoms, and ensure that condom promotion does not become blocked by misinformed opinions or religious and cultural values and sensitivities.

The estimated unmet need for condoms is two billion a year in sub-Saharan Africa alone, although estimates of the unmet needs for young people are currently not available. It is clear that sufficient condoms are available in a sustained and reliable way in only a few countries, and that this unmet need may be even more acute for young people, particularly vulnerable and poorer young people.

A range of strategies and channels have been used to distribute condoms, and this is clearly necessary to reach young people in different settings, and no one mechanism for condom distribution appears better than another. Condom distribution to young people can be achieved through community-based, public or private sector health facility, outreach[19], pharmacy or school-based distribution, vending machines, and may or may not be accompanied by mass media promotion of specific or generic brands, or by social marketing. Aside from the fact that many condom programmes remain limited in the number of beneficiaries that they reach and do not go to scale, the other main challenge appears to be ensuring that sufficient appropriate information about negotiating condom use and correct-use accompanies any increased condom availability.

The evidence confirms that increased condom use is most effectively achieved among adolescents when it is accompanied by behavioural interventions that support the correct and consistent use of condoms. Further efforts are needed to ensure condoms are available in places where young people congregate or initiate sexual activity, that they are affordable, and that condom use is seen as a positive choice by young people and adults, for the prevention of HIV, STIs and pregnancy.

The evidence also suggests that there has been too little explicit promotion of condom use to protect from pregnancy in addition to HIV and other STIs (dual protection), together with efforts to reduce the numbers of partners and encourage avoiding penetrative sex or abstaining from sex. Often these are portrayed as “either/or”

[19] Outreach distribution refers to distribution of condoms to young people through active contact by the distributors e.g. in bars, meeting places, and to youth outside of formal fixed facilities.

choices, not as different options along a spectrum that are adaptable to young people's evolving circumstances. Available data suggest that condom distribution to high risk groups is a cost-effective intervention to prevent HIV, and depending upon local unit costs, market size, and programme maturity, cost effectiveness for distribution to the general population is also achievable (Walker, 2003).

Social marketing has been successfully used to increase sales of condoms, although a focus on cost recovery mechanisms for condom distribution may lead to exclusion of the poorest. Younger and poorer young people appear less able and less willing to pay for condoms, and even where they are willing, they may lack the ability to pay. Branding may also be a useful tool in condom programming and well suited to young people, and successful branding of 'safer sexual behaviours' has also been demonstrated. However, it is still unclear whether branding itself actually increases overall demand or if it merely replaces other public sector products. Further evidence is needed about the overall impact of branding upon demand creation and consistent condom use by young people.

Gender-based norms and practices not only result in HIV infections occurring more frequently among young females in generalised epidemics, but they also have an impact on condom programming, in terms of expectations about who should provide, secure or initiate condom use between sexual partners, with which sexual partners condoms should be used, and which groups condom promotion should be targeted. Current evidence suggests that unless programming efforts address these factors, condom use will always remain below the probable threshold of population-based effectiveness, and that condoms may not be used in the most high-risk sexual encounters.

Recommendations: Condoms as a core element of the health services response for HIV prevention and care among young people

Based on the evidence presented, ensuring access to and correct consistent use of condoms for young people was identified as a priority intervention in both high and low prevalence settings. Initial efforts in countries should intensively focus on higher risk vulnerable young people in both low and high prevalence settings, and must always be accompanied by information and skills related to condom use. Participants also agreed upon the following additional points and research gaps:

There should be greater emphasis on strengthening the programmatic linkages between condoms for HIV prevention and condoms for pregnancy prevention (dual protection).

More attention should be given to strengthening the programmatic links between delaying sexual debut, reducing the number of sexual partners, and using condoms consistently so that these different aspects of prevention can be mutually supportive.

Develop programme measures which reflect combined success rates (i.e. that reflect success in terms of maintaining abstinence, reducing numbers of partners and consistent condom use in high and low risk sexual encounters, and that programmes are assessed in terms of STI, HIV and pregnancies prevented).

Further evidence is needed about the importance of involving sexual partners in condom promotion.

Collect specific evidence about factors affecting condom use by young people, and by different subgroups of young people. This includes the impact of different distribution mechanisms on young people's access to, and use of condoms.

Develop tools and methods to better determine the global and national unmet need for condoms among young people.

Identify and synthesize experiences of effective approaches to overcoming political resistance to condom use among young people.

Examine the evidence relating to links between consistent correct condom use and substance use and abuse (alcohol and drugs).

Sexually transmitted infection care (STI) [20]

Evidence of the effectiveness of STI care for young people to prevent HIV infection

Based upon a presentation made by Dr S. Crowley and a background paper prepared by WHO/CAH (Dr Crowley)

The evidence reviewed highlighted the diversity of adolescents, and their range of sexual experiences and consequent sexual health. Where disease monitoring systems are well established, rising rates of most STIs are being seen among adolescents, and especially among girls. The evidence also clearly demonstrates that adolescents frequently have no symptoms or fail to recognize them, and even if they do recognize the need to seek services they face many barriers, including a profound lack of available services. The available evidence suggests that for young people, particularly in parts of the world with high rates of STIs, the lack of access to STI services is the major factor accounting for the rising STI rates. There are still remarkably little data from resource poor settings.

Currently the evidence does confirm that the syndromic management of STIs, where it includes diagnosis, treatment, health education and condom distribution as part of the package, does have an impact on HIV prevalence and incidence, although not in all settings and not for all populations. These interventions are most effective early in the HIV epidemic and where background STI rates are high. Interventions to screen for asymptomatic STIs have demonstrated successful cost-effective decreases in STI rates, but have not yet been demonstrated to reduce HIV, except in high risk groups where other HIV prevention interventions were also in place (Merson et al 2000).

Policy and legal constraints can sometimes make it difficult to provide services for young people, both at the planning and the provider level. Making existing services

20 The term STI will be used to throughout denote sexually transmitted diseases or infections.

more responsive to adolescents, expanding and using new approaches to delivering services, improving the range of service options for young people (e.g. through provision in pharmacies and youth centres), and generating greater demand for services are all necessary to effectively address STIs among young people. Further specific evidence is needed on the effectiveness of managing herpes virus infections, prophylaxis in cases of sexual assault or unplanned unprotected sex, and partner tracing and management to decrease STI transmission among young people.

Cost-effectiveness data suggest that the diagnosis and treatment of sexually transmitted infections costs just over US $270 per HIV infection prevented, and the cost per DALY gained was around US $1 for programmes that combine the treatment of sexually-transmitted infections and condom promotion, or about US $12 per DALY for STI care alone (largely based upon data in high risk populations). This is therefore a very cost-effective intervention for HIV prevention; quite apart from the positive impact upon STIs themselves.

Recommendations: STI care as a core element of the health service response for HIV prevention and care among young people

The participants agreed that providing STI services was a priority intervention to make available for young people, as long as clinical care included provision of health education and condoms. It was also agreed that:

- STI care should form part of any core set of interventions for all young people in high prevalence settings.

- In low prevalence settings attention needs to focus on ensuring that services are initially targeted to young people at highest risk of acquiring HIV (for example sex workers, injecting drug users, young people living without parental support, incarcerated young people or young people living on the streets, migrant workers, young men who have sex with men). At the same time, efforts should be made to strengthen and increase STI service provision to all young people through routine clinical settings.

- STI care must always be more than just diagnosis and treatment, and needs to be linked to the information, counselling and condom provision components of services for young people.

- Effective STI services require adequate supplies delivered by appropriately trained providers.

- Policy and legal barriers to a wider range of service delivery options need to be explored and addressed, such as age of consent for health care services, provision of treatment packs, and non-physician prescribing in a range of settings.

Participants agreed that further research and programme development needs to focus on the following issues:

Combining approaches for syndromic management with active screening for asymptomatic cases among young people in resource poor settings.

Clarifying how delivery strategies will need to differ in low and high HIV prevalence settings (where needs may be different) and in urban or rural settings (where ensuring access and availability of services is more difficult).

Increased understanding of how young people who do not present to primary care facilities can be assisted and encouraged to access services (for example through screening at school or work health services).

Harm Reduction[21]

Evidence of the effectiveness of harm reduction interventions to prevent HIV in young people

Based upon a presentation made by Dr.J. Howard and a background paper prepared by Ted Noffs Foundation (Dr Howard and Mr A. Arcuri)

The evidence is clear that "harm reduction" is effective in decreasing HIV and that harm reduction services are essential where injecting drug use is identified as an important risk factor in HIV transmission among young people. The provision of sterile injecting equipment (called needle syringe programmes or NSP[22]) has been demonstrated to decrease HIV transmission, especially when accompanied by information and educational interventions, and when delivered either through outreach or face-to-face prevention efforts. Evidence for disinfection programmes is mixed; some evaluations found a protective effect, others did not. It appears that effectiveness relates more to the circumstances in which the bleach is distributed and used, and may be viewed as a second line strategy to the more effective NSPs. Neither of these approaches has been demonstrated to increase the numbers of people injecting drugs, or to induce a switch to injecting from non-injecting drug use. Substitution programmes[23], in which a drug (usually but not exclusively orally) is provided to decrease the use of hazardous or illegal injected drugs (currently only for opioids), have been successfully introduced in many developed countries and appear to decrease the frequency of injecting and sharing injecting equipment, risky sexual behaviour and HIV infection. However there is a lack of experience of substitution

[21] **Harm reduction** here is taken to refer to attempts to primarily reduce adverse health, social, and economic consequences of drugs rather than maintaining the major focus on reducing consumption of these drugs. In certain regions the term 'risk reduction' is preferred over harm reduction, and in some contexts, it is politically unacceptable to use the term 'harm reduction', as it may be interpreted as meaning the legalising of drugs. See review paper for further clarifications.

[22] **NSP**. An intervention in which needles, syringes, other injecting equipment (such as alcohol swabs to clean injecting sites, and water with which to mix powdered drugs) are provided to IDUs through outreach, clinics or shop-fronts, mobile units such as vans and buses and/or vending machines. Most NSPs include a retrieval service for used syringes. In some programmes, IDUs must provide or are encouraged to provide used syringes before they can receive new syringes: these are called: Needle and Syringe Exchange Programmes (NSEPs).

[23] **Drug substitution treatment** is the use of drugs such as buprenorphine and methadone to assist opioid (for example, heroin) users to stabilize their drug use and to move from injecting and other hazardous methods of taking drugs to (usually) oral forms of the drug. The drug is provided under supervised conditions as part of an intervention that may also involve counselling, primary health care, HIV treatment and other services.

programmes in developing countries, and they appear less effective for users who use a range of drugs or use drugs intermittently. Some evidence suggests that new or younger users of injectable drugs are more likely to inject drugs intermittently, use a wide variety of drugs, and are less likely to self identify with IDUs, know about or use harm reduction or substitution services that are available. The evidence reviewed indicates that providing harm reduction interventions to young IDUs can provide entry points into other health related services. There are little data on the cost-effectiveness of harm reduction interventions, which may be less feasible or affordable and therefore less applicable in resource poor settings. Further research is needed to determine if significantly different approaches are needed for younger IDUs.

An important component of harm reduction is assessment (both behavioural and contextual) as drug using patterns and behaviours vary greatly between different populations of drug users and therefore often require different strategies to deliver the interventions. There are significant policy and legal barriers to the implementation of harm reduction interventions, and there is a need to focus more on dealing with these types of obstacles, and the challenges of accessing groups with different profiles. Opposition to harm reduction can be generated by political, community or professional groups, including religious groups, and in some countries the term risk reduction may be preferred. The recent establishment of regional harm reduction networks across Central and Eastern Europe, Asia, Central and South America, Africa and Oceania has alleviated to a great degree the isolation and burden experienced by unsupported programmers, who have been able to achieve policy breakthroughs with greater ease than when they were operating in isolation.

During the consultation, participants emphasized the need to explicitly make the linkages between harm reduction and demand reduction, and between harm reduction and cessation. Clearly services for young drug users, whether or not they inject the drugs, should include measures to help them reduce or discontinue harmful use[24] of drugs, and participants were emphatic that advocating for the longer-term goal of reducing harmful drug use among young people is a priority. Harm reduction should therefore include the provision of drug treatment which may include substitution depending on what is available in the community.

Recommendations: Harm reduction as a core element of the health services response for HIV prevention and care among young people in high or low prevalence settings

The participants agreed that:

- In low prevalence settings, where IDUs are at high risk of infection or already have significant levels of HIV, there is an urgent need to accelerate harm reduction interventions, which should include an explicit focus on the needs of young IDUs.

[24] **Harmful use.** A pattern of substance use that causes damage to physical or mental health including injuries from accidents and violence, infections from blood-borne viruses (such as HIV, hepatitis B and C) and medical conditions such as abscesses and overdose. Injecting drugs is particularly dangerous because of the risk of hepatitis, HIV and other infections from contaminated needles and syringes. Smoking substances can result in disorders of the respiratory system and burns. Some substances such as leaded petrol, benzene and coca paste can cause health damage even if they are taken in small amounts

- In many high prevalence settings there is a need to document the extent and contribution of IDU among young people to the HIV epidemic, and where present, implement a package of harm reduction services based upon the patterns and contexts of the drug use.

- The minimum harm reduction package identified includes information and counselling, sterile injecting equipment, condoms, basic STI services, and the treatment of immediate health problems. This package would need to be modified depending on the settings, resource constraints and infrastructure, and must be based upon local situational assessment.

In most situations there is a need to develop additional programme support tools and provide technical assistance (e.g. training and supplies) to assist national programmes to assess and then implement harm reduction. Additional points made by the participants included:

This area of programming faces serious obstacles due to the extreme levels of discomfort with providing harm reduction, or indeed any services for drug users. The evidence and messages presented to policy makers and the public must be clear, unambiguous and convincing, and respond to concerns that harm reduction programmes implicitly condone practices that are illegal. Further analysis and research are needed to:

- Identify age and sex related variables that are relevant to programming, and the need for youth specific guidelines.

- Determine the effectiveness of peers in terms of information, counselling, support, and demand creation.

- Determine the best mix/package of harm reduction interventions in resource poor settings.

HIV Testing and Care

Evidence of the effectiveness of voluntary counselling and testing for young people on preventing HIV transmission, and upon provision of HIV care to young people

Based upon presentations and papers as follows:

VCT and HIV testing, presentation by Dr Crowley, background paper prepared by Horizons (Dr A. McCauley)

Prevention of Mother to Child Transmission (PMTC), presentation by Dr P. Henderson.

HIV care, presentation by Dr Crowley, background paper by WHO/CAH (Dr Crowley)

In adults, voluntary counselling and testing (VCT) has been reported to reduce the number of partners, reduce STI incidence, increase reported condom use and, among those who are HIV positive, decrease high risk sexual behaviour with primary negative partners. In young people, the evidence (predominantly from studies in North America) suggests that while there are some short-term improvements in behavioural outcomes

resulting from VCT, they are not sustained, and that females in particular may receive less beneficial impact, over and above knowledge of their sero-status. There is currently a lack of evidence that either stand-alone or integrated VCT for young people are effective interventions for the prevention of HIV among young people, although the data from adults suggest that it is worth further investigation. The estimated cost of VCT in adults per infection prevented was estimated to be US $400-500 in Africa and just over US $200 in India, with the cost per DALY saved varying from US $10- 20 (although this is calculated on data from limited sites and using a very high HIV transmission rate, so it is probably an overestimate) (Creese, et al, 2002, Walker 2003).

In high prevalence settings where VCT services are being established, it is clear that increasing numbers of young people are attending VCT services, and that many untested young people want to know their sero-status for a range of reasons, including pre-marital and pre-relationship testing. Young people need access to counselling and testing services, but are concerned about the cost and quality of the services available, particularly that confidentiality may not be guaranteed. Participants agreed that there is a need to collect disaggregated data, by age, sex and marital status from VCT sites, in order to be able to assess the impact and coverage of existing VCT services, and to be much clearer about the policy and legal barriers that may prevent younger adolescents from accessing even the counselling component of VCT services, often counselling is only provided with HIV testing, for which they are unable to consent.

In view of the increasing focus on the development of VCT services, there is an urgent need for further evidence about how to ensure positive outcomes of VCT for young people (for both HIV negative and HIV positive young people), such as sustained behaviour change and increased access to and utilization of services for the treatment of STIs, opportunistic infections and anti retroviral medicines (ARVs). It is currently not clear what the impact of VCT is on young people in high prevalence resource-poor settings, where there is limited access to services for prevention, treatment and care. It is also not clear what the impact of testing is on stigma and discrimination, although anecdotal and project reports suggest that it may have a beneficial effect.

Participants expressed their concerns during the consultation about the ethics of providing testing for young people if the required treatment, care and support elements are not also in place (i.e. HIV specific support and care, not necessarily ARVs). Testing for young people also clearly needs to be linked to other effective preventive interventions such as condoms, and with other clinical and non-clinical services such as STI care, antenatal care, pregnancy prevention and support services.

Participants were provided with data from current prevention of mother-to-child transmission (PMTCT) services that suggest that young people below 18 years are usually excluded from experimental studies and therefore interventions to reduce vertical transmission. Although limited data from testing sites suggest that young people 18 years and over are adequately represented among those being offered and accepting PMTCT interventions, some study sites have reported problems offering interventions to those below the age of consent (younger adolescents). It was felt by participants that PMTCT as it is currently being implemented, functions primarily as an intervention to protect the child, and there may well be missed opportunities for

providing information and condoms to HIV negative young people, especially male partners (although hopefully this situation will change with the advent of PMTCT-plus programmes).

The review clearly identified the lack of evidence available about the clinical course of HIV among young people, and the health care needs and experiences of delivering HIV related care to young people, particularly in resource poor settings. There is a need to better understand how the needs of HIV-positive young people differ from those of adults, and to monitor whether adolescents and young people are effectively receiving whatever care *is* available. It is important to ensure that age, sex and marital status are not used as exclusion criterion for treatment and care services, and to disaggregate the available data in order to better estimate the needs of young people.

Currently the evidence suggests that there are no major biomedical differences between young people and adults in terms of the natural history of HIV/AIDS, and responses to treatment of HIV and opportunistic infections. However, the psychosocial impact and related needs of HIV infected young people, particularly the impact on their sexual and fertility related behaviours, and their adherence to HIV care interventions, is not documented, especially in resource poor settings. The recent reviews of special programmes for HIV infected young people in the USA confirm that medical care alone is not enough, and is not effective without a supportive multi-disciplinary team approach. Often it is concrete service needs such as housing, emergency financial assistance for food and utilities, transportation, childcare, coverage for prescriptions, and public entitlements that most concern young people, and the need to connect isolated youth with a personal support system. It is suggested that addressing these needs helps to facilitate and reinforce treatment adherence and retention (Johnson, et al, 2003).

Young people are increasingly being called upon to provide HIV related care within families, and so it is important that prevention and care programs in high HIV prevalence settings acknowledge that young people perform care giving tasks.

Recommendations: Access to HIV counselling, testing and care as a core element of the health services response to HIV among young people in high or low prevalence settings

During the discussions it was apparent that programmatically and strategically it is extremely difficult to separate care from testing. It was also clear from the evidence that in general there is very little information about how young people's needs for testing and care differ from adults' (in terms of the services that they require, the delivery mechanisms and their impact), but that it is important to know this in order to plan and implement programmes more effectively. As WHO mobilizes partners and governments to make progress towards 3X5, it will be important to ensure young people are not excluded or forgotten in efforts to expand access to treatment and care.

Participants also recommended that:

- Existing care guidelines should be examined to see how appropriate they are for adolescents and young people, and whether home care approaches need to be modified (both in terms of young people being the recipients and the providers of home care).

- Further evidence is needed on the long-term effects of HIV treatment in adolescents, on access, adherence, and compliance to treatment regimens in this group, and on the impact of HIV treatment on young people's behaviours, e.g. whether these are affected positively or negatively by treatment and care being available.

- Evidence is also needed on the impact of stigma and discrimination on the treatment and care of adolescents, by age, sex, marital status and at the community or family level (e.g. adolescent girls may be denied access to care in some cultures as they are believed to be no longer marriageable). Existing published data is almost exclusively from developed countries, mainly North America, and there is a need for experiences from high prevalence settings in developing countries to be better documented.

- In high prevalence settings, access to testing and care needs to be widely scaled up for young people, as for adults. It will be important to ensure that young people are not excluded from those services that *are* available, and to link testing and care with information and counselling, condoms and STI treatment.

- In low prevalence settings the needs and sensitivities are different, and access to reliable information and counselling, with appropriate effective referral for reproductive and sexual health services (including pregnancy prevention, STI diagnosis and management, HIV testing, treatment and support, and post exposure prophylaxis) may be a more appropriate approach than establishing widescale stand-alone VCT services.

- Testing services cannot operate in isolation from care, and local coordination is needed to ensure that testing is established with commensurate investment in developing treatment and support linkages for young people who are HIV positive, and interventions that will help young people who are HIV negative to remain so.

Providing HIV testing, counselling and care services to young people poses multiple problems for service providers, and requires that providers are adequately trained to be responsive to the needs and concerns of young people, and to provide confidential services. Making services convenient, acceptable and affordable for young people may entail the use of rapid or newer testing technologies, off-site or after hour's clinics, and cost waiver schemes.

Strategies for and characteristics of effective service delivery

Based upon the following presentations and short papers:

Global consultation on adolescent-friendly health services: Dr V. Chandra-Mouli

'Choosing a package' short paper and presentation: Dr L. Brabin and Dr V. Chandra-Mouli

Making the linkages: Who is actually doing the work? Dr A. Olukoya

The global consultation on adolescent-friendly health services[25] identified the key characteristics of effective service delivery for adolescents, and outlined the range of services that need to be provided, including promotive, preventive and curative services. Services need to be available, accessible and acceptable to adolescents, although the consultation emphasized that merely having a user-friendly service does not ensure utilization. Provider attributes are recognized to be important to adolescents, as are improving provider competency and skills, and establishing standards of care that ensure confidentiality and respect for adolescents.

The precise service mix or package provided to adolescents varies depending upon local priorities and needs, but must be comprehensive enough to respond to the priority health and development problems of the specific target group. If the selected package of interventions includes ones not proven to be effective, the desired health outcomes are unlikely to be achieved despite a user-friendly and wellused service. Determining the optimal package must therefore be based on the characteristics of the target group, the desired outcomes, the availability of effective interventions, and the options for young people to access the service. A schematic diagram of how these factors operate is included in Annex 7[26]. Clearly specific diseases such as HIV or other ASRH problems can provide an entry point or focus for the development of such services.

Participants were reminded that while health services are provided to young people in a range of settings, including primary health care centres, general outpatient clinics, emergency services, pharmacies, community outlets, work place clinics and youth facilities, in most situations, particularly resource poor settings, a reasonably small cadre of health workers are actually providing the services. The formal public health system and school health services represent the best understood and most documented service delivery models currently delivering health services to adolescents. Some largely public sector services such as ANC, MCH and family planning may see a large proportion of young people in some countries, with other services being provided through private, NGO or faith based organizations, and the non-formal sector (e.g. traditional healers, indigenous systems of medicine)[27].
In many countries gender, marital and socio-economic status determine school attendance, access to public and private sector health facilities, and individual expenditure on health. In many parts of the world, including those with high HIV rates, school attendance, and access to and utilization of health services is low in young

[25] For further details see the Report on the Global Consultaton on Adolescent-Friendly Health Services, and 'Making it happen' available at the WHO/CAH web site http://www.who.int/child-adolescent-health/publications/publist.htm

[26] For an explanation of the diagram see background paper by Dr Brabin and Dr Chandra-Mouli.

[27] For a visual summary of the settings and services provided see presentation by Dr Olukoya details in Annex 4 and Annex 8

people, especially girls. Further research on the health seeking behaviours of adolescents is required, and successful approaches to demand generation need to be further developed.

Strategies to support public and private health facilities were examined, as well as the need to provide linkages, referrals or alternatives to existing services, and the importance of focusing on strategies for meeting the specific needs of vulnerable groups of young people was highlighted. The role and contribution of the private sector is rarely harnessed, and often not well standardized or regulated.

Lessons learned from a recent analytic review of child health programmes through the Integrated Management of Childhood Illness (IMCI)[28] emphasized that despite improvements in individual health worker performance, in the absence of effective functioning health systems this does not necessarily translate into improved health outcomes in terms of child mortality. A number of other issues also require attention, including low utilization of public health services by the target group, and the need for community acceptance and support for the services being provided. The review illustrates the importance of ensuring that interventions for the prevention and care of HIV/AIDS among young people are seen within the context of wider developments and capacity within the health system and that they require both facility-based and community components. Health sector reforms and decentralization of the management of heath care systems may well fail to address inequities, and cannot overcome a lack of infrastructure or stewardship at national level.

Having a clear set of effective interventions for specific health problems will provide an entry point, but cannot be a substitute for a comprehensive strategy to address adolescent health and development in countries, including attending to inequities created by gender and socio-economic characteristics.

Existing health systems face constraints in terms of human, physical and financial resources, and in many high prevalence settings this has been acutely exacerbated by the impact of HIV on health workers themselves. Rigid professional barriers (such as regulations that prevent prescribing by nursing cadres, or counselling by trained peer workers) may mean that a small number of professional staff have to provide all services, with little investment in lay providers who come into contact with young people. Public sector health workers, who are inadequate in number across most cadres, are often poorly motivated due to poor pay, poor equipment, lack of supervision and information, and limited career development. Urban-rural imbalances mean that services are frequently scarce in rural settings, particularly for vulnerable groups such as young people.

Services for adolescents will frequently be provided through existing services, such as family planning, ANC or MCH services settings, although relatively little is known about the equity of provision to certain groups, for example younger clients. The consultation did not seek to generate a call for a parallel system of services for adolescents or young people, but rather to focus on how to *best achieve effective delivery of the identified effective interventions to young people through existing systems.* It also examined what *additional delivery strategies might improve health system efficiency*

[28] Further information on the Analytic Review and Multicountry Evaluation can be obtained through the CAH/WHO web site http://www.who.int/child-adolescent-health/integr.htm and at http://www.who.int/imci-mce/findings.htm

and performance, thereby accelerating action to enable young people to access key effective HIV prevention and care interventions.

Outreach[29]

Evidence of effectiveness of outreach on HIV prevention and care for young sex workers

Based upon paper by UNAIDS, presented by Ms A. Mendoza

Outreach was discussed in the context of the provision of services for young sex workers. However, outreach approaches are used to reach a range of other vulnerable groups who are excluded from health services for a variety of reasons, including stigma, marginalization, lack of awareness of services, and lack of financial or behavioural autonomy to seek services.

Outreach strategies may be used to deliver specific elements of services (e.g. condoms, injecting equipment); tackle specific risk behaviours (such as injecting practices, or unsafe sexual practices); or promote awareness and enhance access to services for prevention and care (STI treatment, drug substitution, etc). Not only may outreach programmes focus on different interventions, but they may also use a variety of delivery mechanisms, ranging from peers to specifically trained health workers working through mobile facilities. As with other delivery mechanisms, it is important to make the linkages between information and skills, and the supplies that are necessary to turn intentions into action (e.g. condoms and needles), and to ensure that these are provided in ways that are effective, accessible and acceptable to the target group. While outreach strategies have been used successfully to reach injecting drug users and young people forced into sex work, there is less available evidence about the use of such strategies to generate demand or reach other vulnerable groups such as child headed households and rural youth, or identify the key elements that are most important for different vulnerable or hard to reach groups. A recent review of approaches to case detection through outreach in American HIV programmes concluded that as HIV-positive adolescents will remain a “hidden population”, a great deal of time and effort will continue to need to be directed to defining and expanding the most effective outreach approaches to HIV counselling and testing for young people (Bell, et al, 2003).

The lessons learnt from outreach programmes require ongoing documentation, analysis and synthesis. Despite the different contexts there are a number of crosscutting issues:

- What are the essential elements of the outreach encounter that are needed, and what are the requirements to engage young people and facilitate their contact with health care services through outreach? (See also Martinez, et al, 2003).

[29] Reaching out by an organization to target members within a defined community or population, either by paid or by lay members, and often involving peers from the target community with services, information, supplies or commodities.

- For peer delivered outreach are there specific settings or target groups where monetary or non-monetary incentives are more effective?

- Do peer-based outreach approaches provide more sustained behavioural outcomes or greater service usage, than other means?

Young people are in a good position to act as 'networkers' for other young people, and to provide information, and linkages or referrals to youth friendly services. For some target groups the illegal nature of the activities undertaken means outreach programmes often operate with a similarly unclear legal status and this can act as an obstacle to scaling up or institutionalising pilot projects. The potential for outreach to generate demand or provide an entry point for vulnerable young people to access other health services that are being provided for the general population of young people needs further research.

In developing outreach programmes it is important to think beyond the familiar contexts of IDU and sex work, and to appreciate that often the high-risk behaviours are linked, and that services need to match the needs of the targeted population. There are, as yet, few data on the costs or cost-effectiveness of outreach interventions, or on the balance between service provision and behavioural interventions.

Social marketing[30] and social franchising[31]

Evidence of effectiveness of social marketing and social franchising approaches to HIV prevention and care

Based upon the following resources:

Social franchising: background paper and presentation by Mr S. Lavake, YouthNet.

Social marketing: presentation by Mr B. Mackay, the Futures Group Europe

Social marketing was described as using marketing techniques to promote and distribute specific health-related supplies, commodities and services using (e.g. condoms, pre-packed treatment kits for STIs, FP supplies, bed nets, oral rehydration solutions). Social franchising was described as applying successful business principles to the provision and supply of health care services for social gain, usually in which a provider or group of providers is contracted to offer a standardized set of services (quality, fixed cost, branded), that may be used by and benefit public or private providers and clients. Social franchising therefore may or may not incorporate marketing techniques to promote supplies of specific products. While social marketing has been used extensively in programmes for young people, there is very little experience of social franchising of health services for young people, although there is clearly overlap between the two.

[30] **Social marketing,** is defined as the application of commercial marketing techniques and strategies to a campaign for social change or promote and distribute commodities, especially to enhance the effectiveness of health education programmes.

[31] **Social franchising** is defined as using authorization granted by a government, company or organization to an individual or group enabling them to carry out specified activities directed towards social gain.

The background paper reviews several social franchising projects that focus on young people. Social franchising involves the franchisee providing and agreeing with the franchiser on a range of possible ways of supporting and providing services, including logos and branding, varying fee schedules, use of local media and client referral mechanisms, shared quality standards, and the training of providers and managers (see Box 2). There was less evidence of effectiveness for social franchising than for social marketing, although this is perhaps not surprising in view of the breadth of activities included in the term, and its relatively new application in the field of health. In the social franchising projects reviewed, the business management and overall capacity of the non governmental organizations (NGOs) and clinics were generally weak, and were rarely strengthened as a result of the social franchising activities.

Box 2
Key techniques identified within social franchise agreements for franchisers providing sexual and reproductive health services to young people

- Shared marketing, branding, logo or media promotion of services
- Standardised training staff in technical areas, management or youth friendliness
- Quality assurance or improvement practices including accreditation
- Information sharing or establishing referral networks
- Cost recovery or cost sharing mechanisms
- Franchise agreements, including memberships fees or insurance and contracting agreements

Social marketing and franchising programmes require external resources, and all the partners in the chain of purchase-distribution-supply need to at least break even financially, and retailers need to make a profit. Usually additional financial investments are needed to initiate and sustain activities, and Ii the programmes reviewed, external donors usually provided these funds. As adolescents frequently cannot pay for services, this may limit the traditional franchise system for clinical services to young people.

Although there is good evidence that social marketing works to make products more acceptable and desirable, it is less clear how far the techniques lead to effective use of the products (e.g. condoms or pre-packed STI treatments), or how effective they are for increasing access to commodities for the most vulnerable groups, who are usually in greatest need. Although the product may be purchased, it is important in terms of the impact of the intervention that the product is used, and used correctly, and more data are needed on the balance between supply, purchase and the preventive measures and messages that need to accompany the products if consistent behaviours are to be sustained. Distribution and sales data do not necessarily reflect these prevention components, and ensuring that this aspect of the services is monitored is very important, but resource consuming.

Understanding and segmenting the market, by identification of different constituents of the target audience and conducting specific research into their likes and dislikes, and purchasing patterns is fundamental to social marketing. This is particularly important when considering adolescents, in view of their often neglected heterogeneity. It was

recognized that rural and out of school adolescents are least likely to be reached by social marketing and franchising approaches.

Social marketing of products to young people has been shown to be effective, notably for condoms and other supplies not needing prescriptions. The social marketing of prescription products (e.g. STI treatment packs) has proven to be more difficult. It is generally accepted that social marketing is a useful way to increase demand for products and related services, and greater use of social marketing together with the delivery of effective interventions to young people needs to be explored and developed.

There is also growing interest and experience of using these same marketing techniques to market "lifestyles" or "behaviours" (e.g. "take care of your sexual health", as in Lovelife[32], and "use condoms to protect yourself" as in SMASH[33]). Early evaluations of Lovelife suggested people were aware of it as symbol of hope and communication about sex, but it is not yet clear whether the project has successfully expanded access to health care services for young people. Such programmes will continue to need strong operations research and evaluation components.

Although there are few examples of social franchising specifically directed to young people, there *are* some successful models that have been used with the private sector, the public sector or public-private partnerships, and many outlets report increased client numbers. The impact of social franchising on the quality of public sector services needs to be further evaluated, although there is some evidence from the examples examined in the background paper that such approaches may help to engage young people, generate demand and expand networks and links between service providers and other projects and community-based organizations.

Providing referral mechanisms and using shared marketing strategies were the most frequently used franchising techniques documented, the least used techniques being establishing quality assurance, or developing common franchising agreements on pricing, or pooled training in business skills. It was reported that frequently the franchise agreements had been poorly developed, and had failed to use techniques to which might offer advantages for franchising outlets, such as applying quality standards or training franchisees in management.

Recommendations: on the effectiveness of social marketing and social franchising for effective delivery of services to care and prevent HIV among young people

Participants concluded that :

- Programmers and policy makers would benefit from better understanding of the possible role of social marketing and franchising techniques.

[32] **Lovelife** is South Africa's national HIV prevention programme for youth, more details can be found at: http://www.lovelife.org.za/corporate/index.html

[33] **SMASH** refers to Social Marketing for Adolescent Sexual Health, operations research in 4 countries, further details are available at: www.measurecommunication.org.

- Marketing and commercial approaches need to be given more attention when planning and evaluating health services for young people, and this requires the private sector to be involved in planning national HIV and ASRH strategies.

- Existing marketing or social franchising activities could be encouraged to ensure there is adequate attention directed to the specific needs of young people.

- Further operations research is needed to determine the impact of social franchising on the quality of public sector services, and the costs and sustainability of social franchising and marketing activities.

- Further research is needed to determine how branding and logos can most effectively contribute to improving health services for young people, and how market segmentation techniques can help target services and generate demand.

Competitive vouchers

Evidence of effectiveness of competitive voucher schemes on HIV prevention and care for young people

Based upon background paper and presentation by Dr A. Gorter

Competitive voucher systems involve providing tokens or vouchers directly to a defined targeted group, which enable them to seek specified goods, services or care, at little or no cost, from the provider of their choice (non competitive voucher schemes offer similar services but at fixed sites or through designated providers). Providers are subsequently reimbursed at predetermined rates, and may receive other incentives to deliver these services, such as training. The approach generates an element of user demand and choice of services, provides a way to ensure specific target groups receive priority services, and aims to increase the quality and efficiency of the services provided. Vouchers can help ensure that particularly vulnerable groups have access to services, and have been used for different groups in different contexts (e.g. to supply education, immunization, nutritional supplements, needle exchange, and water supplies).

Vouchers have been used to provide young sex workers and drug users with sexual health services, and young people with sexual and reproductive health services in Nicaragua and Kenya. The evidence reviewed demonstrates that vouchers can help ensure that such groups' access STI, HIV and pregnancy prevention services, and that especially young clients can be reached. However, in considering effectiveness and cost of voucher schemes there are important aspects of the design of such programmes that need to be considered, including:

> *Recipients*: Which groups are being targeted, for example all young people or a particular group of young people, such as those out of school, or young people involved with sex work?
> *Providers*: Who can provide the services: public, private or NGO providers, or a mixture?
> *Benefits*: What will be included in the package that is provided (e.g. STI care, condoms, and other medical services)?

Value: What is the value of the voucher, both to the person accessing the service (full or partial subsidy) and to the provider (varied or fixed)?

There is often concern about the use of public sector funds to provide services through private providers, for specific groups such as sex workers, and voucher schemes always require some external funding. Establishing the voucher distribution components can be costly and time consuming, but once the initial steps are completed, they are relatively easily scaled up or modified. The distribution agency must be honest and reliable to ensure that there is no leakage, counterfeiting or collusion between providers, and to minimize the potential for vouchers to be passed on to people other than the intended beneficiaries. This requires adequate monitoring systems.

Recommendations on the effectiveness of competitive voucher schemes for effective delivery of services to care and prevent HIV among young people

Although experience is lacking in using vouchers for young people in a wide range of settings, and further evidence is needed about the role of vouchers in providing preventive services such as information and counselling, the evidence so far suggests that competitive vouchers may provide a useful approach to provide specific services to specific segments of young people. Participants recommended that:

- competitive vouchers can be useful to ensure vulnerable groups can access services;
- further experience needs to be documented and evaluated to determine the scope of vouchers in providing services to young people more widely and the impact of competitive voucher schemes on the demand for, and quality of services.

Participation of young people

Evidence of effectiveness of youth participation in HIV prevention and care services for young people

Based upon presentation by Dr S. Thapa, paper by Dr Thapa and Ms S. Sonti, YouthNet

The background review clarified many of the terms used, including youth involvement, youth participation and youth adult partnerships. *Youth participation* provides an umbrella term to describe the continuum of involving young people in different elements of programme design, delivery or evaluation, in a meaningful and substantial way. *Youth-adult partnership is* the preferred term used to describe equitable working relationships between young people and adults. All provide opportunities to involve young people in ways that can benefit both the community and the young people themselves, contributing to their development, and to fulfil and respect their rights, as outlined in the *Convention on the Rights of the Child*. The evidence suggests that this can be achieved in different settings for a range of interventions.

Young people have been used as 'networkers' or outreach contacts; as a way of encouraging other young people to access services; in developing and designing information and education tools and messages; and in delivering the messages that are developed. Within clinical settings young people can act as peer educators or lay

counsellors, advisors or client advocates, and can also contribute to evaluating the services.

Unfortunately, there appear to have been few attempts to systematically explore the links between the successful involvement of young people and improved health outcomes, especially in relation to clinical services, and there is currently little evidence to clearly demonstrate that young people's participation in reproductive health services increases demand for, or utilization of services. Experiences documented in the review report mainly the strengths of young people as outreach workers, acting as contact points for referral into services, and in community mobilization to support greater utilization by young people. Clear evidence is lacking that improved health outcomes or decreased HIV transmission results from their involvement.

There is, however, emerging evidence of effective youth-adult partnerships in other settings, such as school-based peer education[34], mass media based education campaigns, drama-based and youth centre-based educational interventions. Most commonly young people are involved as peer educators (also as counsellors, promoters or facilitators) and trainers. While there is little evidence of the cost-effectiveness or sustainability of peer based approaches, young people clearly represent an important resource and bring important perspectives to programmes, and there is enormous scope and potential that needs to be more thoroughly evaluated.

Recommendations: on the effectiveness of young peoples' participation for effective delivery of services for prevention and care of HIV among young people

Participants agreed from the evidence reviewed and presented that:

- peer approaches are likely to make a contribution to improving the delivery of health related messages, promoting behaviour change, stimulating access to services and possibly creating demand;
- building young people's participation appears to be a critical component of engaging communities more generally, something that is widely accepted as being necessary to enable young people to take advantage of the services that *are* available;
- involvement of young people is likely to have an impact on the services themselves by making them more responsive to the needs of adolescents and youth.

However, while supporting young people's participation and providing opportunities for young people to contribute continues to be a challenge for health services, participants also felt that:

- greater clarity about the impact of this participation on risk behaviours and health outcomes, and on access to and utilization of services by young people is needed;

[34] **Peer Educators**. Members of a particular group target group trained to carry out informal or organized educational activities on a range of health-related topics (in small groups or individually) in fixed facility or outreach settings.

- further research is required to explore the benefits, and limitations of young people's involvement, including the elements of time, cost and sustainability.

Community mobilization

Evidence of the effectiveness of advocacy and community mobilization for HIV prevention and care among young people , and experiences of effective delivery.

Based upon presentation by Dr D. Akinyele, UNFPA (AYA[35]), background paper in preparation

It is generally assumed that in order to increase the utilization of health services by young people it is necessary to work with parents and community power structures to promote and develop support and acceptance for the services. As there are generally considerable sensitivities and stigma surrounding HIV and adolescent sexuality, community awareness and support of the need for HIV-related services such as condoms and STI/HIV testing and care is important. The consultation sought to examine the evidence for the role that advocacy and community mobilization plays in increasing young people's access to, and use of information, services and supplies for HIV prevention and care.

Various different constituencies or groups can be identified within the broad term of 'communities' and the use of participatory planning and evaluation/research techniques have provided insights into the differing constituencies that need to be considered when building support for HIV interventions. These include traditional or cultural leaders, elders, parents, faith based groups, education-based and work-based groups, traditional healers and young people themselves. Although there have been documented success stories, there has not been a systematic review of what works in terms of community mobilization to support HIV services and supplies for young people.

There is a lack of evidence concerning either the impact of community mobilization on young people's use of health services, or the most important strategies for effectively engaging communities to support adolescent friendly health services. Experience in Uganda suggests that against a backdrop of strongly stated political commitment, community groups, including faith-based organizations and groups working in the field of education, can effectively leverage support for priority interventions. This is further facilitated if, concurrently, mass media campaigns, or locally based media campaigns are implemented using posters, pamphlets, radio or television. Through the mobilization of key local or national stakeholders it has been shown to be possible to generate resources and support for health services for the prevention and care of HIV/AIDS among young people.

Experiences from other intervention areas, such as immunization, the Integrated Management of Childhood Illnesses (IMCI) and Roll Back Malaria (RBM), suggest that without efforts to publicize the importance of the services being provided, to generate demand for service utilization among the target client groups and key gatekeepers,

[35] For the African Youth Alliance (AYA) , a programme to address adolescent reproductive health concerns in four African countries more information is available at: http://www.ayaonline.org/

and to counter opposition where it exists, public or private sector provision of services and supplies is likely to be sub-optimal in terms of utilization and impact. This is likely to be even more important for services for young people in view of the taboos, myths and opinions that surround them and that are likely to prevent both the implementation and use of effective programmes.

Recommendations: on the effectiveness of community mobilization and advocacy for effective delivery of services to care and prevent HIV among young people

No specific recommendations were made by the consultation regarding community mobilization. However participants felt that this is an important area for future work, in view of the need to increase resources and demand for health services for young people, and that there is a need to identify the elements of effective community mobilization that will help to increase and support the provision and use of health services by young people. How the health sector and health care providers can contribute to such mobilization requires further elaboration.

Supplies, training and supervision

Based upon presentations by Ms H. Moller, UNICEF and by Dr A. Jamil Faisel, Engender Health

Supply management and planning is crucial to the effective implementation of core interventions. Even if essential medicine policies are in place, establishing the chain of procurement, storage and distribution is necessary to ensure that health systems are able to deliver the supplies that are necessary for interventions to be effective. This requires inventory control, procurement systems, and sustainable funding, as well as systems that can adequately store and distribute drugs and commodities.

In terms of HIV and young people, the key supplies and commodities required for programming are:

- Information materials
- Condoms
- Harm reduction (safe injecting equipment including needles, syringes, waste disposal facilities, drugs for substitution or treatment)
- Diagnosis and treatment for STIs (test kits, syndromic treatments, clinic and laboratory consumables such as slides, gloves)
- Testing and treatment for HIV/AIDS (test kits, laboratory consumables, and drugs for opportunistic infections, ARVs, cancers and palliative care)

There have been few formal assessments or evaluations of the essential health system requirements necessary for the effective delivery of HIV interventions for young people. Using quality improvement or quality assurance approaches locally and at district levels would help identify local problems and solutions, and it is likely that supplies-related problems will be one of the primary causes of ineffective delivery. Experience from immunisations programmes, TB and other infectious disease control programmes, suggests that poor supply management is frequently a major barrier to successfully scaling up interventions. The health system requirements to manage the products needed to deliver a service are often not given adequate consideration prior

to the initiation of clinical services, and local managers may not have sufficient authority to ensure effective supply management, storage and distribution. Participants were provided with an overview of experiences using COPE (Client Orientated Provider Efficient), a self-assessment based, and problem-solving approach to quality improvement of health services. One of the key lessons learned from COPE, both within adolescent reproductive health services and in other settings, is that even if action plans that follow up training are developed and implemented, in the absence of supportive supervision sustainable changes are rarely achieved. As these supervision skills are not always present, they need to be provided and built into any training on adolescent friendly health services, and different skills and competencies are required for managers, supervisors and clinical care providers.

Engender Health has developed a series of training tools that outlines the skills required to provide effective supervision, and incorporate supervision skills into the training programmes for providers of adolescent friendly health services[36]. Often mechanisms or systems for supervision or support are not in place and therefore need to be developed, for example regular follow up meetings, related training on specialist topics, staff rotation.

From the general discussion it was clear that while resources are sometimes made available for training health providers, efforts are often poorly coordinated and do not always address some of the underlying problems, such as poor motivation among staff. The importance of well trained trainers and better selection of trainees, and a shift to results or performance-based management was advocated, as was experimentation with alternative training methods.

Recommendations: relating to supplies and supervision of health care services

Participants agreed that:

- Developing a supply strategy early in the preparatory phase of programming is fundamental to effective delivery of *all* the interventions outlined during the consultation. This has implications for all levels of the health system, including the need to ensure that district level managers have more autonomy (something that should result from decentralization, a key element of health sector reform).

- Attention needs to be paid to staff relations and motivation, encouraging local autonomy and decision making and developing supervision systems and better use of local information, not least to ensure that the resources devoted to training health workers produces the desired outcomes.

[36] For further details on Engender health resources related to adolescents see the web site: http://www.engenderhealth.org/news/newsreleases/021211.html

Conclusions and next steps

Health services for young people; a priority

Within a comprehensive multi-sectoral response to HIV/AIDS we need to make the case for directing resources to the health system and a focus on young people, to ensure these services receive adequate attention and commitment at national, regional and global levels. Only then will young people be able to access and use the range of health services and supplies required to reduce transmission of HIV and reach the global goals on HIV and young people. This consultation reviewed and identified the most effective interventions that health services can provide for the prevention and care of HIV/AIDS among young people, effective approaches to delivering these services, and the characteristics of effective programmes. To enable health systems to deliver these priority interventions at scale, focused advocacy and support, greater collection and dissemination of strategic information, and the creation of a supportive environment through the development and implementation of specific policies will be necessary. To accelerate progress in countries to deliver priority interventions for the prevention and care of HIV/AIDS among young people, it will be important for there to be strong consensus among a range of partners about the priorities for action. The consultation identified and emphasized several over-arching issues:

Young people - similar but different

Cross-cutting through all of the conclusions is the need to recognize and capitalize on the similarities among young people, but, at the same time, to give adequate attention to the differences, in terms of age, sex, marital status, education, rural/urban domicile. It will also be important to be clear about those young people who are particularly vulnerable and least likely to have access to priority services and supplies, such as young people in sex work or who inject drugs, young migrants, and young people living in institutions or in extreme poverty.

Broad vision - but focused action

Many factors influence whether or not young people have access to the information, skills and services that are essential for the prevention and care of HIV/AIDS. While these all need to be confronted, it will be important for the health system to be clear about its specific operational contribution to expanded national responses, to ensure that there are well defined goals and targets, and to be clear about what is expected from individual service providers and facilities in both the public and private sector.

Common interventions- but no one-size-fits-all

While a set of priority interventions that are needed in a variety of different settings were examined and identified during the consultation, there is clearly a need for countries and sub-regions to develop their own specific emphasis, taking into consideration a range of factors including the epidemiological characteristics of the

epidemic (high and low prevalence settings), the primary modes of transmission, social values, cultural practices, national policies, and the national health system infrastructure and resources. The specifics of the intervention mix can only be determined locally, but should be based on the essential services and supplies for prevention and care of HIV/AIDS among young people that were reviewed during the consultation.

Many sources of health services and supplies

A wide range of providers will need to contribute to increasing young people's access to essential services, including government, NGO and private providers, doctors, nurses, pharmacists, and other health workers, using a mix of strategies ranging from public health to marketing approaches.

Supply and demand

It is now well recognized that merely improving the technical quality of services provided will not guarantee increased utilization by young people, and it is therefore important to have a better understanding of young people's health seeking behaviours, to devote more resources to generating demand among young people and developing community support and acceptance for priority services that will be essential for their provision and use.

Strategic links

The health system's ability to respond to HIV among young people has been built from the experiences gained from other aspects of adolescent health and development. Interventions for HIV/AIDS may, at the same time, leverage increased quality and coverage of services for other ASRH issues, and for delivering interventions that address other health issues traditionally ignored, or groups that have been marginalized (e.g. sex work, injecting drug use and young people exposed to gender-based violence and abuse). It will therefore be important for any health system focus on young people and HIV to link with, contribute to, and build on existing national policies and programmes focusing on adolescent sexual and reproductive health (ANC, FP), young people's health and development, HIV/AIDS (PMTCT and care) and wider health sector reforms. Increasing young people's access to services and supplies will also need to be developed in collaboration with other sectors, such as education, employment, and communication, which have mandates and responsibilities for increasing young people's knowledge and skills.

Opportunities and obstacles

The global goals on young people and HIV, the position that HIV has on the political agenda, and the resources that are increasingly available in countries to support action, all provide unique opportunities for the health system to accelerate action towards delivering the prevention and care services that young people need, and that are their right. This will require political commitment, resources and capacity; policies based on the available evidence, and that de-stigmatize HIV/AIDS and prevent the marginalization of vulnerable groups; and a willingness by communities to confront a

range of sensitive issues that need to be tackled if the health system is to maximize its contribution to decreasing the transmission and impact of HIV among young people. The following areas were identified as being central to accelerated action in countries.

Strategic information

Data are needed to:

- be able to make a compelling case for accelerated action for young people;
- plan and monitor the health service interventions on an ongoing basis, and guide decisions about the appropriate intervention mix;
- help improve the quality, coverage and effectiveness of interventions through regular and intermittent evaluation and operations research;
- provide evidence and clarity about what needs to be done, including success stories and lessons learnt.

The consultation emphasized the need to have a much better picture of what is happening to young people, particularly in developing countries. Information is needed about the general population of young people, those particularly vulnerable groups of young people who are often at the centre of the epidemic in terms of transmission and impact, and about related problems, such as alcohol and drug use, STIs and gender based violence. It will be important for policy makers and programme planners to be able to quantify health outcomes, behaviours, determinants (risk and protective factors) and interventions, and to have access to data that provide an assessment of young people *and* the contexts in which they live, learn and earn.

Participants stressed at several points during the consultation the need for better situation assessments (including the use of rapid assessment techniques, mapping the delivery of existing interventions and the identification of effective coordination mechanisms); the need for better disaggregation of data by sex, age, and marital status, both when it is collected and when it is analysed; the need for adequate monitoring and surveillance systems to be in place in order to provide the evidence of effectiveness, fuel advocacy and mobilize partners to focus on young people and HIV; and better documentation of successful programmes.

It is clear that in order for action to be accelerated, national targets will need to be set that can provide a focus for the various partners and for the mobilization of resources. While there are global goals, these are clearly very optimistic for many countries, and in any event need to be made more specific, understandable and operational. National goals and targets can also generate pressure to act by providing comparisons between countries and across sub-regions.

Priority interventions for health care services

There was strong agreement during the consultation about the health service interventions that would provide most impact upon the epidemic. However, although these are common regardless of the context or the phase of the epidemic, there was

consensus that the specific intervention mix needs to be tailored for different groups and settings. Priority health services interventions include:

Information and counselling

The health system has an important role to play in ensuring that young people have access to information, about prevention, about knowing when to seek attention, and about the services that are available. This also needs to include contributions to the development of national education and behaviour change communication programmes. There was a strong emphasis placed on the need to more clearly define the role of health workers in providing young people with information and counselling. The information that young people receive through the health services needs to be linked to counselling in order to ensure it is provided in ways that help young people internalise the real risks of HIV and contribute to health promoting choices (in the same way that the education sector links information with life skills). Information and counselling also need to be integral components of and all the other health service interventions outlined below.

Condoms

All programmes directed to young people and HIV need to focus on encouraging and supporting abstinence and non-penetrative sex. But for those young people who are having penetrative vaginal and/or anal sex, particularly those who are engaging in sex with different partners, the use of condoms is currently the most evidence-based prevention intervention that is available. Condoms are therefore a priority intervention for all young people, especially vulnerable groups, in high and low prevalence settings, and it is essential the health services are able to provide young people with the necessary knowledge, skills and supplies to support consistent and correct condom use. In some countries significant efforts will continue to be directed to clearly articulating the evidence that condoms are effective, that they do not promote sexual activity, and that they are a central element of programmes for the prevention of HIV, STIs, *and* pregnancy among young people (dual protection). Scaling up condom programming requires adequate attention to logistics and supplies, and recognition that health services represent only one source of condoms.

STI testing and care

Ensuring that health services can provide STI testing and care to young people is a priority in both high and low prevalence settings, although in the former the focus should be on all young people, and in low prevalence settings efforts should be directed to providing adequate coverage for particularly vulnerable groups. Greater attention needs to be given to identifying other screening opportunities for detecting STIs in young people. As with condoms, for this aspect of programming to be effective adequate, attention needs to be devoted to training, supervision, logistics and supplies.

Harm reduction

For young people who are injecting drugs (intermittently or repeatedly), harm reduction measures are another effective priority evidence based intervention, particularly important in many low prevalence settings where IDU is the predominant mode of transmission. In view of the difficulties of reaching groups who are injecting drugs, and the association between IDU, sex work, and unsafe sex, consideration needs to be given in outreach programmes to linking harm reduction measures with the other interventions essential for the prevention and care of HIV/AIDS among young people.

HIV testing and care

HIV testing has a clear and important role in identifying young people who would benefit from changing or maintaining their behaviours in order to remain HIV negative, and those young people who need access to treatment and care. Other benefits that result from VCT in adults or from models of testing and care in developed countries with health care systems able to deliver HIV care and support, such as sustained behaviour change, strengthening prevention and decreasing stigma still require a stronger evidence base from resource poor and low prevalence settings. However ensuring testing is linked to access to effective prevention interventions (including condoms and STI care) **and** access to HIV/AIDS related care and support is critical, and currently not assured. Increasing attention will need to be given to treatment and care of young people living with HIV/AIDS, as their numbers rise, and it will be important to ensure that young people's needs are catered for, and that they are not excluded from care and support systems. HIV testing and care needs must be seen as related, and to be integrated into existing medical settings, such as ANC.

Strategies and characteristics of effective intervention delivery

It is clear that a range of strategies for delivering health services and supplies to young people are needed, and that a number of different partners will need to be involved, including but not restricted to existing public health facilities. If interventions are to reach all young people, including particularly vulnerable groups of young people, the public health system's capacity and infrastructure will need to be augmented, through a variety of non-governmental organizations, and including commercial and private sector approaches that both improve the quality of existing services and also generate demand. This requires adequate attention to logistics and supplies, and the engagement of parents and other community members in service delivery. There is an expanding body of experience about what works for which target groups of young people. However, a major challenge that remains for the health system is to take effective service interventions to scale. At the same time, there will be an ongoing need for innovation.

Recognised characteristics of adolescent-friendly health services include trained competent providers able to offer appropriate effective confidential services, in facilities where policies and procedures, promote autonomy and respect the rights and participation of young people.

Advocacy and the creation of a supportive environment for policies and programmes

Prevention among young people remains a priority if the HIV pandemic is to be effectively controlled, and this needs to be constantly stressed. It will be important to continue to make a compelling case; to clearly spell out what needs to be done, and to provide examples of priority interventions being implemented to some reasonable scale in a sustainable way. Within the multi-intervention and mutli-sectoral approach that will be required, there is a need to advocate for a strengthened health system response, and the clarity provided by this consultation will contribute to this.
There is an ongoing need for a clear articulation of the economic, public health, and human rights rationales for directing resources to improving the health system response to young people and HIV. This requires clear articulation of the available evidence of the effectiveness of interventions and delivery strategies, and the potential costs of not acting, *now*, despite the sometimes incomplete evidence base.
At the same time it is important to understand the extent to which policies and social values facilitate or prevent young people's access to services, to be clear how policies themselves may become barriers to action, and to understand how lack of awareness and capacity among health service providers who come into contact with young people may also hamper the implementation of effective interventions.

Consistency among key UN and international development partners about the priority interventions examined in the consultation is essential, as is the importance of ensuring that gender and equity principles underpin accelerated action, and that support for the core elements of accelerated action be sustained. To achieve a more effective health system response in countries, regional and international agencies can assist through strong advocacy for interventions that are politically and socially sensitive (e.g. harm reduction, condoms), and by making a case for action in national, regional and international fora, building on the available evidence base.

Capacity development remains a major challenge, and efforts are currently underway to develop tools and review and collate what is currently available. Increasingly, funds are available in countries to support action, but technical guidance and support are often not available to ensure that these funds are used efficiently and effectively. Lack of coordination and linkages within countries may also dilute the impact of individual interventions and undermine sustainability.

There is a shortage of suitable programme support tools for providers and planners to ensure that existing services are able to effectively deliver services to young people, and to facilitate more effective involvement of the private sector and non-formal health systems. Training for professional health providers and related staff, including lay members and young people, needs to include orientation and basic training to enable them to provide information and counselling more effectively to young people within existing health services. Technical assistance and guidance needs to be based upon the comparative advantages of different organizations.

Annex 1- Recommended next steps

Advocacy

1) Ensure WHO, UNICEF, UNFPA, UNAIDS, YouthNet and partners advocate for accelerated country-level action for the health system response to HIV and young people at all relevant international fora (all).
2) Develop an advocacy publication based on the consultation for wide use and dissemination by the organizations participating in the meeting (WHO and partners).
3) Develop advocacy materials on condoms and safe sex for young people, including a focus on dual protection (UNFPA and WHO).
4) Develop a briefing or advocacy pack for UN and WHO staff in countries (WHO + IATT/YP).

Meeting follow-up

5) Revise and finalize background papers submitted to meeting on HIV testing, HIV care, harm reduction, condoms, competitive vouchers, youth participation (WHO and individual authors).
6) Develop reviews of the evidence on information and counselling in health services, health service provision through public and private health facilities, community mobilization, outreach and commercial approaches to HIV prevention among young people (UNICEF, UNFPA UNAIDS and WHO/Futures/YouthNet).
7) Make the final versions of all the above background papers available to a wider audience through the Internet and consider including a synopsis in a peer reviewed journal (WHO).

Technical developments and research

8) Carry out a detailed epidemiological review of young people and HIV/AIDS, with particular attention to different epidemiological scenarios (regional or sub regional) and phases of the epidemic (global and regional), including trends and projections, and the implications of these differences for decisions about the intervention mix (WHO, UNICEF).
9) Develop guidance on surveillance and monitoring, including age and sex specific data (WHO and UNICEF ongoing).
10) Review existing WHO/UNFPA STI and HIV treatment and care guidelines to ensure that there is an adequate and appropriate focus on the specific needs, clinical presentations and psycho social dimensions of HIV infection in young people (WHO, UNFPA).
11) Compile an inventory of existing training tools for STI care, condom programming and HIV testing and care for young people (UNFPA, WHO, UNICEF, MSI) and identify key gaps in programming tools.
12) Develop a guide for non-medically trained peer educators working in harm reduction (UNDCP and partners).
13) Collate and review existing evidence on counselling programmes directed to young people, HIV/AIDS, and ASRH (WHO, UNICEF and other partners).
14) Conduct situation assessment of existing HIV testing and care practices for adolescents and young people in five or six developing countries (WHO).

15) Conduct situation assessment of injecting behaviours among young people in at least two high prevalence countries (UNDCP plus partners International Open Society, IOS).
16) Conduct operational research in relation to branding of adolescent/youth-friendly health services and associated commodities including condoms, possibly using social franchising approaches (YouthNet/Futures).
17) Conduct operational research into alternate models of providing young people with relevant and appropriate HIV information and counselling, in fixed or mobile sites with or without HIV testing facilities.
18) Conduct operational research in 2-3 selected low prevalence countries to examine the impact and cost effectiveness of stand alone HIV testing (VCT) on young people's subsequent risk behaviour (HIV negative and positive, and for periods greater than 12 months) compared with stand alone information and counselling, or integrated counselling, care and testing services including STI and FP care (WHO, Population Council to stimulate partners).
19) Conduct operational research into syndromic management of STIs in adolescents, particularly the management of vaginal discharge among adolescents (WHO to stimulate other partners including Population Council and USAID).
20) Conduct operational research upon young people's participation in clinical service provision and evaluation of their participation on specific health outcomes and demand for clinical services (YouthNet, WHO and partners).
21) Further operational research into the use of competitive vouchers for different groups of young people in different settings, including the provision of preventive interventions such as information and counselling.
22) Develop methodologies to assess the unmet need for condoms for HIV prevention among young people.
23) Examine the impact of condom size, shape, and consistency on correct consistent usage specifically among young people.
24) Examine equity and poverty related issues of access to health services for young people, and their relation to health sector reform (WHO UNAIDS and other UN partners).

Capacity building

25) Develop and support networks of technical experts for countries and regions to call upon for young people and HIV health services support. This may require some regional training and sensitization (WHO, UNFPA/CST and regional implementing partners).
26) Develop an inventory of specific tools to assist national programmes with a guide to design and implement competitive vouchers and other social marketing and franchising schemes[37].

[37] Currently the Private Sector Advisory Unit of the World Bank is producing a toolkit on competitive vouchers for health, which will contain a 'lessons learned section and a 'road map': an analytical tool that will provide policy makers with a step-by-step guide for designing, implementing, monitoring, evaluating and scaling up of competitive vouchers schemes.

Collaboration

27) Ensure that the IATT plays an active facilitatory role to mobilize key stakeholders to adopt and promote this agenda (WHO, UNAIDS, UNICEF, UNFPA).

Resource mobilisation

28) Mobilize resources to enable the research agenda and work on compiling and analysing existing tools and guides in existence (all).
29) Mobilize resources for multi-partner pilot of an 'accelerated action agenda' in five to six countries and the development of relevant programme support tools (WHO).

Annex 2 – Consolidated matrix of key group work findings; indicative targets and activities to support accelerated action

The following represents a summary of the group work sessions held during the consultation.

Information and counselling

Participants agreed that information and counselling are core effective interventions in both high and low prevalence settings, and should be provided to all young people within health care services. Appropriate, accurate, information is essential but not sufficient for young people to avoid harmful behaviours, maintain protective behaviours and take advantage of the health care services that are available, and must be linked to counselling. In addition participants agreed that:

- Information needs to be provided in an empowering, autonomy supporting and developmental stage appropriate way for young people.
- Information and counselling must be built into services provided to young people and seen as essential element of all the health care services that health workers provide to prevent and care for HIV/AIDS among young people.
- The way the information is provided is probably more important than by who, and where, and it is not always necessary to rely upon doctors or nurses to provide the information.
- Providers need additional skills for them to be able to provide client responsive services which include information and counselling.
- Messages may need to be locally adapted so that they are best suited to different target groups and settings.
- Activities in the wider community are needed to legitimize, normalise and de-stigmatize desired behavioural outcomes (e.g. sex with a condom) or for specific groups (e.g. MSM).
- Different delivery channels or approaches will suit different target groups (e.g. schools, government and private health facilities, community-based interventions, outreach interventions, web or Internet based modes for specific vulnerable or hard to reach groups).
- Cost-effectiveness may well vary in different settings and needs to be established and considered.

Information and counselling

Possible targets identified for 2005 High prevalence settings	**Possible targets identified for 2005 In low prevalence settings (with high rates in specific groups**	**Activities and priorities to accelerate action in countries**	**Key actions regionally/globally to support countries**
-50% increase in district level health care facilities able to provide young people with relevant user-friendly information and counselling services -50% increase in district level health facilities with one or more staff member trained to provide young people with specific information and counselling -50% increase in the number of districts in which one or more district level health facility is deemed adolescent friendly by young people in the community - 90% of young people have access to young people adapted health services in their community	- 90% of young people at high risk of HIV infection (IDUs, sex workers , MSM) have access to information and counselling for HIV prevention (for example harm reduction, condoms and STI treatment) - 50% increase in number of young people who have access to accurate HIV prevention information through health care providers -50% increase in number of disadvantaged young people who know where to access health services and supplies - 30- 40% of district service delivery points/contacts have a young- people- friendly package of services, are trained to provide these, and have adequate supplies - 40% of district-level health services have at least one health promoting activity for young people's health and development, including a focus on HIV/AIDS prevention and care	a. **Review existing situation** Conduct national situation assessment or analysis of ASRH, and identify the needs for information and counselling, and capacity of existing health facilities and providers to meet the needs of young people. b. **Advocacy** Advocacy with political leaders, law makers, politicians and policy makers, to ensure support for quality of YFHS, which include condoms, access to info and counselling and confidentiality c. **Training** Pre and in-service training of health workers designed to cover specific needs of young people, and develop skills to provide information and counselling services to young people in a range of facilities and settings d. **Support for health workers** Diversify media and other available methods to motivate and support health care providers and reinforce their work with young people e. **Youth multi-sectoral committees** To work on multi-sectoral services for young people, including marginalised and vulnerable groups, support for local advocacy campaigns, and strengthening local partnerships, including youth-adult	- Based upon evidence of effectiveness clearly define the concepts of "information and counselling", what is required in health service settings, and what is realistic for health service providers to provide - Document success stories and lessons learnt, including peer based modes - Develop advocacy publication that can be used for information and counselling services (including the rationale for linking the two). - Collect and disseminate information and counselling tools for use by programme managers and health providers.

Condoms

Condoms are 90% effective at preventing HIV transmission (more effective for pregnancy prevention) when used consistently and correctly, with higher effectiveness with perfect use. There is less clear evidence about female condoms, but it appears that they offer slightly less effective protection against pregnancy and HIV, but it may be that where both methods are available, the overall numbers of unprotected sexual acts decline. Ensuring young people have access to and are able to use condoms was identified as a critical core 'intervention' that health care services should offer in both high and low prevalence settings. Initial efforts should intensively focus upon higher-risk young people in low prevalence settings, and must be always be accompanied by information and skills provision related to using condoms.

Further evidence or programmatic attention is needed on:

- Health care services promoting 'dual protection' for young people, both males and females.
- Strengthening programme linkages to ensure promotion of all prevention efforts is encouraged, including delay of sexual debut, reducing the number of partners, and protection through condom use.
- Developing outcome measures that capture combined success rates incorporating dual protection, abstinence, reduced numbers or frequency of partner change, and increased condom use.
- Involving partners in condom promotion.
- Factors affecting condom use by young people, and by different subgroups of young people, particularly in terms of age, size and quality of condoms.
- Evidence of impact upon different distribution mechanisms specifically targeting young people, including outside health facility distribution.
- Attention to supplies and distribution related barriers to condom availability for young people.
- Developing methodology to determine the global and local unmet need for condoms among young people.
- Developing further evidence on links between consistent correct condom use and the use of substances such as alcohol and drugs.

Condoms

Possible targets for 2005 High prevalence settings	Low prevalence settings (with high rates in specific groups)	Activities and priorities to accelerate action in countries	Key actions regionally/globally to support countries
- 50-100% of district health facilities able to provide free or affordable condoms to young people. - At least 50% of district level facilities have system for community based distribution of condoms designed to reach young people. - 90% of young people have access to free or affordable condoms as needed, and know how to use them. - All health workers know how to promote and demonstrate the use of condoms. - District-level development of alternative channels of distribution for condoms specifically designed to reach young people, e.g. social marketing, vending outlets, kiosks, machines, etc.	- 90% of high-risk groups of young people have access to free/affordable condoms and know how to use them. - 70% of all young people have access to condoms and know how to use them - District-level development of alternative channels of distribution for condom, e.g. social marketing, vending outlets, machines kiosks, etc.	a. **Supply** - Ensure effective logistic system is in place, which includes forecasting, sustainability, quality control, and channels for distribution. b. **Training** - Standardise pre- and in-service training for service providers and so that it includes condoms promotion and demonstration, for a range of providers including community based distribution workers(CBD), peer educators, pharmacists and formal health workers). c. **Demand creation and promotion** - Explore branding of condoms specifically for young people. - Provide condoms in a range of venues and outlets, especially family planning outlets and explore other demand creation techniques. - Ensure strong sustained linkages with family planning services, and promotion of dual protection. d. **Monitoring and evaluation** - Ensure data from district level and or facility/clinic provides information on distribution, use and supplies of condoms that allows some analysis by age and sex. e. **Technical support and capacity building** - Situation analysis or needs assessment of condom programming at all levels, with specific focus on young people. - Review existing tools and guides for providers and planners on condom programming. - Operations research to explore the determinants of condom use among young people (size, quality, etc. as above).	a. **Condom needs assessment** - Estimate the current use and unmet need for condoms by young people. -Identify actions to facilitate access to and use of condoms by young people. b. **Capacity building** - Develop capacity for providing technical assistance and tools to assist countries with the logistics and supply of condoms for young people (promotion and programming). - Develop inventory of available tools to assist programming that include an explicit focus on young people. - Identify and develop technical support networks to assist countries use the tools that are available. c. **Resource mobilization** Ensure country specific resource allocation for greater condom distribution. d. **Advocacy** - Focusing on de-stigmatizing and dispelling myths about condoms, so clearly articulate the evidence that condoms are effective and that they do not promote sexual activity, and that they are a central element of programmes for the prevention of HIV and pregnancy among young people (in addition to abstinence, partner reduction, and other approaches to safer sex). e. **Supporting learning-by-doing** - Identify up to 10 focus countries where existing programmes could be strengthened or new ones established, and carry out a rapid assessment and develop coordination mechanisms to ensure that a focus on condoms is adequately reflected in wider prevention efforts.

STI care

The evidence suggests that syndromic management of STIs where it includes diagnosis, treatment, education and condoms as part of the package, does have an impact on HIV prevalence and incidence, but not in all settings and populations. It is most effective early in a fast growing HIV epidemic and where STD rates are high. Interventions to screen for asymptomatic STDs in young people have demonstrated successful cost-effective decreases in STD rates, but have not yet been demonstrated to reduce HIV except in high risk groups where other HIV prevention interventions were in place. Syndromic management alone is unlikely to be sufficient to prevent STIs (and HIV) for young people especially females, as STIs are so frequently asymptomatic or not detected by young people.

Further evidence or programmatic attention is needed on:

- Ensuring clinic-based services can combine approaches for syndromic management with active screening or case finding for asymptomatic STI in young people.
- How programme approaches might need to differ in low or high HIV prevalence settings and in rural or urban settings, and where basic health care services are very weak.
- Ensuring that STD services for young people are more than just STI treatment, and include a strong information and counselling component, and the provision of condoms.
- Greater understanding on how young people who do not present to primary care facilities can be assisted and encouraged to access services (for example screening in school health services, institutions and the workplace).

STI care

Possible targets for 2005 High prevalence settings	**Possible targets for 2005 Low prevalence settings (with high rates in specific groups**	**Activities and priorities to accelerate action in countries**	**Key actions regionally/globally to support countries**
- At least one staff member in facilities providing young people with health services is trained in the management of STIs. - At least 15% of service delivery sites (or an increase of 15% from 2000 levels) at district level have adequate staff and supplies to provide STI care to young people. - 25% of health facilities have uninterrupted supply of available drugs for the syndromic management of STIs among young people (or an increase by 25% from 2000 levels). - National guidelines for quality STI services developed that outline treatment and care standard protocols and essential supplies and include young people. - Standardised training in above is available to all health service providers, in government, NGO and private settings.	- 90% of young people in high risk groups have access to services for STI screening and treatment. - 60% of young people in high risk groups have knowledge about STI prevention, symptoms and treatment facilities. - STI syndromic management and providing STI care for young people are part of pre-service training, and in-service training (using the standardized training materials).	- Clear national targets and guidelines for STI care agreed by key partners. - Adequate resources allocated to increase young people's access to relevant information through the media, schools and communities. -Policy guidance for service providers on specific considerations for young people (e.g. who can provide what, where and with what consent) developed , and disseminated. -Designated person responsible for STI care among young people in the MOH. -Protocols for STI management of young people in high risk populations (e.g. MSM, sex workers and IDUs) developed. -Test mechanisms for increasing the demand and use of health services by high risk groups, involving public and private service providers such as vouchers. - Curricula developed for pre- and in-service training relating to STIs among young people, including a plan for training of trainers.	**Training** -Situation analysis to assess what is needed and what is already available in terms of programme support materials. - Compile a package of materials for distribution to countries to make aware of available training resources. - Establish clearing house of training and educational materials , easily accessed by organizations working in low resource settings. - Develop standardized training curriculum for service providers that includes syndromic management and treatment protocols for young people for national adaptation/(an included in-service component). - Review key textbooks to see if they reflect current thinking about STI care among young people. -Provide clinical guidance to countries regarding algorithms for appropriate diagnosis and management of STI/RTI for young people (including vaginal discharge). - Ensure that protocols take into account the needs of populations at high risk, especially young IDUs, sex workers and MSM. **Supplies of drugs, commodities and information** - Examine and revise essential drug lists and ensure that they include drugs identified in the relevant protocols. -Identify newer drugs, including one dose regimens, that should be considered for inclusion in essential drug lists, including inexpensive regimens.

Possible targets for 2005 High prevalence settings	Possible targets for 2005 Low prevalence settings (with high rates in specific groups	Activities and priorities to accelerate action in countries	Key actions regionally/globally to support countries
- STI syndromic management and providing STI care for young people are part of pre-service training, and in-service training (using the standardized training materials). - A 60% increase from 2000 levels in the proportion of young people who know key signs and symptoms of STIs is made.			- Examine cost effectiveness of one-off regimens for young people versus standard treatments. - Establish efficient procurement processes, with international assistance as needed. - Set national and regional targets for STI treatment (possibly tables of achievement, availability of services, those not able to offer STI services especially for vulnerable populations). - Dissagregate data where possible by age and sex to monitor access to services by young people. **Information and advocacy** - Explore involving other sectors in STI prevention and care (education, mass media, workplace/industry). -Seek and reinforce high level commitment to STI care among young people through advocacy. - Prepare and disseminate short documents supporting and reviewing issues relating to the treatment of STI s in young people, including a focus on high-risk populations. -Review existing information and educational materials, and disseminate programme support materials.

Harm reduction

The evidence is clear that harm reduction measures are effective in decreasing HIV, and that harm reduction services are needed where injecting drug use is identified as an important risk factor in HIV transmission among young people. Harm reduction measures with documented success in decreasing HIV transmission are based upon providing sterile injecting equipment (especially if accompanied by information and educational materials) delivered either through outreach or peer based methods, and using distribution or exchange or needles and injecting equipment (called needles syringe programmes, NSP). There is less evidence of effectiveness for providing disinfecting materials such as bleach, but it has been demonstrated to be effective in some settings, notably where it supports needle syringe exchange programmes, or in settings where NSPs are not feasible. Needle syringe programmes need to be supported by complementary activities such as information and education interventions to effectively control HIV transmission. None of the harm reduction measures reviewed have been demonstrated to increase the numbers of people injecting drugs or hasten initiation of injecting drug behaviour in non injecting users. The most frequent barriers to effective delivery of these services are policy and legal barriers to implementation. Assessment of the behaviour and contexts of drug use among the target population is required to most effectively plan and implement harm reduction services.

Harm reduction interventions do not necessarily provide young people with assistance to reduce or address their drug taking, and making available additional measures such as treatment to assist young people towards reducing drug use are recommended. Young people using drugs are also at risk of HIV from sexual exposure and need access to services for provision of condoms and STIs.

Further exploration is needed to determine:

- whether there are any significant age or sex related variables relevant to programming, and whether youth specific guidelines should be developed;
- the effectiveness of peers in terms of information/education, counselling/support, and demand creation for harm reduction measures;
- the best mix/package of interventions particularly in resource poor settings and the feasibility of substitution services.

Harm reduction

Possible targets for 2005 **High and low prevalence settings**	**Activities and priorities to accelerate action in countries**	**Key actions regionally/globally to support countries**
- 90% of young IDUs have access to a basic harm reduction package that includes information and counselling. - minimum package for IDU should include needles, equipment, condoms, basic STI services, information and counselling on HIV and drug related risks and the treatment of immediate health problems - all health services for young IDUs involve young current or ex-IDUs in their design, and where appropriate, in their implementation and evaluation	a. **Policies** - advocacy on need to address problems of drug use (tools are available to help countries do this), and to emphasize the potential impact of not addressing injecting drug use, based upon the local situation - examine restrictive law and policies. b. **Training** - in-country adaptations of existing training materials (e.g. WHO Harm Reduction manual) - develop practical guide for non-medically trained peer educators (needs local adaptation and translation). c. **Equipment** - examine the supply chain for needles and equipment. - ensure easier access to needles, injecting equipment, condoms and STI drugs, including means of destroying used needles. - develop standards and guidelines for quality of materials and costing (need initially to check what is already included by WHO and UNDCP in country guidelines). d. **Research** - operational research on the implementation of harm reduction interventions in a range of settings, (including how to deal with resistance and barriers to services, and how to operate at scale with a range of partners). - rapid appraisal of the scale of injecting drugs in settings where IDU is not necessarily perceived to be a big problem, including some high prevalence settings, for example the Caribbean (e.g. rapid use of WHO RARs). e. **Resource mobilization** - in particular funds for outreach work, including peer educators and interventions in hard to reach settings.	a. Rapid Assessment for Response (RAR) to enable in-country stakeholders to understand and advocate for services for young people who use drugs. b. Programme support tools are needed to assist countries develop, implement and monitor interventions (existing tools may need adaptation). c. Financial support and advocacy to stress that harm reduction is a priority intervention in many settings, with action needed by a range of agencies and partners.

HIV testing and care

There is currently a lack of evidence that either stand alone or integrated VCT specifically for young people is an effective intervention to prevent HIV among young people. However, evidence in adults suggests that counselling and testing may reduce high risk sexual behaviour with primary and non primary partners, particularly in males, but behavioural outcomes may not be sustained, and may vary by sex.

In high prevalence settings where VCT services are being established, it is clear that increasing numbers of young people are attending and that many untested young people would like and have a right to know their sero-status. Young people want access to counselling and testing services, but are concerned that services may not provide privacy and confidentiality.

Further evidence is needed on the positive outcomes of VCT for young people (for both HIV negative and HIV positive), such as sustained behaviour change and increased access to and utilization of services for the treatment of STIs, opportunistic infections and ARVs. It is not clear what the impact of VCT is on HIV negative young people in high prevalence resource-poor settings where there is limited access to services for prevention, treatment and care. It is also not clear what the impact of widespread VCT and HIV testing is on stigma and discrimination, although it is claimed to decrease. Programme experience suggests that expanding access to HIV testing does raise community awareness of HIV.

It is necessary to determine if adolescents are actually able to widely access VCT services developing countries, as policy and legal barriers may prevent very young or unmarried people from accessing either the testing or the counselling. Young people should not be excluded from access to testing, care or referral within health care facilities.

Young people 18 or over appear to be able to access PMTCT interventions, and many programmes are not focusing sufficient attention on the prevention options PMTCT offers for young people especially males.

Evidence suggests that there are no major differences in how HIV behaves in a biological sense for young people as compared with adults. The psychosocial impact and related care needs of HIV infected young people, and the impact that HIV has upon sexual and fertility related behaviour and adherence to HIV care interventions is not documented, especially in resource poor settings. There is a lack of evidence about the health care needs and experiences of delivering HIV related care to young people, particularly in resource poor settings. Currently even where services do exist, young people frequently do not access them.

HIV testing and care

Targets for 2005 **High prevalence settings:**	**Targets for 2005** **Low prevalence settings (with high rates in specific groups**	**Activities and priorities to accelerate action in countries**	**Key actions regionally/globally to support countries**
- All districts to have clear policies and procedures for HIV testing in young people, which stipulate that young people should not be excluded from testing facilities based upon age, and clearly outline practices and procedures on consent and confidentiality. - Establish multi-disciplinary district committees to supervise/register or accredit all testing services, and ensure that adequate standards, referrals, resources and linkages are in place for care and support. - Ensure one or more district level facility has staff trained to provide HIV testing and care to young people. - All pregnant women under 24 years of age are offered information, counselling, HIV testing and care interventions in antenatal settings.	- Information and counselling services about HIV and other sexual health issues are provided to all young people but with special efforts to reach high-risk young people. - As above for ANC services. - As above for policies and procedures. - As above for prevention and treatment services.	a. **Policies** - Ensure clear national policies and procedures for HIV testing in young people under the age of consent, and identify legal or procedural barriers to testing and care. - Involve national and international professional bodies in disseminating and lobbying for relevant standard setting and policy or legal changes. b. **Research** - Local situational assessment to identify whether young people are being denied services based upon age, sex and/or marital status, especially in existing ANC settings and pregnancy related services. - Explore the impact of HIV testing on sustained sexual behaviour, and access to treatment and care (for those who are HIV positive and those who are HIV negative). - Determine the impact of counselling plus effective referral versus classical VCT model (counselling and testing), particularly the impact of testing on the sexual behaviours and STI rates of young people who are HIV negative. - Conduct operational research and further evidence on mobile HIV. counselling and testing, referral and rapid testing.	**Policies and procedures** -Develop an inventory of international commitments/statements and national policies, standard operating procedures and practice guidelines for medical and non medical staff upon key elements of informed consent for HIV testing in minors under age of consent - Develop and disseminate a model policy for access to all HIV information and services for young people regardless of age, sex or marital status - Perform comparative analysis to identify key elements for international guidance based upon principles of public health and rights -Review existing UN/WHO and key international HIV testing and care guidelines and tools for appropriateness for young people, specifically adolescents

Targets for 2005 High prevalence settings:	Targets for 2005 Low prevalence settings (with high rates in specific groups	Activities and priorities to accelerate action in countries	Key actions regionally/globally to support countries
- All pregnant females under 24 years diagnosed HIV positive are provided access to ongoing medical care throughout and after pregnancy. - All pregnant females under 24 years diagnosed HIV negative are provided with HIV prevention information and counselling, and referral to appropriate services and supplies to remain negative. - 90% of staff providing ANC counselling and testing are trained in dealing with young people. - 90% of HIV testing services have staff trained in delivery of adolescent friendly health services. - Home care services are established or adapted at district level that includes young people (as recipients and resources).		- Collect data on costs and evidence of impact of using lay and peer counsellors on sexual behaviour, STI/HIV incidence, and patterns of testing. c. **Programme support**- Establish district level multi-sectoral supervision and or registration or accreditation for HIV testing centres (to ensure that testing does not take place without adequate information and counselling, care and support services and age, sex or marital status are not used as barriers to services; and that local networks for HIV care are developed, sustainably resourced, and linked to community support and actions to decrease stigma). - National AIDS Programmes should develop terms of references and criteria for membership or accreditation or registration for these committees. - Existing training tools and other programme support materials need to be examined to see if they are relevant for young people, particularly adolescents. d. **Training** - All pre-service and in service training of HIV counsellors needs to include skills and competencies to ensure staff are able to address sexuality and HIV in adolescents.	**Research** - Collate and synthesize the evidence of the impact of VCT on the HIV/AIDS prevention and care elements for young people, including where available determining the counselling and testing components, in different epidemiological settings and phases of the epidemic. - Operations research to document experiences of access and needs of young people and approaches to ensure equity in HIV testing and care service provision. - Conduct specific formative research into adherence and longer term behavioural effects of HIV testing in adolescents. **Mobilize resources :** - To support the global research agenda. - To develop technical capacity to scale up care and support. - To provide countries with support to conduct basic research and analysis of HIV care and support systems for young people.

Annex 3 - Final meeting agenda and list of participants

Time	Day 1 - Chair: Jane Ferguson Session	Persons
09.00	Introductions and working methods	Bruce Dick, WHO
09.30	Overview of HIV in young people	Txema Callejas, WHO
10.00	Overview of Adolescent Friendly Health Services - what we know, what we don't know	V Chandra Mouli, WHO
10.30	Tea/coffee	
11.00	Condoms	Julitta Onabanjo, UNFPA
11.15	Harm reduction	John Howard,TedNoffs
11.30	STI care and treatment	Siobhan Crowley, WHO
11.45	Mobile discussions - All	Rapporteurs STI – Chandra Mouli Condoms - Richard Mabala, UNICEF Harm reduction - Bruce Dick
12.15	Feedback from mobile discussion	Rapporteurs
14.00	HIV testing and counselling	Siobhan Crowley
14.15	Prevention of mother to child transmission	Peggy Henderson, WHO
14.30	Information and counselling	Richard Mabala Kirstine Nojgaard, UNICEF
14.45	HIV treatment and care	Siobhan Crowley
15.00	Mobile discussion of interventions	Rapporteurs PMTCT/VCT-Doreen Mulenga, AYA HIV care - Gottfried Hirnschall WHO & Viviane Castello Branco MoH Brazil Info and counselling - Kim Dickson Tetteh, RHFU
15.45	Tea/coffee	
16.15	Working groups - developing consensus around core health service interventions	A & B high prevalence C & D low prevalence

Time	Day 2 - Chair: Siobhan Crowley Session	Persons
08.30	Administration and feedback from day 1	Ears and Chair
09.00	Report back from working groups Reality check	
09.45	20 Minutes live from Montreux - reality of health services for young people	Ebrima Saidy, IPPF, Marcela Rueda IPPF, interviewed live by Holo Hachonda, JHU
10.15	Making the linkages - who is actually doing the work?	Peju Olukoya, WHO
10.45	Tea/coffee Strategies and settings for intervention delivery	
11.15	Government and private facilities	Kim Dickson, Joy Mukaire and Firewot Berhane, MOH Ethiopia
11.30	Outreach to vulnerable groups	Aurorita Mendoza,UNAIDS
11.45	Vouchers and demand side financing	Anna Gorter, Independent
12.00	Social marketing	Bruce Mackay, Futures Int.
12.15	Social franchising	Steve Lavake, YouthNet
12.30	Mobile discussion on strategies to deliver interventions	Rapporteurs Vouchers: Susan Adamchak, Pop Council Social marketing: Abu Faisel, EngenderHealth Social franchising: Julitta Onabanjo, UNFPA Outreach: Farah Usmani,UNFPA
13.00	Lunch	
14.15	Feedback from mobile discussions	
14.30	Working groups For interventions identified what are most effective strategies of delivery?	Bruce Dick
15.30	Tea/coffee	
15.45	Report back from working group	Bruce Dick
19.30	Dinner	All
20.00	Market place Group evaluation of available tools and resources	Stalls: ADO Health, Rio De Janeiro Brazil, WHO, UNICEF, UNFPA, MSI, Engender Health, Population Council, IPPF, RHRU (Lovelife/NAFSCI)

Time	Day 3 - Chair: Doreen Mulenga Session	Person
08.30	Administration and feedback from day 2	
09.00	Group work: By 2005 identify what health services at the district level should be able to do to reach the global goals: in the form of a target for health services groups A, B C and D	Bruce Dick
10.00	Plenary discussion Feedback from groups and synthesis of outputs	Group rapporteurs
10.30	Tea/coffee	
11.00	Group work: What action needs to be taken in countries to achieve these targets in relation to: ▪ Information and counselling ▪ Condoms ▪ Sexually transmitted disease care ▪ Harm reduction ▪ VCT and HIV care In particular consider the technical assistance needs, programme support tools, capacity development research questions and identify other crosscutting issues	Self selecting groups based upon interest expertise
12.30	Lunch	
13.30	Feedback from groups Plenary discussion	Group rapporteurs
15.30	Tea/coffee Characteristics of effective programmes	
16.00	Advocacy and engaging communities	Akinyele Dairo, UNFPA
16.15	Participation of young people	Shyam Thapa, YouthNet
16.30	Training and supervision	Abu Faisel
16.45	Supplies and commodities	Helene Moller, UNICEF
17.00	Questions and answers	
	Day 4 Chair: Bruce Dick	
Time	Session	Person
08.30	Evaluation and feedback from day 1, including the multi- sexual approach	Ears and chair
09.00	Group work Key elements for a 12 month action plan	
10.00	Report back from groups	Intervention group rapporteurs
10.30	Tea/coffee	
11.00	Identifying levers and opportunities	
12.00	Evaluation of the consultation	Bruce Dick
12.30	Closing and thanks	Jane Ferguson

Consultation on the health services response to the prevention and care of HIV/AIDS among young people

List of Participants

Dr Lucille C. Atkin
Program Director
Margaret Sanger Center International
Planned Parenthoood of NYC
26 Bleecker Street
New York NY 10012
Tel +1 (212) 2747272
E-mail: lucy.atkin@ppnyc.org

Dr Susan Adamchak
Senior Associate for Global Operations Research
Frontiers in Reproductive Health
Family Health International/Population Council
4301 Connecticut Ave. N.W., Suite 280
Washington D.C. 20008, USA
Telephone: +1 202-237-9400
Facsimile: +1 202-237-8410
E-mail: sadamchak@pcdc.org

Dr Doris Bartel
Regional Advisor for Reproductive Health CARE
1625 K St. NW
Washington, DC, 20006
Tel: +1 202 595 2804
Fax: +1 202 296 8695
Email: dbartel@dc.care.org

Dr Loretta Brabin
Reader, Women's Health
Academic Unit of Obstetrics & Gynaecology & Reproductive Health Care
Whitworth Park
Manchester M13 OJH
Tel: +44 161-276 6388/6446
Fax: +44 161-276-6134
E-mail loretta.brabin@man.ac.uk

Ms D. Braeken-Van Schaik
Medical Technical Unit IPPF
IPPF, Regents College
Regents Park
Inner Circle
London NW1 4NS
Tel +44 207 4877836
Fax: +44 207 4877865
E-mail: dbraeken@ippf.org

Dr Kim Dickson
Reproductive Health Research Unit (RHRU)
Department of Obstetrics and Gynaecology
Chris Hani Baragwanath Hospital
PO Bertsham 2013 South Africa
Tel: +27 11989 9207
Fax: +2711989 9298
E-mail: kimdt@rhrujhb.co.za

Dr Anna Gorter
Beryldijk 4
4706 EA Roosendaal
The Netherlands
Tel/fax: +31 165 561405
E-mail: agorter@ibw.com.ni

Ms Sophia Henderson
Health and HIV/AIDS Adviser
Africa Policy Department
UK Department for International Development
1 Palace Street
London SW1E 5HE
Tel: +44 (0) 207 023 1636
Fax: +44 (0) 207 023 0342

Dr John Howard
Director Clinical Services, Training & Research
Ted Noffs Foundation
PO Box 120
Randwick, NSW 2031
Australia
Tel: +61 02 9310 0133
Fax: +61 02 9310 0020
E-mail: howardj@noffs.org.au

Mr Bruce Mackay
Futures Group Europe
Director of Programmes & Research
2nd Floor, Edgar Buildings
17 George Street
Bath BA1 2EN, England
Tel: +44 (0) 1225 321840
fax: +44 (0) 1225 443656
email: b.mackay@tfgi.com

Mr Steven LaVake
Private Sector Involvement
YouthNet Project (seconded from DTT)
2101 Wilson Boulevard, Suite 700
Family Health International
Arlington, VA 22201,U.S.A.
Telephone: +1703 516-9779 ext. 143
Fax: +1 703 516-9781
E-Mail: SLaVake@fhi.org

Mr Holo Muchangwe Hachonda IV
Youth Communications Coordinator
Johns Hopkins University Field Office
Zambia Integrated Health Programme
Red Cross House, Los Angeles Boulevard
Long Acres PO Box 37230, Lusaka
Tel: +260 1 254 555
Fax: +260 1 253 839
E-mail: holoh@zihp.org.zm

Joy Mukaire
Country Director
Pathfinder
African Youth Alliance (AYA) Project
2 Kafu Road, Nakasero
Uganda
P.O. Box 29611 KI
Tel: +256 41 255940\1
Fax: +256 41 255942
E-mail: jmukaire@pathfinder.org

DrDavid Ross
Reader in Epidemiology & International Public Health
London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT, UK
Tel: +44 (0) 20 7927 2264
Fax: +44 (0) 20 7636 8739
Email: david.ross@lshtm.ac.uk

Dr Shyam Thapa

Senior Scientist
YouthNet Program Department
Family Health International
2101 Wilson Blvd, Suite 700
Arlington, VA 22201
Tel: + 1 703 516 9779 x138
Fax: + 1 703 516 9781
E-mail: sthapa@fhi.org

Dr Irena Yacobson
YouthNet
Family Health International
2101 Wilson Boulevard, Suite 700
Arlington, VA 22201
USA
Email: iyacobson@fhi.org

UN Organizations

Gautam Babbar
Demand Reduction Section
Coordinator, global youth network
United Nations Office on Drugs and Crime - UNODC
P.O. Box 500 A-1400 Vienna, AUSTRIA
Tel: + 43 1 260604244
Fax: + 43 1 26060 5928/ 260607 4244
Email: gautam.babbar@unodc.org

Dr Akinyele Dairo
Senior Program Adviser
Africa Division
UNFPA
220 East, 42nd Street,
New York, N.Y. 10017 USA.
Tel: +1 212 2975162
Fax: + 1 212 297-4951
E mail: dairo@unfpa.org

Mr Richard Mabala
HIV/AIDS and Young People,
UNICEF Nairobi Regional Office,
Kenya
P. O. Box 44145
Nairobi, Kenya 00100
Tel: + 254 2 622 382
Fax: + 254 2 622 678/9
rmabala@unicef.org

Ms Aurorita Mendoza
Prevention and Vulnerability Adviser
Strategic Information Unit
UNAIDS Geneva
Tel: +41 22 7914508
E-mail: mendozaa@unaids.org

Dr Helene Moller
Technical Officer PMTCT and HIV/AIDS UNICEF Supply Division:
UNICEF Plads, Freeport
Copenhagen
DK-2100 Copenhagen, Denmark
Telephone +45 35 27 30 80
Fax: +45 35 26 94 21
E-mail: hmoller@unicef.org

Dr Doreen Mulenga
Project Officer HIV/AIDS PMTCT
UNICEF House
3 United Nations Plaza
New York, New York 10017
U.S.A.
Tel: +1 212 326 7192
Fax: +1 212 824 6460
Email: dmulenga@unicef.org

Ms Kirstine Nojgaard,
Adolescent Development and Participation,
HIV prevention among young people
UNICEF NYHQ
UNICEF House
3 UN Plaza
NY 10017
Tel: +1 212 326 7188
Fax: +1 212 824 6470
Email: knojgaard@unicef.org

Dr Julitta Onabanjo
HIV/AIDS Technical Officer
Technical Support Division
United Nations Population Fund (UNFPA)
220 East, 42nd Street,
New York, N.Y. 10017 USA.
Tel: +1 212 297 5262
Fax: +1 212 297-4908
E mail: onabanjo@unfpa.org

Dr Farah Usmani
Advisor RH and HIV/AIDS
CST UNFPA, Office for South & West Asia
P.O. Box 5940
Kathmandu, Nepal
Tel: No.: (977-1) 523-880
Fax: No.: (977-1) 527-257
E-mail: fusmani@unfpa.org.np

Ms Karina Vartanova
UNICEF Russia
Programme coordinator
Young People's Health and Development
Tel: +7 095 933-88-22/+7 095 933-88-18
Fax: +7 095 933-88-19
kvartanova@unicef.org

Representatives of governments/organizations involved in supporting the provision of health services to adolescents in selected countries

Bangladesh
Dr Abu Jamil Faisel
Country Representative
Engender Health
House # 52, Road # 15A (New)
Dhanmondi R. A.
Dhaka - 1205
Bangladesh
Tel: +880 2 8119234/8119236
Fax: +880 2 8119235
E-mail: afaisel@engenderhealth.org

Sri Lanka

Dr Dula Shanmukadatta de Silva
Deputy Director General of Health Services
No. 385, Ven. Baddega Wimalawansa Mawatha
"Suwasiripaya"
Colombo 10, Sri Lanka
Tel/Fax: + 941 674 682
E mail: dulads@yahoo.com

Viet Nam
Ms Margaret Sheehan
Technical Officer on Health Promotion
Contact address:
WHO Viet Nam
63 Tran Hung Dao, Ha Noi
PO Box 52
Tel: +84 4 9433734 (ext. 36)
Fax: + 84 4 9433740
Sheehanm@vtn.wpro.who.int

Brazil
Dr Viviane Castello-Branco
Co-ordinator of the programme for
Adolescent Health
Municipal Secretary of Health
Rua Benjamin Batista 204.202,CEP 22.461-120
Rio de Janeiro
Brazil
Tel: +55 21 22737398/5521 25032246 /
E-mail: vcbranco@pcrj.rj.gov.br

Ethiopia
Dr Firehiwot Berhane
BSS Research Project Manager
Addis Ababa University
Department of Community Health
PO box 13719
Addis Ababa, Ethiopia
Tel: +251 1 72 1193
Fax: +251 9 22 8524

Tanzania
Mr Maurice Hiza
Training Officer Reproductive & Child health Section
Ministry of Health
PO Box 9083,
Dar-es-Salam
Tanzania
Tel: +255 2152977
Email: mauricehiza@hotmail.com

Young people working in HIV and health service related projects

Ms Marcela Rueda Gomez
Latin American and Caribbean Youth Network
for Sexual and Reproductive Rights
Co-ordinator Colombian Peer Educator Network of Profamilia
220 42nd St 18 Floor UNFPA
Tel: 1 212 297 5191
Email: rueda@unfpa.org
marcela811@yahoo.com

Kisanbira Ezekile Kisirira
Youth Officer
Access for Youth project
Busoga Diocese
PO Box 1658
Jinja Bugmebe Hill
Uganda
Tel: +256 77 910 224
Fax: +256 77 449157
Email: tituskisa@yahoo.com.uk

Mr Ebrima Saidy
Assistant technical Officer, Youth
IPPF, Regents park Inner Circle
Regents College
London NW1 4NS
Tel Fax /: +44 207 487 7866+44 207 487 7865
Email: Esaidy@ippf.org

WHO
Headquarters:
Dr Monica Beg (HIV)
Dr V. Chandra Mouli (CAH)
Dr Gottfried Hirnschall (HIV - technical support)
Dr Ivan Lejnev (CAH - technical support)
Dr Peju Olukoya (CAH)
AFRO
Dr Antoine Serufilira
Adolescent Health Focal Point, AFRO
Brazzaville, Congo
Tel: 47 241 39114
Email: serafiliraa@afro.who.int

SEARO
Dr Patanjali Dev Nayar
Adolescent Health and Development, Focal Point
WHO SEARO, New Delhi
Tel: +91 11 237 0804
Email: nayarpd@whosea.org

WHO Secretariat:
Dr Siobhan Crowley (CAH)
Dr Bruce Dick (CAH)
Ms Jane Ferguson (CAH)

Mr Peter McIntyre
Freelance journalist and writer
21 Crown Street,
Oxford
OX4 1QG UK
Tel: +44 (0) 1865 721496
Fax: + 44 (0) 1865 721107
Mobile: +44 (0) 7961 173848
E-mail: petermcintyre@compuserve.com

Invited participants unable to attend:

Dr Getachew Gizaw
Senior Health officer - Global Programme on HIV/AIDS
International Federation of Red Cross and Red Crescent Societies
P.O Box 372, 1211 Geneva 19, Switzerland
Tel: + 41 (22) 730 42 22
Tel direct line. +41 (22) 7304474
Fax . +41 (22) 733 03 95
Email : **getachew.gizaw@ifrc.org**

Dr Ann P. McCauley
International Center for Research on Women
(seconded to Horizons Program)
Population Council, Suite 280
4301 Connecticut Avenue, N.W.
Washington, D.C.
U.S.A.
Tel: 202-237-9401
Fax: + 1 202-237-8410
Email: **amccauley@pcdc.org**

Dr Kwame Ampomah

UNAIDS CPA Botswana
c/o UNDP
Email: **kwame.ampomah@undp.org**

Dr Subhash Raghunath SALUNKE
Director-General
Directorate General of Health Services
Government of Maharashtra
Government Dental College Building (4th Floor)
St. George's Hospital Compound
Mumbai - 400 001
Tel: + 91 22 22621006, 22621031-35 (General)
Fax: + 91 22 22674480/91 22 22621062
Email: **dir001@vsnl.net**; **dir1201@vsnl.com**

Ms Laura Laski
Reproductive Health
Technical Support Division,
United Nations Population Fund (UNFPA)
220 East, 42nd Street, 22nd Floor
New York, N.Y. 10017 USA.
Fax: + 1 (212) 297-4908
E mail: **laski@unfpa.org**

Dr Natalie Broutet (WHO, RHR)

Christopher Armstrong
HIV/AIDS Policy Officer
Canadian International Development Agency (CIDA)
Tel.:. 819-994-3774
Fax: 819-953-8058
Email: **CHRISTOPHER_ARMSTRONG@acdi-cida.gc.ca**

Susan Igras
Senior Program Advisor for Reproductive Health, CARE
151 Ellis Street NE
Atlanta, GA 30303
Tel: + 1 404-979-9303,
Fax: + 1 404-589-2607
Email: igras@care.org

Josselyn Neukom
PSI Youth services
Technical services Division
Douglas House 1st Floor
16-18 Douglas Street
London SW1P 4PB
Email:**JNEUKOM@psi.org**

Robin Gorna
HIV Advisor
Department of International Development
1 Palace Street
London SW1E 5HE, UK
Tel: +44 (0) 20 7023 0000
Fax: +44 (0) 20 7023 0016
Email: R-Gorna@dfid.gov.uk

John W. Townsend
Snr Program Associate & Program Director,
International Programs Division, Population Council,
4301 Connecticut Ave. N.W.
Suite 280, Washington, D.C. 20008
Tel: +1 202 237 9400
Fax: +1 202 237 8410
Email: **jtownsend@pcdc.org**

Shanti Conly
Senior Technical Advisor
US Agency for International, Development, Population, Health and Nutrition Centre
Room 3.6.47, 1300 Pennsylvania Avenue NW,
Washington D.C. 20523-3600
USA
Tel: +1 202 712 0892
Fax: +1 202 216 3046
Email: **sconly@usaid.gov**

Annex 4 - List of presentation papers and resources from the consultation

The complete proceedings of the consultation are available in a web-based 'village' accessible on the World Wide Web at:

/http://www.mayeticvillage.com/QuickPlace/who-cah-development/main.nsf/h_Toc/4DF38292D748069D0525670800167212/?OpenDocument

To access the village you will need to use the user name and password provided below (both are case sensitive).

User name: MVGuest

Password: harrypotter

Within the village there are a number of background materials called discussion papers that were prepared for this consultation. You can use this workspace to read those papers on line or download them. In the meeting outputs section you will find a brief summary of each day with the presentations, the outputs of the group work and key related materials for the sessions. The summary report is also available for review. The village also provides useful links for the meeting organisers, and participating organizations.

A brief summary of the resources that are included in the village is provided below:

Day 1

Topic or session	**PowerPoint presentation**	**Documents**
Overview of the HIV epidemic in young people	PP_1	Note on PP_1
Adolescent-friendly health services	PP_2	Global consultation AFHS
Evidence of effectiveness of key interventions for prevention and care of HIV among young people, and experiences of delivering these interventions to young people		
Information and counselling	PP_3	BP_info and counselling
STI treatment and care	PP_4	BP_STI care
Condoms	PP_5	BP_condoms
Harm reduction	PP_6	BP_ harm reduction
HIV testing	PP_7	BP_HIV testing
HIV care	PP_8	BP_HIV care
PMTCT	PP_9	X
Intervention mix	PP_10	BP_choosing a package
Group work		Feedback on reviews of the evidence

DaY 2

Topic session	PowerPoint presentations	Documents
Who is actually doing the work?	PP_11	X
Social marketing	PP_12	BP_Social marketing
Social franchising	PP_13	BP_Social franchising
Vouchers	PP_14	BP_vouchers Notes on PP_14
Group work		Feedback from evidence reviews and prioritizing interventions

Days 3 and 4

Topic session	PowerPoint presentation	Documents
Community mobilization	PP_16	X
Participation of young people	PP_17	BP-youth participation
Supervision	PP_18	
Supplies	PP_19	
Health system definitions	PP_20	
Group work		Reports from groups examining interventions, harm reduction, STI, condoms, HIV testing and care
Miscellaneous	PP_VCT David Miller presentation	MDG Summary UNGASS Special session on HIV
Group work		Summary group work

If you need further information on the consultation or on the reports and resources, please contact:

Dr Siobhan Crowley, Medical Officer
Adolescent Health and Development
FCH/CAH, WHO
20, Avenue Apia
CH-1211 Geneva 27
Switzerland
Tel +41 22 791 1609
Fax +4122 791 4853
crowleys@who.int

Annex 5: Notes from '20 minutes live in Montreux'

Key issues to consider during the consultation: perspectives of young people

Notes from an interview with the young participants at the consultation, Ebrima Saidy and Marcela Rueda, conducted by Holo Hachonda

Youth diversity: that means to recognize young people as a heterogeneous group, with different sexual attitudes, sexual behaviour, sexual beliefs and with different needs in accordance with their age, gender, sexual orientation, education, religion, work, among others. We are not suggesting to have a different health package for each one, we are suggesting the importance to understand each group in order to reach them in a successful way. For example, we can not pretend to reach young boys with health services if we do t recognize that in many cultures sexual and reproductive health is understood as a "women concern", then, there are some beliefs based on sex and gender that present obstacles. We find many examples of differences among young people (gays, lesbians, out of school, sex workers, married, unmarried, non-sexual active youth and sexual active youth even same age)

Youth participation: It's necessary to involve youth in defining and determining youth-friendly health services. This entails involving youth in design, planning, implementation and evaluation of the health services. The youth clients could give inputs about the effectiveness of service provision. Traditionally, youth participation is considered with peer educators programs, but this is a short idea: youth participation also requires the young people vision in decision-making (gap)

We hate clinics: We don't feel comfortable going to clinics: places where there are sick people, a particular smell of drugs, places where you get lectured. We prefer friendly services where we find information, services, easy process, low prices, friendly people (including doctors, nurses, peer educators, other members of the staff, even the watchman should be sensitized) and where we don't feel afraid to express our doubts or questions and fears on sexuality. There are some useful and good experiences in Latin America in Mexico, Colombia, Peru, Trinidad and Tobago and other countries…young people find quality services, available, accessible and with comfortable buildings, places where they feel at home. They are offered by some NGO's.

Donors role: they apply standard strategies around the world. Even if we are developing countries and we are placed in Africa and South America, we have different social contexts, and these are important in what needs to be done and how. There isn't enough available money to evaluate youth projects (youth education, youth services) and donors should do more.

Youth rights: that means to understand that access to services, information and education are part of youth rights and this point also guarantees that young people can take their own decisions, with information and liberty. It's important for young people and adults to understand and recognize sexual and reproductive rights like human rights.

Annex 6: Additional references

Bell DN, Martinez J, Botwinick G, Shaw K, Walker LE, Dodds S, Sell RL, Johnson RL, Friedman LB, Sotheran JL, Siciliano C. Case finding for HIV-positive youth: a special type of hidden population. Journal of Adolescent Health. 2003 Aug; 33(2 Suppl):10-22

Creese A, Floyd K, Alban A, Guinness L. Cost effectiveness of HIV/AIDS interventions in Africa: a systematic review of the evidence. Lancet; vol. 359; 2002

Hedberg VA, Klein JD, Andresen E. Health counselling in adolescent preventive visits: effectiveness, current practices, and quality measurement. Journal of Adolescent Health. 1998 Dec;23(6):344-53

Jemmott JB and LS. AIDS 2000 HIV risk reduction behavioural interventions with heterosexual adolescents. AIDS 2000, 14 (suppl) 2: S40s52

Johnson BT, Carey MP, Marsh KL, Levin KD, Scott-Sheldon LA. (2003). Interventions to reduce sexual risk for the human immunodeficiency virus in adolescents, 1985-2000. A research synthesis. Arch Pediatric Adolesc Med. Vol. 157, Apr 2003.

Johnson RL, Botwinick G, Sell RL, Martinez J, Siciliano C, Friedman LB, Dodds S, Shaw K, Walker LE, Sotheran JL, Bell D. The utilization of treatment and case management services by HIV-infected youth. Journal of Adolescent Health. 2003 Aug; 33(2 Suppl):31-8.

Martinez J, Bell D, Dodds S, Shaw K, Siciliano C, Walker LE, Sotheran JL, Sell RL, Friedman LB, Botwinick G, Johnson RL. Transitioning youths into care: linking identified HIV-infected youth at outreach sites in the community to hospital-based clinics and or community-based health centres. Journal of Adolescent Health. 2003 Aug; 33(2 Suppl):23-30.

Merson M, Dayton J and Reilly K. AIDS 2000, Effectiveness of HIV prevention interventions in developing countries. AIDS 2000, 14 (suppl 2) s68-s84

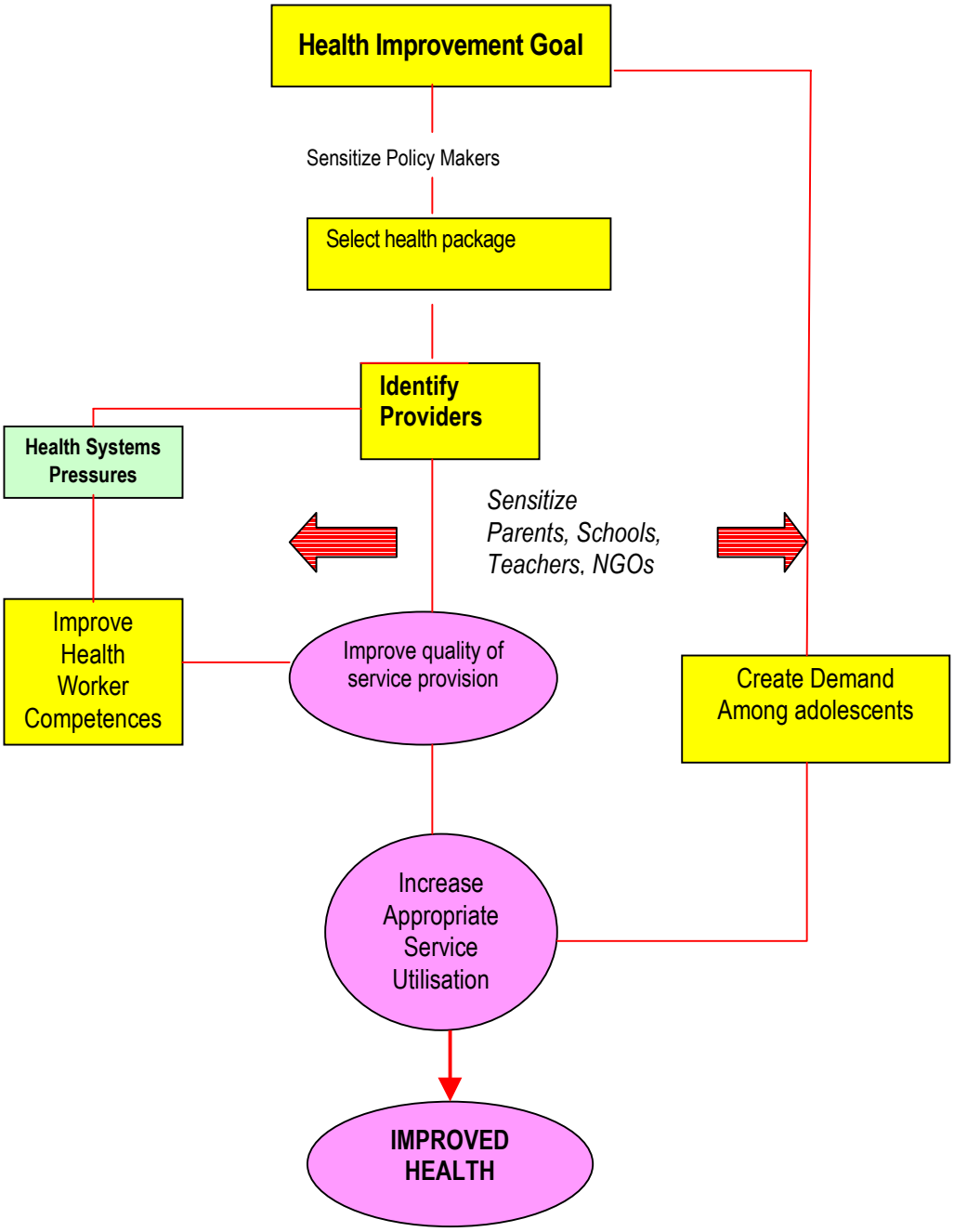
Moos M, Bartholemew N, Lohr K. Contraception 2003, Counselling in the clinical setting to prevent unintended pregnancy: an evidence based research agenda. 67;115-132.

Walker D. 2003. Cost and cost effectiveness of HIVAIDS prevention strategies in developing countries: is there an evidence base? Health Policy and Planning ;18(1):4-17

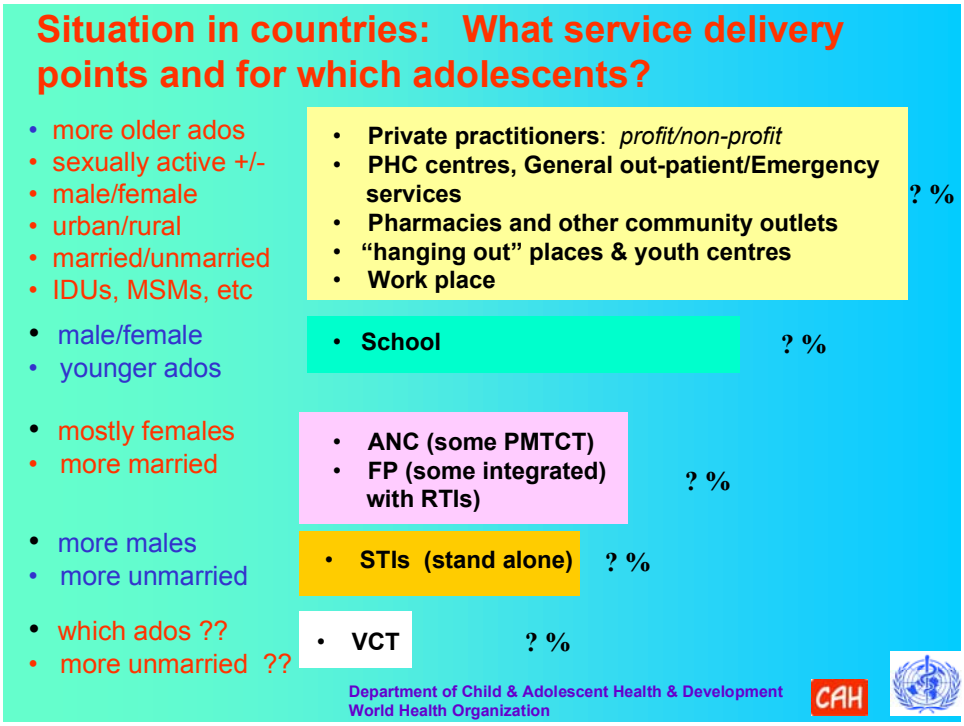
Wendell DA, Cohen DA, LeSage D, Farley TA. Street outreach for HIV prevention: effectiveness of a state-wide programme. International Journal of STD and AIDS. 2003 May; 14(5):334-40.

Annex 7. Selecting interventions; a visual guide

ADOLESCENT HEALTH IMPACT MODEL (Brabin et al, 2002)



Annex 8 : Who is doing the actual work
(from the presentation made by Dr Olukoya at the consultation)



For further information please contact:

Department of Child and Adolescent Health and Development (CAH)

World Health Organization
20 Avenue Appia
1211 Geneva 27
Switzerland

Tel +41-22 791 3281
Fax +41-22 791 4853

website: http://www.who.int/child-adolescent-health

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