

HEALTH, RIGHTS AND WELL-BEING

A Practical Tool for HIV and Sexual and Reproductive Health Programmes with Young Key Populations in Eastern Europe and Central Asia



TABLE OF CONTENTS

ACKNOWLEDGEMENTS	4	SERVICES	73
ABBREVIATIONS	6	HIV PREVENTION	76
DEFINITIONS OF KEY POPULATIONS	7	4.1.1 Condoms and lubricant	76
GLOSSARY OF OTHER TERMS	8	4.1.2 Pre-exposure prophylaxis (PrEP)	78
HOW TO USE THIS TOOL	9	4.1.3 Post-exposure prophylaxis (PEP)	80
		4.1.4 Risk reduction and sexuality-related communication	80
INTRODUCTION AND BACKGROUND	11	4.1.5 STI prevention, screening and management	81
		HARM REDUCTION	85
YOUNG KEY POPULATIONS AND HIV RISK	14	4.2.1 Needle and syringe programmes (NSP)	86
THE EASTERN EUROPEAN		4.2.2 Opioid substitution therapy (OST)	89
AND CENTRAL ASIAN CONTEXT	15	4.2.3 Overdose management	90
SEXUAL AND REPRODUCTIVE		4.2.4 Addressing harmful drug and alcohol use	91
HEALTH AND RIGHTS	17	4.2.5 Further considerations	92
1.3.1 Human rights as the basis for sexual and reproductive rights	17	HIV TESTING SERVICES (HTS)	93
1.3.2 What are sexual and reproductive health and rights?	17	4.3.1 Approaches to delivering HTS	94
1.3.3 Why do sexual and reproductive health and rights matter?	18	SRHR SERVICES	96
PRINCIPLES FOR PROGRAMMING	20	4.4.1 Contraceptive choices and counselling	98
WITH YOUNG KEY POPULATIONS		4.4.2 Prevention and screening of HPV-related cancers	100
RESOURCES	22	4.4.3 Safe abortion services	101
		4.4.4 Prevention of perinatal transmission of HIV	102
COMMUNITY EMPOWERMENT, PARTICIPATION AND RIGHTS	23	4.4.5 Prenatal, newborn and infant care	103
COMMUNITY EMPOWERMENT		4.4.6 Gender-affirming services	105
AND CAPACITY DEVELOPMENT	24	HIV TREATMENT AND CARE	106
2.1.1 Community empowerment	24	4.5.1 Pre-ART care	106
2.1.2 Capacity development	30	4.5.2 Antiretroviral therapy	107
PARTICIPATION, RIGHTS		4.5.3 Viral load monitoring	107
AND SOCIAL INCLUSION	35	4.5.4 Adherence and retention	107
INFORMATION AND EDUCATION		4.5.5 Prevention, screening and management of common co-infections	109
FOR AN ENABLING ENVIRONMENT	38	OTHER CARE AND SUPPORT SERVICES	111
COMPREHENSIVE SEXUALITY EDUCATION (CSE)	40	4.6.1 Clinical care following violence	111
RESOURCES	44	4.6.2 Mental health	112
		4.6.3 Social services	113
LEGAL CONTEXT, STIGMA, DISCRIMINATION AND VIOLENCE	46	RESOURCES	114
THE LEGAL AND POLICY ENVIRONMENT	47	SERVICE DELIVERY	119
LEGAL REFORM	41	ACCESS TO SERVICES FOR YOUNG KEY POPULATIONS	121
3.2.1 Parental consent	54	SERVICE COORDINATION	127
ADDRESSING STIGMA AND DISCRIMINATION	57	SERVICE INTEGRATION	132
ADDRESSING VIOLENCE	59	SERVICE DECENTRALIZATION	135
3.4.1 Types of violence	59	COMMUNITY AND PEER OUTREACH	
3.4.2 Perpetrators	60	AND SUPPORT	138
3.4.3 Interventions to address violence	61	RESOURCES	144
SENSITIZING LAW ENFORCEMENT		ANNEX. FOCUS GROUP DISCUSSIONS WITH YOUNG KEY POPULATIONS TO DOCUMENT ACCESS AND BARRIERS TO SRHR AND HIV SERVICES	145
AND SERVICE-PROVIDERS	66		
3.5.1 Sensitizing law enforcement	66		
3.5.2 Sensitizing service-providers to work with young key populations	68		
RESOURCES	71		

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ABBREVIATIONS

ARV	antiretroviral	LGBTI	lesbian, gay, bisexual, transgender and intersex
CRC	Convention on the Rights of the Child	MSM	man who has sex with men/men who have sex with men
CSE	comprehensive sexuality education	MSMIT	Implementing comprehensive HIV and STI programmes with men who have sex with men: practical approaches for collaborative interventions (MSM implementation tool)
EECA	Eastern Europe and Central Asia	NGO	nongovernmental organization
EECARO	Eastern Europe and Central Asia Regional Office (UNFPA)	PEP	post-exposure prophylaxis
GLOBAL FUND	The Global Fund to Fight AIDS, Tuberculosis and Malaria	PrEP	pre-exposure prophylaxis
HBV	hepatitis B virus	SRH	sexual and reproductive health
HCV	hepatitis C virus	SRHR	sexual and reproductive health and rights
HIV	human immunodeficiency virus	STI	sexually transmitted infection
HPV	human papilloma virus	SWIT	Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions (sex worker implementation tool)
HTS	HIV testing services	TRANSIT	Implementing comprehensive HIV and STI programmes with transgender people: practical approaches for collaborative interventions (transgender implementation tool)
ICESCR	International Covenant on Economic, Social and Cultural Rights	UNAIDS	Joint United Nations Programme on HIV/AIDS
ICF	international charitable foundation	UNFPA	United Nations Population Fund
IDUIT	Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical approaches for collaborative interventions (injecting drug use implementation tool)	WHO	World Health Organization
IEC	information, education and communication		
IPPF	International Planned Parenthood Federation		
IPPF EN	International Planned Parenthood Federation European Network		
IUD	intrauterine device		

DEFINITIONS OF KEY POPULATIONS

Young people are those aged 10-24 years, as defined by the UNAIDS Interagency Working Group on Key Populations.¹ Within this age range, children are below the age of 18 years, unless, under the law applicable to the child, majority is attained earlier. **Adolescents** are those aged 10–19 years.

Key populations are those populations who are epidemiologically considered to be at higher risk of HIV in all parts of the world, and always include sex workers, men who have sex with men, transgender people, people who inject drugs and prison populations (people in detention and other closed settings). **Young key population** refers to an individual young person who is a member of a key population, or a young key population group as a whole.

Young people who sell sex refers to female, male and transgender people 10–24 years of age, including children aged 10–17 who are sexually exploited and adults aged 18–24 who are sex workers. **Sex workers** (female, male or transgender adults aged 18 and above) receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work may vary in the degree to which it is “formal”, or organized.

Young men who have sex with men (MSM) refers to all young males who engage in sexual or romantic relations with other males. The words “men” and “sex” are interpreted differently in diverse cultures and societies, as well as by the individuals involved. “Men who have sex with men” includes not only those who self-identify as gay or homosexual and have sex only with others of the same sex, but also bisexual men, and those who self-identify as heterosexual (and who may marry and father children) but who also have sex with others of the same sex.

The abbreviation “young MSM” is used in this tool to avoid the confusion that would arise by writing “young men who have sex with men” when referring to males under the age of 18.

Young transgender people is an umbrella term for all young people whose internal sense of their gender (their gender identity) is different from the sex they were assigned at birth. Someone born female who identifies as male is a transgender man/boy. A transgender woman/girl is someone born male who identifies as female. Transgender people may choose a variety of terms to describe themselves, including “trans”, “trans man”, “trans woman”, or simply “male” or “female”. In some cultures specific indigenous terms may be used. Young transgender women and young transgender men who have sex with men are most affected by HIV, but all transgender people have particular sexual and reproductive-health vulnerabilities and needs.

Young people who inject drugs refers to young people who inject non-medically sanctioned psychotropic (or psychoactive) substances. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. (This definition of injecting drug use does not include people who self-inject medicines for medical purposes, referred to as “therapeutic injection”, nor individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body-shaping or for improving athletic performance.) Although this tool focuses on people who use injecting drugs, young people who use other non-injecting drugs may also be vulnerable to HIV, for example because of the effects of some drugs on sexual desire or decision-making capacities.

Young people in detention refers to young people in any stage of the criminal justice system during which they are deprived of their liberty, including detention at a police station, in a jail while awaiting charges or trial, or imprisonment following conviction. Detention also refers to immigration detention centres, juvenile detention centres, and so-called drug detention or rehabilitation centres. Young people in detention are characterized by relatively high prevalence of HIV, hepatitis B and C and tuberculosis, and relatively higher risks for transmission, as well as less access to health services.

¹ / Young people most at risk of HIV: a meeting report and discussion paper from the Interagency Youth Working Group. U.S. Agency for International Development, UNAIDS Inter-Agency Task Team on HIV and Young People, and Family Health International. Research Triangle Park (NC): Family Health International; 2010. Available at: <http://www.unfpa.org/resources/young-people-most-risk-hiv>

GLOSSARY OF OTHER TERMS

Community: In most contexts in this tool, “community” refers to key populations or young key populations, rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, “community members” are (young) members of a key population, “outreach to the community” means outreach to (young) members of a key population, and “community-led interventions” are interventions led by (young) members of a key population.

Community outreach worker means a person from a key population who conducts outreach to other people from the same key population, and who may or may not be paid as full-time staff of an HIV intervention (full-time staff might be called “staff outreach workers” or simply “outreach workers”). Community outreach workers may also be known by other terms, including “peer outreach workers”, “peer educators” or “outreach workers”. However, the terms “peer” or “community” should not be understood or used to imply that they are less qualified or less capable than staff outreach workers, and they should receive appropriate compensation for their work.

Drop-in centre is a place where young key populations may gather to relax, meet other community members, and hold social events, meetings or training.

LGBTI refers to lesbian, gay, bisexual, transgender and intersex people. Although it is preferable to avoid abbreviations whenever possible, LGBT (or LGBTI) emphasizes a diversity of sexuality, gender identities and sex characteristics.

The letter “**Q**” is sometimes added to the end of the acronym, meaning either “queer” or “questioning”. Young people may question their sexuality or gender, along with the diverse areas related to it, as they explore and construct their identity, particularly during adolescence. The use of “queer” may reflect this ongoing exploration and a choice not to apply a more specific label to themselves.

HOW TO USE THIS TOOL

CHAPTER 1 of this tool introduces the key issues of HIV risk and sexual and reproductive health needs of young key populations, especially in the Eastern Europe and Central Asia Region (EECA). It also enumerates the most important principles for programming with young key populations. The topics covered in the following chapters of the tool are shown in Figure 1. Community empowerment, participation and rights (**CHAPTER 2**) is foundational for all programming with young key populations. The legal context of young key populations and issues of stigma, discrimination and violence are

described in **CHAPTER 3**; while these may be familiar to those involved in on-the-ground programming, there is an ongoing need for advocacy with government and other service-providers who may not be as aware. The minimum package of comprehensive HIV and SRHR services for young key populations is described in **CHAPTER 4**, and **CHAPTER 5** discusses issues concerning effective service delivery. Each chapter ends with a list of key resources addressing the specific topics covered in that chapter.

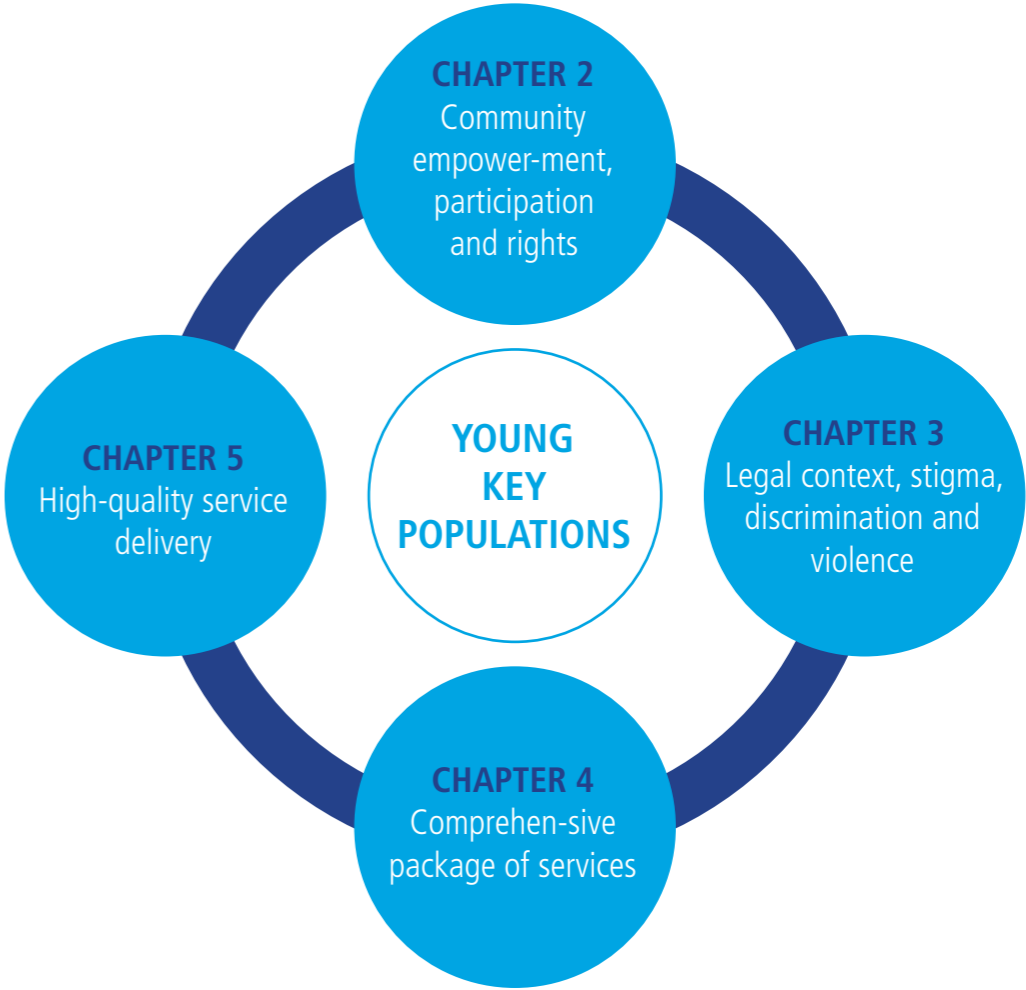


Figure 1. **STRUCTURE OF THE TOOL**

**THROUGHOUT THE TOOL, COLOURED BOXES
ARE USED TO PRESENT DIFFERENT KINDS OF INFORMATION :**

VOICES OF YOUNG KEY POPULATIONS

Quotations taken from focus-group discussions with young people in the EECA Region, led by UNFPA and IPPF (see the Annex for more details).

RECOMMENDATIONS

Relevant, evidence-based or evidence-informed recommendations appearing in published guidelines or other authoritative publications.

GOOD PRACTICE

Programming suggestions or overarching principles appearing in published guidance.

CASE EXAMPLES

Illustrative examples of programming with young key populations from the EECA Region or other parts of the world. Many of these were provided by the contributors listed in the Acknowledgements. Where the source is another published document, this is indicated in the box.

INTRODUCTION AND BACKGROUND

Young people aged 10–24 years constitute one-quarter of the world’s population, and they are among those most affected by the global epidemic of human immunodeficiency virus (HIV). In 2015 an estimated 3.9 million people aged 15–24 were living with HIV, 80,000 of them in the Eastern Europe and Central Asia (EECA) Region. Young people aged 15–24 made up almost one-third (670,000) of the 2.1 million people who became infected with HIV in 2015, and 23,000 of them were living in the EECA Region.²

Young people are particularly vulnerable to HIV for a number of reasons. These include lack of access to comprehensive sexuality education (CSE) and to protection commodities such as condoms and lubricant; lack of access to services for sexual and reproductive health (SRH), often because of laws requiring parental consent for health care; power imbalances in relationships; sexual violence; and the desire of some adolescents to experiment with sexual or drug-using behaviours at an age when they may not be equipped to make fully informed decisions about risk.

Young people who are members of key populations—i.e. sex workers of all genders, men who have sex with men (MSM), transgender people, people who inject drugs and people in detention (prison or other closed settings)—are especially vulnerable to HIV in all epidemic settings. This is due to widespread discrimination, stigma and violence, and potential alienation from family and friends. In many cases, young key populations are also made more vulnerable by policies and laws that demean, criminalize or penalize them or their behaviours, and by education and health systems that ignore or reject them and that fail to provide the information, services and treatment they need to keep themselves safe. These factors increase the risk that they may engage - willingly or not - in behaviours that put them at risk of HIV, such as unprotected sex, and sharing needles and syringes to inject drugs.

All these factors are evident in countries of the EECA Region. Organizations working on HIV and sexual and reproductive health and rights (SRHR) must engage with a complex environment where governments and civil society face significant political, economic and social constraints in openly addressing these issues.

This tool is designed to support the development of regional and country programming plans for HIV and SRHR for young key populations in the EECA Region by the United Nations Population Fund (UNFPA) and International Planned Parenthood Federation (IPPF) and their partners. It is based on work done by UNFPA, IPPF and partners across eight countries in the EECA Region. It describes the context in which such services are to be developed, and strategies to address essential issues of empowerment, participation and rights, and to confront stigma, discrimination and violence. It outlines a comprehensive package of services for young key populations and the ways in which they can be delivered. Examples of services for young key populations from the region and around the world are included.

This tool is designed for use by public-health officials and managers of HIV and SRHR programmes; nongovernmental organizations, including community and civil-society organizations; and health workers. It may also be of interest to international funding agencies, health policy-makers and advocates.

Key publications that underpin this tool include the four key populations implementation tools (the SWIT, MSMIT, TRANSIT and IDUIT) and the four technical briefs on young key populations and HIV, published by the UNAIDS Interagency Working Group on Key Populations.³ These publications are based on recommendations endorsed by all major United Nations agencies working on HIV and the health and rights of young people. They provide a basis for evidence-informed, human-rights-based programming in the EECA Region. Details of these and other documents mentioned in this chapter that address HIV and key populations at the global level are given in Section 1.5. (Additional reading and resources are listed at the end of each chapter.)

This tool also builds on the work of UNFPA and IPPF in the EECA Region. In 2015 UNFPA and IPPF convened focus group discussions with young key populations aged 18-24 in eight countries - Albania, Bosnia and Herzegovina, Georgia, Kyrgyzstan, Serbia, Tajikistan, the former Yugoslav Republic of Macedonia, and Ukraine. For ethical reasons, adolescents under the age of 18 were not included in the focus group discussions. The aim was to document the needs of young key populations and their experiences in accessing SRHR and HIV services, and in particular the barriers and challenges that they faced, in order to support their overall health and well-being. Discussions were held with young key populations in each country, led by a trained facilitator from organizations of key populations, together with country-level UNFPA HIV focal points. Topics covered included:

- Social and cultural context of young key populations
- Access and availability of SRH and HIV services
- Legal context, discrimination and violence
- Participation and rights
- Key recommendations to address main barriers to accessing SRH/HIV services for young key populations.

Following the focus group discussions, two regional consultations were held, in Tbilisi in November 2015 and in Kyiv in 2016, bringing together government, young key populations, regional networks of key populations, health-service-providers, UNFPA and IPPF (at country, regional and global levels).

There has been meaningful participation of young key populations throughout the development of this tool and in the development of country-level action plans: their experiences inform much of the text.

2 / <http://aidsinfo.unaids.org/> - 3 / See Section 1.5, Nos. 1-8.

YOUNG KEY POPULATIONS AND HIV RISK

Relatively few data are available on the prevalence of HIV among young key populations, and this in itself indicates the lack of attention to the issue. However, what data there are suggest that HIV is more prevalent among young members of key populations than among their older counterparts. HIV prevalence among young female sex workers in Cambodia was found to be 23%,⁴ and among young male sex workers in Mexico City it was 38%.⁵ Among young MSM, HIV prevalence has been estimated globally at 4.2%,⁶ and among young transgender women, the global estimate is 19%.⁷

Data on HIV prevalence among young key populations in the EECA Region are incomplete, but underlying trends suggest that prevalence is also high. In Ukraine, for example HIV prevalence among key populations as a whole is estimated at 7.3% for female sex workers, 5.9% for men who have sex with men, and 19.7% for people who inject drugs (there are no estimates for transgender people).⁸ Reported syphilis prevalence across 12 EECA countries in 2006-2012 ranged from 0.6% (Belarus) to 23.8% (Georgia) among sex workers, while among men who have sex with men the range was 0.5% (the former Yugoslav Republic of Macedonia) to 31.4% (Georgia).⁹

Young key populations are known to be at greater vulnerability for HIV infection than their older counterparts through a series of biological, behavioural, social and structural issues, often interlinked. Biological and behavioural vulnerability and risk factors for HIV include inconsistent use of condoms and lubricant. For young MSM or transgender individuals who engage in unprotected receptive anal intercourse, the risk of HIV infection is particularly high, but it is significant for people having unprotected vaginal intercourse too. Intercourse without a condom also puts young people at risk of other sexually transmitted infections (STIs). In the case of young people who inject drugs, sharing non-sterile injecting equipment presents a high risk of transmitting HIV as well as hepatitis C virus. Such risk behaviours may be driven by factors associated with adolescence, such as experimentation, a different understanding of risks and consequences, and vulnerability to manipulation or peer pressure. The use of drugs or alcohol may also impair decision-making abilities.

However, it is important to be aware of the social and structural factors that often lie behind high-risk sexual or drug-using behaviours. First, young people who start selling sex, practising same-sex sex or using drugs are extremely vulnerable to HIV because of their age, the stigmatization of their behaviour or sexual/gender identity and a lack of knowledge about ways to protect themselves. Young people may be unaware or poorly informed about the risk of HIV and other STIs because of a lack of CSE, or inadequate harm reduction information regarding drug use. Second, SRHR services, including prevention commodities (condoms, lubricant, sterile injecting equipment) may be unavailable or too expensive for young people. Third, in the case of young sex workers, economic need often leads to sex with a large number of clients and makes them vulnerable to offers of higher pay for unprotected sex, or threats of violence if they refuse. Fourth, those under the age of 18 may be unable to access medical or social services without the permission of a parent or guardian, to whom they may be unwilling to disclose their SRH needs or their identity as a key population member. Untreated STIs like herpes and syphilis can in themselves increase the risk of HIV acquisition at least threefold. And fifth, health and social services may also be difficult to access because of their location or opening hours, or because they are not designed to serve young people, or are unprepared to address the specific needs of young key populations.

Just as importantly, the severe stigmatization or criminalization of drug use, selling sex, same-sex behaviour or transgender identity in the EECA Region makes it still harder for members of key populations to access prevention commodities and SRHR services even where these are available. Young people may be refused such services if they reveal their identity as a key population, or fear that they will be reported to the police if they do so. For many young key populations, a justified fear of violence makes it harder for them to refuse invitations or demands for unsafe sex, or indeed to seek the protection and services they need. They may experience violence—including sexual assault—not only at the hands of sex-work clients, intimate partners, family members or members of the public, but also from law-enforcement authorities and sometimes even health-care providers.

The stigmatization of young key populations—which is itself a form of violence—and their social and economic marginalization includes the bullying of young MSM and transgender people, and can lead to them dropping out of school or other forms of education (particularly young MSM and transgender people who are bullied because of their perceived difference from “normal” appearances or behaviours). They may become unemployed or homeless, and thus more vulnerable to violence or more likely to sell sex. Unsurprisingly, the experiences of marginalization, stigma, discrimination and violence can also lead to significant mental-health problems. Foreign citizens or internal migrants are often also marginalized and excluded from access to medical and social services. Finally, many young key populations experience overlapping vulnerabilities. For example, a young MSM might face bullying at school, violence at home, a lack of relevant information about sexual health, depression, drug or alcohol use, and involvement in selling sex. Young members of other key populations may also have multiple vulnerabilities of their own. For the purpose of planning programmes at the national level, and delivering services on the ground, it is therefore important to see young people holistically and not assume that they can easily be divided into separate key populations.

Underlying these vulnerabilities is the frequent failure of governments and legal, educational and health-care systems to take young people seriously and devote the appropriate resources and attention to them. Governments have a legal obligation to respect, protect and fulfil the rights of children to life, health and development, and indeed, societies share an ethical duty to ensure this for all young people. This includes taking steps to lower their risk of acquiring HIV, and to safeguard and improve their SRHR.

THE EASTERN EUROPEAN AND CENTRAL ASIAN CONTEXT

Eastern Europe and Central Asia is the only region in the world that did not achieve Millennium Development Goal 6A on halting and reversing the AIDS epidemic. While the overall global number of HIV infections has declined by 35% since 2000, at the end of 2015 the overall trend of new HIV infections in the World Health Organization (WHO) European Region continued to increase, with 190,000 new infections in 2015. The region has among the lowest rates of antiretroviral therapy (ART) coverage, at 21%, along with high rates of late HIV diagnosis and HIV-related deaths. In 2014, 96% of all new infections in the region were among key populations and their sexual partners.¹⁰

The high rate of new HIV infections indicates that existing HIV prevention programmes, including harm reduction, condoms, and formal and non-formal sexuality education, have not had sufficient coverage or intensity to stem the spread of HIV. Alarming, around half of all people estimated to be living with HIV across the region have not been tested for HIV and do not know they are infected. However, significant progress has been made in all United Nations Member States in the European Region in preventing perinatal transmission of HIV, thanks to high coverage of HIV testing and antiretroviral prophylaxis for pregnant women living with HIV (>95% in the majority of countries).

HIV transmission in most countries in the EECA Region occurs overwhelmingly through sexual transmission. Given the low testing rates among men who have sex with men, transgender people, young key populations, and migrant men returning from the Russian Federation and Europe, the proportion is likely to increase. Currently, 51% of all new infections in the WHO European Region occur through injecting drug use. This reflects the high rates of HIV among people who inject drugs in the Russian Federation, although rates have decreased significantly in many other countries in the region, thanks to the success of harm reduction programmes.

Countries in the EECA Region continue to face a number of significant gaps in being able to fast-track their HIV response, which is a part of ending AIDS by 2030—the new HIV-specific target in the United Nations Sustainable Development Goals (Goal 3.3). All countries

4 / Couture MC, Sansothy N, Sapphon V, Phal S, Sichan K, Stein E, et al. Young women engaged in sex work in Phnom Penh, Cambodia, have high incidence of HIV and sexually transmitted infections, and amphetamine-type stimulant use: new challenges to HIV prevention and risk. *Sex Transm Dis.* 2011;38(1):33–9. - 5 / Galárraga O, Sosa-Rubí SG, González A, Badial-Hernández F, Conde-Glez CJ, Juárez-Figueroa L, et al. The disproportionate burden of HIV and STIs among male sex workers in Mexico City and the rationale for economic incentives to reduce risks. *J Int AIDS Soc.* 2014;17(1):19218. - 6 / The gap report. Geneva: Joint United Nations Programme on HIV/AIDS; 2014. http://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report - 7 / Baral SD, Poteat T, Strömdahl S, Wirtz AL, Guadamuz TE, Beyrer C. Worldwide burden of HIV in transgender women: a systematic review and meta analysis. *Lancet Infect Dis.* 2013;113(3):214–22. - 8 / <http://aidsinfo.unaids.org/> - 9 / Report on global sexually transmitted infection surveillance 2013. Geneva: World Health Organization; 2014. <http://www.who.int/reproductivehealth/publications/rtis/stis-surveillance-2013/en>

10 / Global AIDS Update 2016. Geneva: Joint United Nations Programme on HIV/AIDS; 2016. <http://www.unaids.org/en/resources/documents/2016/Global-AIDS-update-2016>

in the region need to scale up targeted, combination HIV prevention programmes, with a particular focus on harm reduction, condom and lubricant programming, community empowerment, addressing stigma and gender-based violence and gender inequality, and the SRH of key populations, young key populations (including migrant men) and their sexual partners. This must be contextualized within local and regional sexual norms, including that the vast majority of men who have sex with men in the EECA Region are also married to women, or will be expected to marry women, and fathers to children. The review of laws and policies that impede service access and uptake also remains a priority.

All countries in the region must accelerate progress to reach the UNAIDS “90–90–90” targets by 2020: 90% of people knowing their HIV status; 90% of people who know their status receiving treatment; and 90% of people on HIV treatment having a suppressed viral load so that their immune system remains strong and they are less likely to be infectious. This will require an accelerated and simplified approach to HIV testing, including the removal of age and parental consent barriers, accessing SRHR services, and the immediate provision of ART for everyone with an HIV diagnosis. Integrated and localized service provision for HIV, SRHR, tuberculosis, viral hepatitis and STIs is critical, as is scale-up of condom and lubricant programming to reduce onward transmission of HIV and STIs.

Critical enablers must also be scaled up to end the HIV epidemic. Social, economic, cultural, political and environmental factors—including poverty, ethnicity, migration, rural locations, increasing religious conservatism, stigma, gender-based violence and gender inequalities, punitive laws, policies and practices, differential school retention, high rates of youth unemployment, humanitarian settings—all have an impact on HIV risk and vulnerability, on the availability, accessibility, affordability and appropriateness of HIV and SRHR services, and on the promotion and protection of human rights of those being left behind, particularly in this context young key populations.

Insufficient commitment to the HIV response, distrust and lack of support for civil-society organizations, as well as prevailing attitudes of rejecting and excluding key populations, remain significant challenges throughout the region. Community empowerment will improve access to HIV testing, prevention and treatment services, and will promote adherence to HIV treatment. In addition, synergies with other development sectors—including education, health, employment, social protection and gender equality—will help improve HIV and SRHR outcomes.

The bedrock of an effective and gender-sensitive HIV response is a clear commitment to protecting human rights, strengthening access to justice and ensuring zero discrimination. To achieve this, emphasis needs to be placed on strengthening legal environments for HIV and on preventing and addressing human-rights violations. This can include advocacy for the review of legislation that discriminates on the basis of sexual orientation; for changes to laws and policies that criminalize sex work and administrative laws that are used to harass and abuse sex workers; for the prevention of arbitrary arrest, harassment, extortion and entrapment by law-enforcement officers; and against any forced or coercive measures for HIV testing, abortion or the criminalization of HIV transmission.

Restrictions on the work of nongovernmental organizations in some countries can harm community engagement and empowerment and undermine the rights of communities. The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) has invested in regional networks of key populations, supporting their empowerment, collaboration and engagement in policies, advocacy and programming on HIV, including integrated HIV, SRHR and gender-based violence programmes. As yet there are no known networks or organizations specifically addressing the needs and priorities of young key populations in the EECA Region, with the exception of the recently established Teenergizer (see Chapter 2, Box 2.1); this situation must improve, and it is hoped that this tool will support such a change.

The challenge to ensure all young people from key populations have access to high-quality HIV and SRHR services is made harder by the withdrawal of many development partners from the region or a significant drop in their investments. Furthermore, a focus that reduces the HIV response to primarily testing and treatment will not make any impact on these highly marginalized young people, who are not covered by mainstream adolescent and youth programming and have a wide range of needs.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

1.3.1 Human rights as the basis for sexual and reproductive rights

Four international conventions are relevant to sexual and reproductive rights. Because they express human rights, they are relevant to young people and to members of key populations.

The **United Nations Convention on the Rights of the Child** (CRC) obliges States parties to protect the rights of all people under 18 years of age, with an emphasis on the four guiding principles of the best interests of the child; non-discrimination; the right to life, survival and development; and respect for the views of the child. The CRC also recognizes the important concept of children’s evolving capacities, stating in Article 5 that States parties must respect the “responsibilities, rights and duties” of parents (or other persons legally responsible for the child) to provide appropriate direction and guidance, taking into account the capacities of the child to exercise rights on his or her own behalf.

The **International Covenant on Civil and Political Rights** (ICCPR), signed by 195 countries, specifically prohibits discrimination based on “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” (Article 26). In 1994, the United Nations Human Rights Committee ruled that “sex” as used in the ICCPR also includes sexual orientation, and held that States are obligated to protect individuals from discrimination on the basis of their sexual orientation.

The **International Covenant on Economic, Social and Cultural Rights** (ICESCR), which has been signed by 164 countries, recognizes the right to enjoy “the highest attainable standard of physical and mental health” by all persons (Article 12).

The **Convention on the Elimination of All Forms of Discrimination against Women** (CEDAW), signed by 189 countries, recognizes the equality of women in all spheres of life, particularly education, employment and health.

In addition to these conventions, the **United Nations Human Rights Council Resolution on sexual orientation and gender identity** (2011, updated 2014), which has been signed by 96 countries, asserts the universality of

human rights and focuses on violence and discrimination based on sexual orientation and gender identity. For more information, see also the technical briefs on young key populations.

1.3.2 What are sexual and reproductive health and rights?

Health is a fundamental human right indispensable for the exercise of all human rights... sexual and reproductive health are integral elements of the rights of everyone to enjoy the highest attainable standard of physical and mental health.

Preamble to Sexual rights: An IPPF declaration (International Planned Parenthood Federation)

Sexual rights are the norms that emerge when human rights are applied to sexuality, including freedom, equality, privacy, autonomy, integrity and the dignity of all people. The IPPF Preamble states: “Sexual rights guarantee that everyone has access to the conditions that allow fulfilment and expression of their sexualities free from any coercion, discrimination or violence and within a context respectful of dignity.”

IPPF DECLARATION ON SEXUAL RIGHTS

"Health is a fundamental human right indispensable for the exercise of all human rights... sexual and reproductive health are integral elements of the rights of everyone to enjoy the highest attainable standard of physical and mental health."

*Preamble to Sexual rights: An IPPF declaration
(International Planned Parenthood Federation)*

The IPPF Declaration lists the following 10 rights, which are applicable to young key populations as well as all other people:

1. Right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender
2. Right to participation for all persons, regardless of sex, sexuality or gender
3. Rights to life, liberty, security of the person and bodily integrity
4. Right to privacy
5. Right to personal autonomy and recognition before the law
6. Right to freedom of thought, opinion and expression; right to association
7. Right to health and to the benefits of scientific progress
8. Right to education and information
9. Right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when to have children
10. Right to accountability and redress

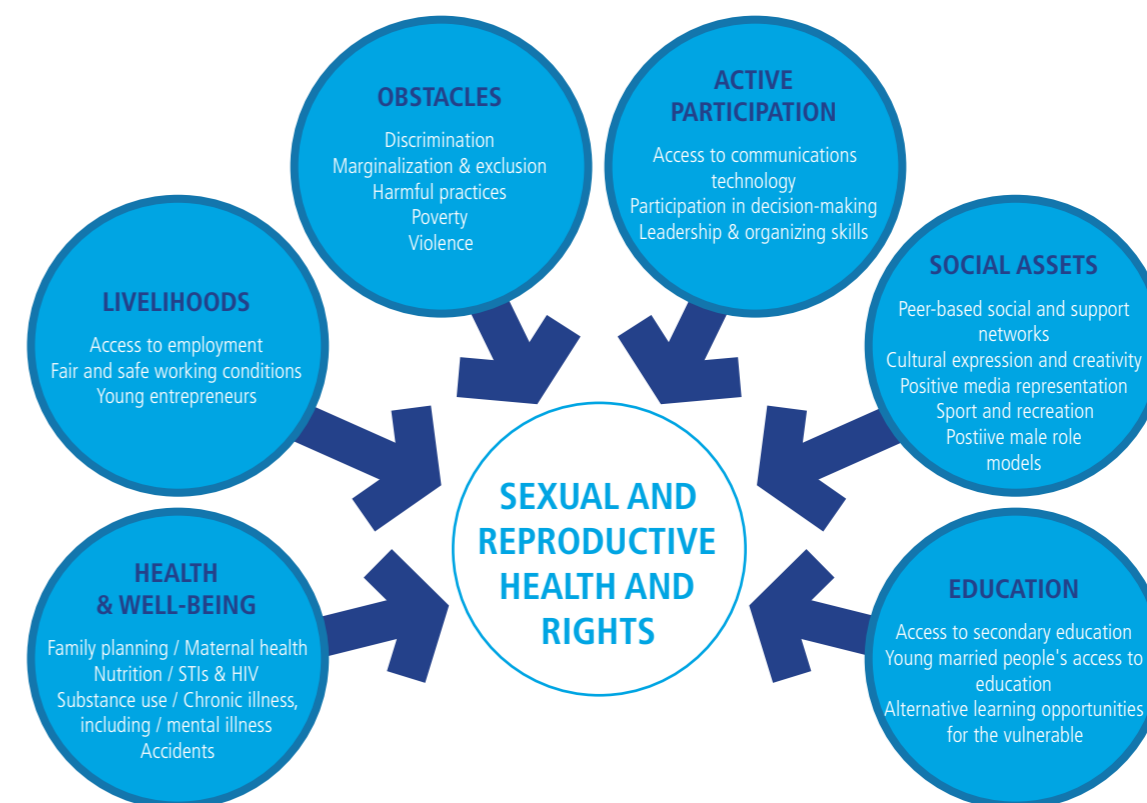


Figure 1.1 UNFPA CROSS-SECTORAL APPROACH TO SRHR

Source: UNFPA strategy on adolescents and youth (2013)

1.3.3 Why do sexual and reproductive health and rights matter?

SRHR are not only an expression of human rights: they also have a very practical impact on the life of young people. The UNFPA Strategy on adolescents and youth proposes a cross-sectoral approach (Figure 1.1) that

illustrates the centrality of SRHR to the physical, mental, socioeconomic, cultural and political well-being of young people.

Sexual and reproductive health and rights are a cornerstone of young people's transition to adulthood, influencing outcomes for both adolescents and youth across a range of fronts. Unless sexual and reproductive health and rights are supported and upheld across a range of dimensions and within a range of settings, young people's lives will be negatively impacted. Likewise, without access to opportunities to learn, contribute and explore; if deterred or excluded from active participation; if subjected to violence, or deprived of resources: the consequences for young people are almost always evident in the status of their sexual and reproductive (ill) health.

UNFPA strategy on adolescents and youth (2013)



Figure 1.2 SUSTAINABLE DEVELOPMENT GOALS RELEVANT TO SRHR OF YOUNG PEOPLE

PRINCIPLES FOR PROGRAMMING WITH YOUNG KEY POPULATIONS

Several fundamental principles underlie all the interventions and programmes described in this tool. They should be kept in mind when designing, planning, implementing, monitoring and evaluating programmes.

Do no harm: The participation of young key populations in programmes and services should always be designed to ensure they are not exposed to harassment, abuse or violence. This requires robust efforts to reduce stigmatization and discrimination among service-providers (including discrimination against young people from key population organizations). It means ensuring that the confidentiality of the young person will be respected, and that information about their identity as a key population member or their HIV status will not be shared without their permission and knowledge. It also means providing clear and honest information to young key populations so that they are aware of foreseeable risks before they agree to participate in a programme or receive a service.

Human-rights-based: Several international conventions lay out the human rights of young people and adults that are relevant to the provision of HIV and SRH services. These are described in Section 1.3.1 above and should be used as a basis for advocating for programming for young key populations.

Gender-sensitive: Programmes should provide services that take into account the needs of male, female and transgender young people. The kinds of clinical services that are required will vary according to gender; girls and young women may be more susceptible to violence than some boys and young men; and they may have less access to services because of relative economic disempowerment, or cultural norms. In addition, it is important for programmes to understand that young transgender people—especially young transgender women—should not be grouped together with young MSM for the purposes of planning or delivering services. Gender identity is not the same as sexual orientation, and the clinical and psychosocial needs of young transgender people will differ in some ways from those of young MSM.

Gender-transformative: Interventions and services should create opportunities for individuals to actively challenge gender norms, promote positions of social and political

influence for women, and address power inequities between persons of different genders. Gender norms, sexism, homophobia, transphobia and other forms of prejudice, stereotypes, discrimination and violence are structural factors that limit the possibilities for young people to grow and develop. Young women and LGBTI youth are especially affected and are not treated equally at all levels. As we develop youth programmes it is important that we understand how interventions affect and need to be applied differently to young women, young men and sexually diverse youth because of these layers of inequality.

Evidence-based: Programmes should be based on the best available evidence. Given that relatively few HIV and SRH programmes in the EECA Region have been evaluated, programmes in other regions can be used as models for adaptation and implementation. Absence of data should not be used as an excuse for inaction. Where possible, national programmes should build evaluation activities into the design of programmes so that their impact can be assessed and useful evidence can be compiled for other programmes in the country or region.

User-friendly: Programmes and services should be easy for young key populations to access. This means that their location and timing should suit the schedules of these communities. Services must be provided in a respectful, non-stigmatizing way, and they should use language and informational materials that are appropriate to the culture and developmental stage of young key populations, bearing in mind also local conditions.

Participatory: Wherever possible, programmes should seek the active involvement of young key populations themselves, while respecting the principle of Do no harm (see above). The insights, perspectives and expertise of young key populations can make programming more relevant and effective and increase service uptake and adherence.

Affirming sexuality: All people, including young people, have the right to the highest attainable level of health and well-being in relation to sexuality, including the possibility of pleasurable, satisfying and safe sexual experiences. Therefore, programmes should be based on a positive approach to the sexuality of young people that celebrates sexuality as an enhancing part of life that brings happiness, energy and celebration. An affirming approach to sex acknowledges and tackle the various risks associated with sexuality without reinforcing fear, shame or taboos around young people’s sexuality.

These principles are depicted in Figure 1.3, which shows how they can translate into services, advocacy and strong systems that serve the overall goal of mitigating the HIV epidemic among young key populations and improving their SRH and well-being.

We know what works in providing human-rights-based and evidence-informed integrated HIV and SRHR programming for young people. There have been

significant successes in East and Southern Africa, and we have excellent examples of community-led processes among young key populations in the Asia Pacific Region. We now need to develop solid and effective programmes for young key populations in Eastern Europe and Central Asia so that they can fulfil their potential and are no longer left behind. The strategies and approaches in this tool are presented as a guide to achieving universal access to HIV and SRHR for young key populations.

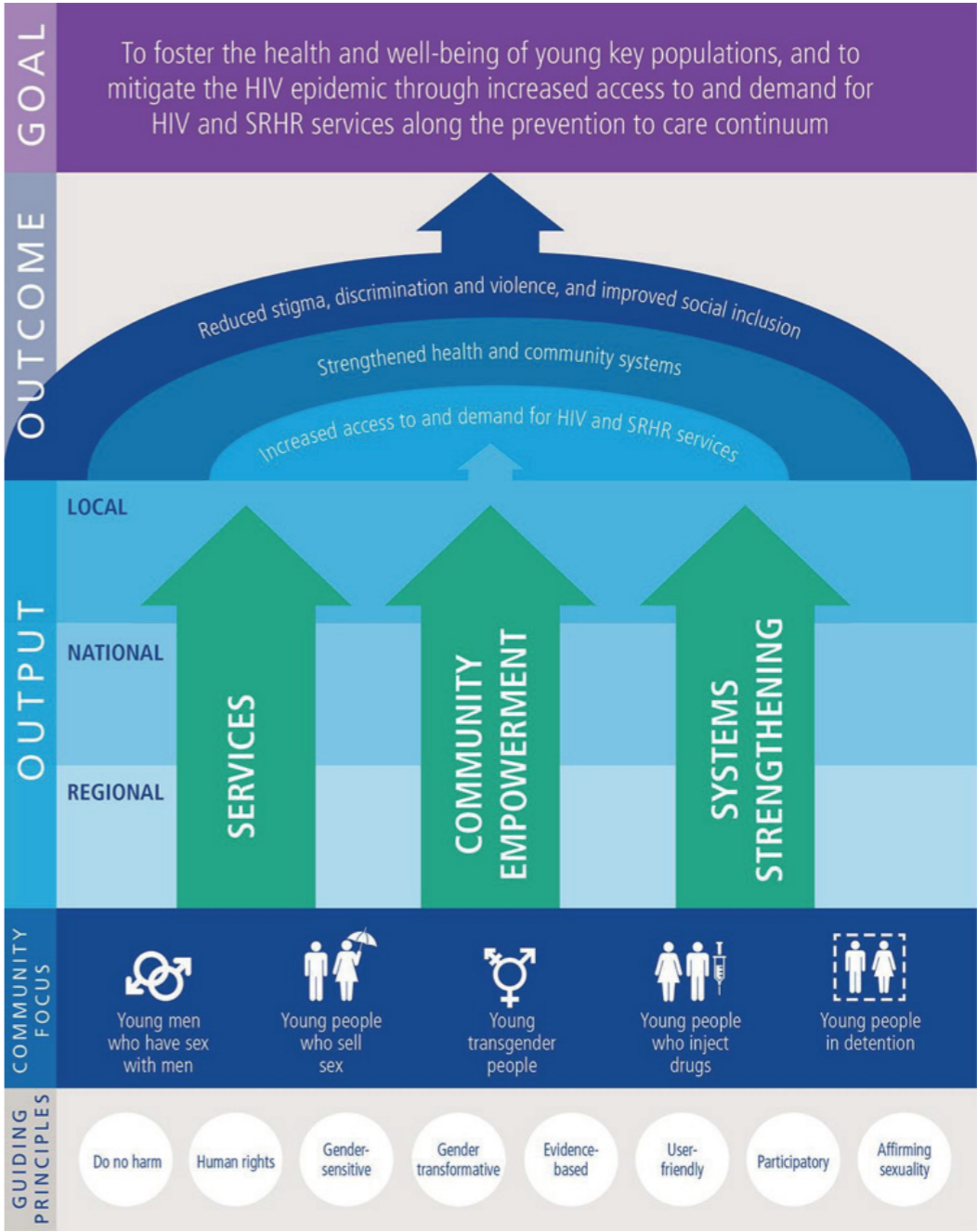


Figure 1.3 SUSTAINABLE DEVELOPMENT GOALS RELEVANT TO SRHR OF YOUNG PEOPLE

Source: IPPF

Resources

1. *HIV and young people who sell sex: a technical brief*. Geneva: World Health Organization, 2015.
<http://www.who.int/hiv/pub/toolkits/hiv-young-sexworkers/en/>
2. *HIV and young men who have sex with men: a technical brief*. Geneva: World Health Organization, 2015.
<http://www.who.int/hiv/pub/toolkits/hiv-young-msm/en/>
3. *HIV and young transgender people: a technical brief*. Geneva: World Health Organization, 2015.
<http://who.int/hiv/pub/toolkits/hiv-young-transgender/en/>
4. *HIV and young people who inject drugs: a technical brief*. Geneva: WHO, 2015.
<http://www.who.int/hiv/pub/toolkits/hiv-young-idu/en/>
5. *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions*. Geneva: World Health Organization; 2013.
http://www.who.int/hiv/pub/sti/sex_worker_implementation/en
6. *Implementing comprehensive HIV and STI programmes with men who have sex with men: practical approaches for collaborative interventions*. New York (NY): United Nations Population Fund; 2015.
<http://www.unfpa.org/publications/implementing-comprehensive-hiv-and-sti-programmes-men-who-have-sex-men>
7. *Implementing comprehensive HIV and STI programmes with transgender people: practical approaches for collaborative interventions*. New York (NY): United Nations Development Programme; 2016.
<http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html>
8. *Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical approaches for collaborative interventions*. Vienna: United Nations Office on Drugs and Crime; 2017.
http://www.unaids.org/en/resources/documents/2017/2017_HIV-HCV-programmes-people-who-inject-drugs
9. *UNFPA strategy on adolescents and youth*. New York: United Nations Population Fund; 2013.
<http://www.unfpa.org/resources/unfpa-strategy-adolescents-and-youth>
10. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. Geneva: World Health Organization; 2014, updated 2016.
<http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>
11. *Sexual rights: an IPPF declaration*. London: International Planned Parenthood Federation; 2008.
<http://www.ippf.org/resource/sexual-rights-ippf-declaration>
12. *Fulfil! Guidance document for the implementation of young people's sexual rights*. London: International Planned Parenthood Federation; 2016.
<http://www.ippf.org/resource/fulfil-guidance-document-implementation-young-peoples-sexual-rights-ippf-was>
13. *Exclaim! Young people's guide to 'Sexual rights: an IPPF declaration'*. London: International Planned Parenthood Federation; 2011.
<http://www.ippf.org/resource/exclaim-young-peoples-guide-sexual-rights-ippf-declaration>

COMMUNITY EMPOWERMENT, PARTICIPATION AND RIGHTS

COMMUNITY EMPOWERMENT AND CAPACITY DEVELOPMENT

YOUNG KEY POPULATIONS TECHNICAL BRIEFS (2015)¹¹

Involve young key populations meaningfully in the planning, design, implementation, monitoring and evaluation of services suited to their needs in their local contexts. Partner with community-led organizations of young people, and with community-led organizations and networks of key populations as appropriate, building upon their experience and credibility with young key populations. Acknowledge and build upon the strengths, competencies and evolving capacities of young key populations, especially their ability to express their views and articulate what services they need.

More broadly, community empowerment means that young key populations take concrete actions, individually and collectively, to address social and structural barriers to their broader health and human rights, such as violence, stigma, discrimination and unequal access to services

Community empowerment of key populations anywhere is challenging because of the stigma and discrimination they face. Eastern Europe and Central Asia has strong regional networks of people who use drugs, sex workers, men who have sex with men and people living with HIV. They have forged impressive alliances and have been working constructively with governments in many countries in the region. Their empowerment as a united community of key populations has resulted in several Global Fund grants to further strengthen cohesion, coordination and cooperation across populations and countries. However, all none of the networks and member organizations has yet adequately addressed the HIV and sexual and reproductive health and rights (SRHR) needs of young key populations. Similarly, organizations and networks of young people have had limited success in including young key populations among their members or as a focus of their work.

Key steps in community empowerment are shown in Figure 2.1 and outlined in the following pages, with examples from organizations of key populations or young key populations that show community empowerment at work and its effect on HIV programming.

2.1.1 Community empowerment

Community empowerment is at the centre of human-rights-based programming for young key populations, including young people living with HIV. Community empowerment is a process in which young key populations take ownership of programmes in order to achieve the most effective HIV responses. Ownership of programmes means not only participating in them (i.e. receiving services), but also taking meaningful and leadership roles in planning, running and monitoring them.

A core area of advocacy and future programming needs to be community empowerment of all young key populations. Their inclusion as members in adult networks and organizations of key populations, and among those whose focus is all adolescents and young people, will require resources, commitment and technical assistance.



Figure 2.1 KEY ELEMENTS OF COMMUNITY EMPOWERMENT

Ensure safe spaces for young key populations to come together: Because of marginalization and social exclusion, young key populations need safe spaces—rooms or centres dedicated for their use where they can come together to relax, socialize, and receive resources and information. Safe spaces may also be known as trust points or drop-in centres. They may offer very practical and needed services such as showers or snacks for people who live on the street, as well as resources connected to HIV and SRHR and other services. Above all, safe spaces are places where young people can begin to discuss with others like them the common issues and difficulties they face. Learning that they are not alone and forming bonds of friendship and solidarity is a crucial first step in moving from being individuals to forming a community.

Collaborate with young key population communities in programming: In many settings services for young key populations may be started by groups that are not themselves led by young key populations, such as nongovernmental organizations (NGOs), governmental organizations, youth organizations, or other regional or country-level key-population networks and organizations without a youth focus. Such organizations must remember that young key populations will know best how to identify their priorities, and they have special insight into the strategies best suited to their context to address those priorities. The meaningful participation of young key populations in programming is therefore essential to establishing partnerships that have integrity and are sustainable.

11 / For references, see Chapter 1, Section 1.5, Nos. 1–4.

Meaningful participation means that young key populations choose whether to participate, how they are engaged in the process, how they are represented and by whom, and have an equal voice in the management of partnerships with service-providers. Services should be planned and developed so that, where possible, young key populations are increasingly engaged in their scale-up.

Table 2.1 describes the differences between programmes that are delivered “for” communities (i.e. without their meaningful participation, and on terms largely set by the service-provider) and programmes that are done in collaboration with (or even led by) the community.

Table 2.1 **COMPARISON OF PROGRAMMATIC APPROACHES**

DONE “FOR” YOUNG KEY POPULATIONS	DONE “WITH” OR “LED BY” YOUNG KEY POPULATIONS
<p>PRESCRIPTIVE: Programmes focus on telling young key populations what to do and how to do it.</p>	<p>COLLABORATIVE: Programmes listen and respond to young key populations’ ideas about what to do and how to do it.</p>
<p>PATERNALISTIC: Often assume that programme staff have knowledge, skills and power, rather than young key populations.</p>	<p>PARTICIPATORY: Honour and actively seek to leverage the knowledge, skills and power possessed by young key populations.</p>
<p>TOKENISTIC: Involve young key populations in programme implementation mainly as volunteers, not as equal partners.</p>	<p>INCLUSIVE: Involve young key populations as equal partners in designing, implementing and evaluating programmes, and where possible as paid employees.</p>
<p>COMMODITY-ORIENTED: Monitoring mainly focuses on goods and services delivered and targets to be achieved.</p>	<p>QUALITY ASSURANCE-ORIENTED: Monitoring mainly focuses on quality, safety, accessibility and acceptability of services, community engagement and community bonds, as well as extent of service coverage.</p>
<p>HEALTH-PROVIDER-FOCUSED: Focus on building relationships mainly within the health system with health-care providers.</p>	<p>COMMUNITY-FOCUSED Focus on building relationships within young key populations, and between them and other organizations, service-providers, human-rights institutions and similar groups.</p>

Partnerships must be built and maintained in a way that does no harm to young key populations. This could mean choosing secure locations for meetings and other programme activities, so that young key populations will not risk identification and public exposure; and safeguards to secure information (written or electronic) that could identify young key populations against their will. Organizations should have explicit non-discrimination policies and procedures, and these should be actively enforced. There should also be a commitment to ensuring that young key populations, service-providers and law-enforcement officers are educated about the legal rights of young key populations (see Chapter 3).

Build organizational and networking capacity: It is important that government, donors and other organizations provide money, capacity-building support and other resources directly to young key population organizations, programmes and communities, where these exist. More information on organizational capacity-building is given in Section 2.1.2. Key populations, in particular young key populations, often depend more upon community systems than members of the general population. Developing social networks and organizations for support, advocacy and kinship is crucial for key populations and can help them engage in health care and other services where they may fear discrimination.

Networking can also mean becoming involved with government organizations and programmes by joining oversight committees for health or social programmes. Young key populations may also mobilize by joining with NGOs and civil-society groups, for example by forming alliances on common advocacy issues such as health or rights.

In the EECA context, it is particularly important to:

- support the establishment of community-led organizations of young key populations, with the goal of forming community organizations of young key populations where this is possible (see Section 2.1.2)
- support the integration of these organizations within regional and national key-population networks and organizations
- develop and strengthen partnerships with organizations and networks of adolescents and youth.

Support community mobilization and build advocacy capacity: Community mobilization is closely linked to community empowerment. It is a process whereby young key populations use their knowledge, strengths and skills to address shared concerns through collective action. Examples of community mobilization include:

- identifying barriers to HIV prevention and access to HIV services
- reducing health risks, including sexual-health risks, and promoting health-seeking behaviours
- offering support for those who suffer violence, including through crisis response teams
- developing community leadership
- forming purposeful partnerships with community-led organizations of young people or adult key populations
- soliciting mentoring and support from experienced networks and organizations of key populations within the region and beyond (see below)
- effective advocacy by young people from key populations to mobilize external support.

TEENS MOBILIZING TEENS IN THE EECA REGION

Teenergizer is an organization and online platform created by teenagers for teenagers in the EECA Region. Its goal is to create a world where every teenager can realize their potential, free from discrimination in all areas, including HIV, and the rights of teenagers and youth are fully respected.

The seeds of the organization were planted in 2010, when the Eastern Europe and Central Asia Union of People Living with HIV began to focus on children and teenagers affected by HIV. A leadership development programme supported by UNICEF Ukraine led to initiatives by teenagers in seven countries, and in 2014, 10 teens created teenergizer.org as a website where HIV-affected teens could share knowledge, support each other and create new initiatives. The website receives 4,500 visits every month.

Teenergizer was registered in 2015 (as the Eurasian Union of Adolescents and Youth Teenergizer) with members in Armenia, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation and Uzbekistan), along with a separate organization in Ukraine. In 2016 Teenergizer signed a co-operation programme with UNICEF on HIV-affected adolescents in Ukraine.

In addition to its website, Teenergizer produces publications and has developed a smartphone app which helps teens living with HIV with ART adherence. The organization holds events, training sessions and meetings with HIV-affected adolescents in EECA countries. Independently, teen volunteers hold peer-to-peer training sessions and webinars on HIV, gender and discrimination. Teenergizer activists have taken part in conferences, meetings and discussions on HIV at global, regional and national levels. Teenergizer is representing the interests of the region's HIV-affected adolescents on the Coordinating Committees of the AIDS 2018 Amsterdam Conference and the EECAAC-2018 Moscow Conference.

Y-PEER

Y-PEER is a youth-led peer-based network of young people and civil-society organizations that aims to promote SRHR, including HIV awareness, and foster the development of all young people including young key populations across Eastern Europe and Central Asia, the Arab States and the Asia-Pacific. Y-PEER works at both international and grassroots levels.

Y-PEER has been an active contributor to the post-2015 process and the International Conference on Population and Development review, where it promotes the rights of young key populations. At the international level, Y-PEER advocates for full access to CSE in formal and informal settings, involving not only mainstream youth but also young key populations. This is shown in the Youth Declaration of the 2016 International AIDS conference, for which Y-PEER chaired the drafting committee.

In Eastern Europe and Central Asia, especially at the national level, Y-PEER builds the capacity of young people, including young key populations. Since 2015, Y-PEER in Tajikistan (NGO Hamsol ba Hamsol) has partnered with organizations to support young key populations on health and legal issues. Y-PEER has adopted training modules and programming activities for inclusive engagement of young key populations from partnering organizations, particularly in programmes about making choices to maintain one's health.

MOBILIZING AN INTERNATIONAL COALITION FOR YOUTH RIGHTS

Have You Seen My Rights? was a coalition of more than 40 youth organizations convened to advocate for global, regional and national high-level commitment to young people's SRHR in the post-2015 agenda, including the rights of young key populations.

Participants learned to recognize the importance of establishing realistic goals and having a clear vision of the target group for each message and anticipated outcome. The importance of adaptability was also emphasized. The campaign highlighted that building a social movement is a slow and complex process, requiring long-term investment and commitment.

ADVOCATING FOR THE RIGHTS OF SEX WORKERS IN KYRGYZSTAN

In 2006 and again in October 2012, Tais Plus, together with allies, successfully put a stop to legal initiatives of the Ministry of Interior to penalize sex work in Kyrgyzstan. Sex workers and supportive civil-society groups were mobilized to conduct a broad advocacy campaign, submit petitions and hold interviews with parliamentarians. The draft bill was withdrawn in February 2013.

IPPF's YouthHub website provides a range of materials on youth-centred advocacy, as well as comprehensive sexuality education (CSE) and service delivery. Resources can be downloaded directly from the site: <http://www.ippf.org/youthhub/>

Advocacy is a core process for empowering communities and addressing inequity. It can improve access to, funding and quality of programmes and services for young key populations by bringing disparities to the top of the agenda of decision-makers. Advocacy efforts are often most powerful and successful when led by those affected by the issue. For young key populations in the EECA Region, relevant advocacy issues include:

- policies and laws to protect and promote the human rights of young key populations, in order to reduce violence, discrimination, stigma, mental-health problems and risk for HIV.
- policies and laws to reduce inequality and facilitate access to services. This is essential in order to ensure that service-providers have the capacity to deliver services and young key populations are empowered to use them. It involves not only health and mental-health services, but access to education, employment and housing, among other issues.
- media work to improve reporting on young key populations and human-rights violations.

Promote a human-rights framework: Promoting and protecting the human rights of young key populations is central to community empowerment and an effective HIV response. It is not just the right thing to do, but it also makes sense from a health perspective. Activities to promote the human rights of young key populations can include awareness-raising activities for young key populations themselves, as well as advocacy with government, community leaders, and national human-rights organizations.

HUMAN RIGHTS, HIV AND SRHR

The 2001 United Nations *Declaration of commitment on HIV/AIDS* highlights that realization of human rights and fundamental freedoms for all is essential to reduce vulnerability to HIV, and that the vulnerable must be given priority in the response.

The 2011 United Nations General Assembly Political Declaration on HIV/AIDS includes the commitment to “eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms”.

The 2016 International AIDS Conference Youth Call to Action calls for the involvement of young people in formulating policy and programmes as “a critical part of the response”, including the integration of human-rights-based principles in all laws and policies, particularly those relating to health, and accountability to young people in implementing and monitoring the 2030 Agenda for Sustainable Development. The Call to Action was developed by more than 100 young people at a pre-conference meeting and is itself an example of community empowerment.

Many guidelines on HIV prevention promote health and human rights for young key populations, including the *Key Populations Consolidated Guidelines* (2016)¹² and the *UNAIDS 2016-2021 strategy*.

The World Health Organization (WHO), UNFPA and Global Network of Sex Work Projects (NSWP) guidelines on *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries* (2012) were the first official United Nations document to call for decriminalization of sex work, as well as making health services available, accessible and acceptable based on the principles of avoidance of stigma, non-discrimination and the right to health.

Adapt to local needs and contexts: Many regional, national and local factors will determine the specific issues and needs of young key populations, and thus the kinds of programmes necessary to address them. Examples include geographical settings, migration, humanitarian crises, rural poverty, the legal freedom of NGOs to function, and the ability to establish safe spaces for young key populations.

It is important to remember also that young key populations are not monolithic groups, either within countries or across the EECA Region. Young people live, learn, work and play in diverse legal, political, social and health environments and identify themselves in many ways or none. They may wish to be part of an identified community with other young members of the same key population; or they may choose not to do this, for a variety of reasons. HIV and SRHR programmes need to be sensitive to this diversity. Flexibility, responsiveness and adaptability are essential in implementing community empowerment initiatives. Intervention goals need to be aligned with and address the needs of young key populations, even if these change over time.

2.1.2 Capacity development

Building capacity is at the heart of community development and community empowerment. Having a set of approaches that foster the capacity development of networks of young key populations is crucial for their future role in providing support, services or raising awareness among their communities or beyond. By investing in strengthening their governance, leadership and strategic planning, these groups or networks are better placed to successfully deliver HIV programming and ensure local sustained ownership.

If communities are to be fully engaged in discussions, decisions and actions around their needs and problems, they need the ability to work on equal terms with service planners and providers. Capacity-building is a process of strengthening the abilities of individuals, organizations and systems to perform core functions sustainably, and to continue to improve and develop over time. For a group or organization, this means learning to plan, manage and finance itself so that it can implement its own vision and strategy. Capacity-building leads to stronger

organizations with the ability to adapt and continue to develop over time.

At the same time, capacity-building helps a service-delivery organization achieve the indicators and targets of government, donors and technical assistance agencies, where these are a source of funding. Whether organizations of young key populations are already established or come into being as a result of HIV prevention programming, it is important for them to understand the goals and needs of donors, while developing the ability to shape those goals where necessary to ensure that they do not conflict with the organization’s own vision.

Tools for capacity-building include training, meetings and knowledge-sharing workshops. Capacity-building support should be:

- **Readiness-based:** The type, level and amount of capacity-building should be based on the organization’s ability to absorb and use the support being given.
- **Inward/outward-oriented:** While it is essential for an organization to ensure the health of its staff and internal structures, it is also important to remember that any organization is part of a larger community and needs to understand opportunities for partnership and the potential benefits from external links.
- **Sustainability-based:** Capacity-building should strengthen an organization’s ability to maintain a resource base so that it may continue to function well.

An organization or network of young key populations needs technical and financial support in order to continue. Thus capacity-building is needed not only for organizational development, but also because it helps to develop the leaders or staff of a group, who may be new to managing a community-led organization or delivering services. Capacity-building can institutionalize support for young key population organizations and further empower these groups to lead their own responses. This creates an organizational structure that provides consistency over time and establishes processes so that key people are replaced if they leave, ensuring that community empowerment continues.

Beginning and sustaining an organization among young key populations will be challenging. Policy and legal barriers pertaining to NGOs in general, and key populations in particular, are multiplied for young key populations, who suffer extraordinary economic, educational, social and cultural exclusion, are at risk of

detention, often lack stable home environments and have few external supports. Where young people from key populations do come together in safe spaces, they must be vigilant with neighbours to protect against police harassment, and such groups exist on almost non-existent budgets. Small-scale local NGOs and local community organizations should support safe spaces and seek to provide mentoring for young people.

In some countries across the region, open engagement of young people from key populations will place them at harm. Here, the experience of networks and organizations of key populations (see Box 2.6) is crucial. Not only do they have strategies for working in these complex environments, but they have lived experiences common to the young key populations themselves. Further, their sophisticated advocacy with the Global Fund has created political space to openly discuss the needs of key populations. Combined with the joint advocacy of UNFPA and IPPF EN, along with other Cosponsors of UNAIDS and development partners, the political space needs to be opened so that young key populations are provided with the capacity development support they need to meaningfully participate in comprehensive HIV and SRHR responses.

KEY POPULATIONS NETWORKS AND ORGANIZATIONS IN THE EECA REGION

Eurasian Coalition on Male Health (ECOM)
– ecom.ngo/homepage/

East Europe and Central Asia Union of
People Living with HIV (ECUO) – ecuo.org

Eurasian Harm Reduction Network (EHRN)
– www.harm-reduction.org/

Eurasian Network of People who Use
Drugs (ENPUD) – [www.harm-reduction.org/
partners/eurasian-network-people-who-
use-drugs-enpud](http://www.harm-reduction.org/partners/eurasian-network-people-who-use-drugs-enpud)

Eurasian Women’s Network on AIDS
(EWNA) – [eecaplatform.org/en/partner_
assoc/ewna/](http://eecaplatform.org/en/partner_assoc/ewna/)
Sex Workers Rights Advocacy Network
(SWAN) – www.swannet.org/en

12 / Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2014, updated 2016.

YOUTH LEAD AND THE NEWGEN LEADERSHIP TRAINING MANUAL

Youth LEAD is a network of young key populations that advocates for their SRHR needs in the Asia Pacific Region. SRHR is part of the NewGen Asia Leadership course which Youth LEAD has piloted in the region. The course uses an interactive approach to build the capacity of young key populations to advocate for themselves and their communities, and act as leaders and agents of change in the HIV response. The course was designed and piloted over a period of 11 months with leadership and direction from young key populations, who were involved in writing and designing the curriculum and as facilitators, in consultation with United Nations agencies, academic practitioners, international NGOs, local partners and trainers.

The NewGen process has led to the formation of young key population networks in Myanmar (Myanmar Youth Star Network) and Indonesia (Fokus Muda), and the adoption of the NewGen manual by the Indonesia National AIDS Council as the national leadership manual for young key populations.

EMPOWERING YOUNG KEY POPULATIONS TO BECOME LEADERS IN TRAINING IN KYRGYZSTAN

In August 2016 a community-level training on the MSMIT was conducted in Kyrgyzstan by UNFPA, ECOM, Kyrgyz Indigo and other civil-society partners. This is believed to have been the first such training anywhere in the world, and it was a turning point for the further roll-out of the tool and the capacity-building of other sectors.

The majority of the participants were young people, many of whom were not “out” to their families and friends. The MSMIT training became a moment of community connectedness, providing the young men and women from the lesbian, gay, bisexual, transgender and intersex (LGBTI) communities an opportunity to learn for the first time how to programme for their communities, identify other community members to work with, and develop approaches to outreach and to condom and lubricant programming. It also gave them an understanding of sexual health, HIV and STI prevention and treatment; and the chance to discuss community empowerment, including the need to stay safe in highly stigmatized environments. Since the training the young participants have themselves become trainers on the MSMIT, planning and implementing trainings with representatives of the government, NGOs and the international sectors. They have acted as real professionals, confident in their knowledge and skills on HIV programmes. Targeted trainings have also been held for health-care specialists, again with the participation of the young people. This demonstrates the significance of investing in community empowerment, so that the services designed and provided are tailored to the needs of key population communities.

Source: <http://youth-lead.org>

COMMUNITY SYSTEMS STRENGTHENING FRAMEWORK: SIX CORE COMPONENTS OF COMMUNITY SYSTEMS

1. **Enabling environments and advocacy** – including community engagement and advocacy for improving the policy, legal and governance environments, and for affecting the social determinants of health.
 2. **Community networks, linkages, partnerships and coordination** – enabling effective activities, service delivery and advocacy, maximizing resources and impacts, and coordinated, collaborative working relationships.
 3. **Resources and capacity-building** – including human resources with appropriate personal, technical and organizational capacities; financing (including operational and core funding); and material resources (infrastructure, information and essential commodities, including medical and other products and technologies).
 4. **Community activities and service delivery** – accessible to all who need them, evidence-informed and based on community assessments of resources and needs.
 5. **Organizational and leadership strengthening** – including management, accountability and leadership for organizations and community systems.
 6. **Monitoring and evaluation (M&E) and planning** – including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management.
- When all these components are strengthened and functioning well, they will contribute to:
- improved outcomes for health and well-being
 - respect for people’s health and other rights
 - social and financial risk protection
 - improved responsiveness and effectiveness of interventions by communities
 - improved responsiveness and effectiveness of interventions by health, social-support, education and other services

Source: MSMIT

It is important to ensure adequate funding of youth initiatives from state and non-state resources to enable young people to plan, implement and evaluate HIV and SRHR programmes and projects. Steps in resource mobilization include the following:

1. **Assess your capacity** to apply for and manage funding: what elements of the organization need to be improved—e.g. financial management, tracking funding, competitor analysis—and who else is trying to access funds?
2. **Demonstrate your credibility:** highlight the specialties you work on, show that you’re doing good work, and how you will use funds effectively. Show the donor that you report fully and on time, and have systems in place to manage funds.
3. **Ensure that you remain relevant and adaptable:** look at the environment in your locality/country. How are opportunities changing, how are the needs of the communities you serve changing? What do they need and want? Can you adapt to suit those needs? For example, as promotion of healthy lifestyles occupies a much higher position on national agendas

and it is easy to make a connection between HIV and public health, this may be one way to ensure continued financial and policy support for young key populations. (Data from Global Fund projects are helpful for providing evidence-based reasoning for investments of this sort.)

4. **Increase your visibility:** by attending meetings, improving social media, web presence and other communications, preparing a capability statement, examples of your work. Have this material ready and share it with others (it may get passed on by someone to a potential funder).

5. **Strengthen your relationships:** Funding is tending not to go just to one organization but to a consortium. Build relationships with organizations doing similar work, or see what role you can plan in a larger programme. Look for champions at the local level, such as mayors, religious leaders or women’s group who may support programming or applications for funding.

6. **Be prepared:** Don’t wait for the call, but have the information ready to go. This can be helpful too if a small pot of money (e.g. year-end surplus funds) becomes available.

GLOBAL FUND TRANSITION PLANS

The Global Fund has \$10.3 billion funding available for 2017-2018. The allocation to the EECA Region is 2.9% of this total, a reduction from 8.5% in the previous funding round. The Global Fund says allocations have been made to reflect the epidemiological burden (and EECA has about 2.5% of the global burden of HIV).

There is also a catalytic funding mechanism of \$800 million, for three types of intervention:

- 1. incentivizing allocation of funding for specific issues, e.g. human-rights-related interventions
- 2. multi-country regional approaches, i.e. bringing a regional approach
- 3. strategic investments, a dedicated fund used at the discretion of the global secretariat.

Transition of countries can vary from 2–10 years, so NGOs have an important role to play. A significant challenge is that once Global Fund funding is lost, NGOs may stop working with key populations, including young key populations. Often funding is needed for community-led organizations at the most basic level of paying bills for rent, electricity and water, and providing vehicles for their work.

PARTICIPATION, RIGHTS AND SOCIAL INCLUSION

VOICES OF YOUNG KEY POPULATIONS

“No one (in my family) knows about my homosexuality and I don’t plan to come out. I am afraid of negative consequences, as my relatives have no idea that “such people” exist. It’s still difficult to live in the closet, and I don’t want to think that in a few years they will begin to put pressure on me because of marriage.” *Young MSM, Kyrgyzstan*

“Ten years ago it was better. Now it is very hard. Radicals and nationalists constantly hunt us down and beat us.” *Young MSM, Ukraine*

“When I was 15, I posted a text on Facebook and told everybody that I’m living with HIV. I expected some discrimination or aggression, but I never really faced it. Most of the people I met tried to support and help me. But I was lucky to be born in the capital. The situation in small towns in the regions is terrible. For example, I helped a girl who was beaten at school because of her status. She had to go to hospital because of this” *Young person living with HIV, Ukraine*

“When you find yourself on the street, you are quite alone—you cannot get medical help from anywhere. All my friends are afraid to call an ambulance, because the police will arrive as well.” *Young person who injects drugs, Russian Federation*

“The worst experience is to be stigmatized within the human-rights-activist field. At the training sessions on project management for human-rights defenders, I had cases where I had to protect myself from homophobic incidents, and had to challenge the stereotypes that suggested I am mentally ill due to my sexual orientation.” *Young MSM, Ukraine*

Participation, rights and social inclusion are closely linked. Young people are entitled to a say in the decisions that affect their lives. When young key populations participate in policy and programming bodies, there is a better chance that decisions on programmes that affect them will reflect and respond to their needs (for health, education, employment, housing etc.), safeguard their rights and help to achieve social inclusion.

Social inclusion for young key populations means that social structures—government, policy-making bodies, the police, health services, education, housing and other social services, as well as private providers of services and employers—respect and support the dignity of young key populations, not just as young people and as key

populations but in all the diversity of their identities. It means that young key populations do not experience consistent stigmatization, or rejection by their families or the wider community.

Too often young key populations are unable to benefit from the rights and privileges of the social system that are generally available to other people. Initiatives for social inclusion mean taking into account their economic vulnerabilities, e.g. those who leave orphanages with nowhere to go and no employment, often finding that sex work is the only available economic option, along with the risk of homelessness, vulnerability to drug use or violence and therefore to HIV.

VOICES OF YOUNG KEY POPULATIONS

"Because I cannot integrate I drink and use drugs. This is the only way I can forget that no one needs me." *Young MSM, Ukraine*

"It always affects me when I see a happy heterosexual couple with children walking through the Central Park in Bishkek. Then I think that in the next 20–30 years I won't be able to walk with my partner like this. ." *Young MSM, Kyrgyzstan*

The first step to asserting the rights of young key populations and working towards social inclusion is that they participate in the groups and bodies that affect their lives. Participation can be through membership of local or national planning bodies on HIV, SRHR, or more general health and mental-health issues, as well as other topics such as education, housing and employment. Young people may do this as individuals, but their voice may be more influential if they do so as a group, or as chosen representatives of a group or organization, such as a youth organization or a key population organization.

However, being a representative presupposes that a young key population is actually welcomed to participate in a youth organization, or that a young person is welcomed to participate in a key population organization. Sometimes even this level

of participation requires advocacy with the relevant organization. Fostering participation therefore means that programmes working with young key populations should build their capacity to understand their rights and understand social inclusion, reduce self-stigma, and build their skills to participate effectively in organizations, programmes and processes that affect them. At the same time, it is necessary to work to reduce stigma and discrimination towards young key populations within organizations and among service-providers (see Section 3.5.2).

Social inclusion strategies and programmes should recognize the specific needs and realities of young key populations, with a particular emphasis on education and employment. An important aspect of this is including young key populations within resource allocations for all adolescents and young people.

ALBANIA'S NATIONAL ACTION PLAN FOR THE LGBT COMMUNITY

In May 2016 the National Action Plan for the LGBT community (2016-2020) was approved by the government of Albania, marking a milestone towards the advancement of human rights. Following the Law on Protection from Discrimination in 2010, this plan envisions a model of addressing and improving legislation, social policies and public services related to LGBT people, and promoting a comprehensive culture of inclusiveness and diversity among the general public.

An example from Georgia shows how by building the capacity of young women living with HIV they were able to claim a space for economic empowerment and participation in a national HIV planning body.

STRENGTHENING A GROUP FOR PEOPLE LIVING WITH HIV IN GEORGIA

With technical support from Association HERA XXI, members of the group PAPA (Positive Attitude, Positive Action), who are women living with HIV, mostly under the age of 30, were trained on sexual, gender, health and reproductive rights, and on organizational strengthening. Group members can now protect themselves more effectively against discrimination and stigma, and many are confident enough to be open about their HIV status, and to advocate about the problems and needs of people living with HIV. Some are planning social enterprise projects, which will enable them to continue advocacy and to overcome self-stigma. In 2016 a PAPA representative became a member of the Country Coordinating Mechanism (CCM), an important platform for advocacy and for supporting and protecting the interests of the community of people living with HIV.

INFORMATION AND EDUCATION FOR AN ENABLING ENVIRONMENT

VOICES OF YOUNG KEY POPULATIONS

"Finding a job is difficult. My appearance is not the same as the one on my identification card. Whenever I get a job, when employers get to know of my gender identity, they fire me." *Young transgender person, Kyrgyzstan*

"I have been rejected from several workplaces I applied to with no open reference to my sexual orientation—that I never disclosed nor was asked to—but with obvious non-verbal and sometimes verbal reactions during job interviews." *Young MSM, Serbia*

"At the beginning of 2016 I started my hormone therapy. My friends and work colleagues accepted me. But it didn't last long. When the CEO of my company saw me, he screamed at me, called me hermaphrodite... I was fired immediately without a chance to even get my last salary." *Young transgender man, Ukraine*

"I work at Teenergizer because I want to create a strong team of teenagers that will fight down the discrimination and stigma among young people even in the most oppressive regions of Eastern Europe and Central Asia." *Young person living with HIV, Ukraine*

An enabling environment is one that supports policies and programmes that work for the health and well-being of young key populations. In most countries, creating an enabling environment through information, education and communication requires several approaches:

- **Actively combating stigma and discrimination towards young key populations:** stigma may come from parents and other family members, especially in patriarchal environments; from members of the wider community or religious leaders; from educators or employers; from police and other law-enforcement officials; and from service-providers. Stigma may also be directed at young key populations because of their ethnic origin (e.g. Roma and others), or because of their national or migrant status.
- **Countering inaccurate perceptions in the general population about HIV and SRHR.**
- **Empowering young key populations with the information and education they need** to make

informed choices in their lives, particularly regarding their identity as key populations, HIV and SRHR, and their legal and human rights.

Media portrayals of key populations are often problematic and create stigma. Broad mass-media campaigns should be conducted using various channels of communication—social ads through TV, radio and the Internet, printed materials, printed media—to raise awareness, influence public opinion and change societal attitudes that stigmatize and discriminate against young key populations. An important approach to consider is an awareness-raising campaign (involving government representatives, academics and health and social-care professionals) to delegitimize unscientific statements and claims in public discourse and education curricula that stigmatize key populations, especially members of sexual minorities.

MEDIA ADVOCACY ON SRHR IN GEORGIA

The media is a powerful way to spread information across the breadth of society. To increase media interest in SRHR, HERA XXI trained media representatives from five regions of Georgia. The training covered SRHR and gender, and gave guidance on how to properly prepare reports on these issues (including the correct use of terminology), as well as the role and importance of media in the SRHR field. The media participants came with low awareness of the issues and did not know sources of good information. In the training, examples of reporting on SRHR issues in the Georgian media were discussed so that the participants could see where reporting had been inadequate and how it could be improved. Following the training the media representatives prepared TV programmes, articles and social media interviews featuring experts who talked about the barriers and problems in SRHR space. To encourage coverage, a competition was held for the best reporting on SRHR.

The work with media representatives demonstrated that popularization of SRHR issues by media outlets is an effective tool. In 2016 HERA XXI supported the creation of a TV studio to conduct advocacy work, destigmatize SRHR and provide accurate information, including on contraceptive choices, safe abortion and women's rights. Stories are broadcast from different regions of Georgia, and experts, politicians, decision-makers and stakeholders in the SRHR field present their positions on the issues.

Organizations working with young key populations should develop and implement a communications strategy and action plan with the participation of young key populations, community-led NGOs, government representatives and other relevant organizations and structures, reflecting the specific needs of each young key population group and identifying key messages, e.g. SRHR, HIV prevention, skills-based risk reduction issues, including condom and lubricant use and education on the links between the use of drugs and alcohol and unprotected sex. Involving young key populations in the design of materials is essential to ensure that they are relevant in content and format. Information should be disseminated via multiple media, including websites, social media, and mobile phones. The input of young key populations is essential to ensure that the information is disseminated where it will be most widely viewed.

COMPREHENSIVE SEXUALITY EDUCATION (CSE)

VOICES OF YOUNG KEY POPULATIONS

“If a school student has [sexual and] reproductive health problems, they will be in a very difficult situation, because they are not provided with any information on reproductive health—for example, about ways of protection. And about diseases and where one can go. And also they would not serve you, as a minor, without parental consent. This is a barrier.” *Young person from an orphanage, Georgia*

RECOMMENDATIONS ON COMPREHENSIVE SEXUALITY EDUCATION

It is recommended that sexuality education programmes for adolescents, both in and outside of schools, be scientifically accurate and comprehensive and include information on contraceptives, including how to use them and where to get them. *Key Populations Consolidated Guidelines (2016)*

All young people have the right to education and information, including comprehensive, gender-sensitive and rights-based sexuality education. All young people have the right to access accurate, easy to understand information and education about sexuality, sexual health, reproductive health, sexual rights and reproductive rights in order to make decisions freely and with informed consent. *Exclaim! Young people's guide to 'Sexual rights: an IPPF declaration' (2011)*

The United Nations Convention on the Rights of the Child states that children and young people have the right to enjoy the highest attainable health, access to health facilities (Article 24), and access to information which will allow them to make decisions about their health (Article 17), including family planning (Article 24). Young people also have the right to be heard, express opinions and be involved in decision-making (Article 12). They have the right to education which will help them learn, develop and reach their full potential and prepare them to be understanding and tolerant towards others (Article 29). Additionally, young people have the right not to be discriminated against (Article 2).

CSE is an age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic, nonjudgemental information. It recognizes that information alone is not enough. CSE seeks to equip young people with the knowledge, life skills, attitudes and values they need to determine and enjoy their sexuality—physically and emotionally, individually and in relationships. CSE can be provided inside or outside school settings. There is clear evidence that it has a positive impact on SRH, contributing towards reducing STIs, HIV and unintended pregnancies.

Young people are increasingly demanding their right to sexuality education (the 2011 Mali Call to Action; the 2012 Bali Global Youth Forum Declaration; the 2014 Colombo Declaration on Youth). At the 2016 AIDS Conference in Durban, youth leaders sent a clear message in their Call to Global Leaders to address the needs of young key populations by implementing informal out-of-school CSE. International agreements mandate that CSE promote gender equality. CSE programmes are effective only when linked to SRH services.

To promote SRH as well as gender and sexual rights through a systemic approach, appropriate training should be offered by experienced and knowledgeable trainers, with clear goals and objectives based on a curriculum. There are few models for CSE curricula in the EECA Region, and where such curricula exist, they are often not comprehensive or rights-based, and information is often biased.

There are several good practices for comprehensive CSE:

- Curricula should be designed to ensure that the education is suitable for all young people, including members of key populations.
- CSE should include information on sexuality and happy, healthy sex.
- Referrals should be available between CSE and integrated SRHR and HIV services, including support services.
- CSE should also be provided in non-formal settings for out-of-school young people.

THE INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION AND OUT-OF-SCHOOL YOUNG PEOPLE

Achieving universal access to high-quality CSE requires specific strategies for reaching left-behind young people who are out of school. Young people who face discrimination and violations of their human rights—including the right to education—are at greatest risk of poor SRH outcomes. Failing to provide them with CSE will deepen the social exclusion that many experience, limiting their potential and putting their health, futures and lives at greater risk.

NGOs have played an important role in developing strategies for reaching vulnerable and hard-to-reach young people through Internet and mobile technologies, new media, community and youth centres, as well as sport. Many of the most successful interventions have been developed in partnership with young people. CSE that includes community-based components—including involving young people, parents and teachers in the design of interventions—results in the most significant change. However, at the global level there are currently no analyses of the effectiveness of out-of-school CSE, nor is there a minimum standard package for CSE.

In 2017 UNFPA is leading the development of Volume 3 of the International Technical Guidance on Sexuality Education (ITGSE, first published in 2009). This volume covers out-of-school CSE to reach young people left behind (Volumes 1 and 2 of the Guidance focus on in-school informal education). The intended audience for ITGSE Volume 3 is professionals within the health, education and youth development sectors who work with adolescents and young people outside of formal education contexts, with responsibility for developing, funding, implementing or evaluating sexuality education materials and programmes. Those working on the SRHR of left-behind young people—including from key populations—and on adolescent health or gender equality are also part of the target audience because of their important role in advocating for, and supporting, the delivery of out-of-school CSE.

CSE MATERIALS FOR OUT-OF-SCHOOL YOUTH

The UNFPA East and Southern Africa Region has developed a regional resource package for out-of-school young people. It contains a SRHR/CSE programming guide, a facilitator's manual and participants' workbook, and a set of four pamphlets. The material aims to strengthen national capacity and improve and expand comprehensive SRHR for adolescents. Lesotho, Namibia and Zambia have adapted the manual as part of their national framework for out-of-school CSE.

As a related initiative, a UNFPA-supported online platform, TuneMe.org, helps young people access SRHR information relevant to them. The platform targets more than 320,000 users in five countries of the East and Southern Africa Region.

PEER-LED CSE IN SCHOOLS AND UNIVERSITIES IN BELARUS

In Belarus, university student volunteer groups organize capacity-building initiatives on SRH for pupils and students aged 15–24, with the national Y-PEER network and the Red Cross as the main actors. Most of the sessions are based on Y-PEER's standardized peer education methodology: students are prepared by certified trainers to cover the topics of SRH, HIV prevention, gender and other related issues. The interactive and experiential learning allows the participants to gain crucial life skills and act more responsibly in their daily lives.

Although the initiatives do not specifically target key populations, the sessions are organized as safe spaces, and participants and trainers are often key populations, which encourages young key populations to participate. Although Belarus still faces challenges related to key populations' rights and access to services, the peer education approach has proven very effective in overcoming the initial barriers the participants face in opening up and acquiring knowledge and skills.

DEVELOPING CSE FOR PRE-UNIVERSITY STUDENTS IN ALBANIA

The introduction of CSE in formal education at pre-university level was the result of almost six years of efforts (2009-2014) by UNFPA, the Albanian Centre for Population and Development (ACPD), an IPPF Member Association and other stakeholders. This process included advocacy, delivering CSE in school and out of school, trainings with teachers, parents and community leaders, awareness-raising among public and media, and developing and piloting teaching modules.

In 2015 the cross-curricular modules, entitled Sexuality and Life Skills, were approved by the Ministry of Education for use in schools. They are taught within the subject areas of biology, health education and physical education. Training for teachers at national level was carried out by the Institute for Education Development with the support of UNFPA. ACPD and partners working with young key population have used the curriculum to deliver SRH information among young key populations in and out of school, including those who use drugs, young people who sell sex, and young MSM.

All partners are working to improve coordination and integrate feedback, including more focus on underserved groups, i.e. those who are not in school and populations particularly vulnerable to HIV, with information about their specific SRH needs, contraceptives and the availability of facilities providing such SRH information and services.

Resources

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LEGAL CONTEXT, STIGMA, DISCRIMINATION AND VIOLENCE

THE LEGAL AND POLICY ENVIRONMENT

Laws prohibit or permit specific behaviours, and in this way they shape politics, economics and society. Thus law has the power to bridge the gap between vulnerability and resilience to HIV.¹³ The United Nations political declaration on HIV and AIDS (2016) affirms the work of national parliaments “to unlock political and legislative obstacles to ensure an enabling legal environment supportive of effective national responses to HIV and AIDS” while noting that “restrictive legal and policy frameworks, including those related to HIV transmission, continue to discourage and prevent people from accessing prevention, treatment, care and support services.”

International conventions establish the rights of young people—which includes young key populations—in the areas of civil rights, protection, non-discrimination, health and well-being. These apply to effective HIV prevention and treatment services and an environment that enables access to them.

The **International Covenant on Economic, Social and Cultural Rights (ICESCR)**, which entered into force in 1976, enshrines the right to the highest attainable standard of physical and mental health (Article 12) for all people without discrimination (Article 2).

The **International Covenant on Civil and Political Rights (ICCPR, 1976)** prohibits discrimination based on sex (among other attributes, Article 26). In 1994, the United Nations Human Rights Committee ruled that “sex” as used in the ICCPR also includes sexual orientation, thereby making discrimination against sexual minorities a violation.

The **United Nations Convention on the Rights of the Child (CRC, 1990)** is a legally binding international instrument that sets out the civil, political, economic, social and cultural rights of children. It has four guiding principles, which represent the underlying requirements for their rights to be realized. These are:

- **non-discrimination (Article 2)**, i.e. rights under the CRC apply to all children everywhere
- **the best interests of the child (Article 3)** must be a primary consideration in all actions concerning children

- **the right to life, survival and development (Article 6)**, in order that children can survive and reach their full potential
- **respect for the views of the child in matters affecting them (Article 12)**, recognizing that children have the right to express their views and for these views to be given due weight in accordance with their age and level of maturity.

Although the CRC creates a framework of rights which national laws and policies should comply with in order to respond to the needs of young people, in practice this often does not happen. This makes it challenging for programme implementers and service-providers to ensure that the rights of young key populations are respected and fulfilled. It is more complicated still for those under the legal age of majority, when the rights or wishes of parents or guardians may conflict with what may be considered within the best interests of the child. In some countries medical services, including HIV tests and sexual and reproductive health and rights (SRHR) services, cannot be provided to those under 18 without the consent of a parent or guardian (see Table 3.1, and Section 3.2.1).

The behaviours that characterize key populations—selling sex (at any age), same-sex sex or injecting drug use—are illegal in some or all countries of the region (see Table 3.1). The UNAIDS 2016-2021 strategy encourages countries to “remove punitive laws, policies and practices that block an effective AIDS response, including ... those related to HIV transmission, same-sex sexual relations, sex work and drug use.”

Those who design or implement programmes serving young key populations often face considerable legal and ethical dilemmas. For example, international conventions describe the participation of children under 18 years of age in selling sex as sexual exploitation and a contravention of human-rights law.¹⁴ However, while young people over the age of 18 who sell sex are considered sex workers,¹⁵ law-enforcement agents or service-providers may assume that they have been trafficked, which is a human-rights violation,¹⁶ without understanding that some young people freely choose to engage in sex work, while others do so for reasons that do not involve direct coercion or deceit, such as a lack of alternative economic opportunities.

13 / HIV and the law: risks, rights and health. New York (NY): Global Commission on HIV and the Law; 2012. Available at: <http://www.hivlawcommission.org/index.php/report> - 14 / United Nations protocol to prevent, suppress, and punish trafficking in persons, especially women and children (Palermo Protocol); also the ICESCR. - 15 / UNAIDS guidance note on HIV and sex work (updated April 2012), p.3. - 16 / The Palermo Protocol defines trafficking as “the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, abduction, or fraud, of deception, of abuse of power...or the giving or receiving of payment or benefits to achieve the consent of a person having control over another person, for the purposes of exploitation.”

POLICY BRIEF: YOUNG SEX WORKERS (2016)¹⁷

In 2016, the Global Network of Sex Work Projects (NSWP) developed a policy brief summarising available research on young people who sell sex, including both young people who sell sex below the age of 18 and young sex workers between the ages of 18 and 29. It provides an overview of the legal framework that impact people under 18 who sell sex, and summarises the available literature on the experiences of young people who sell sex. It also includes the voices of sex workers following community consultations, including the EECA region. Young people who sell sex face specific challenges, including systemic discrimination, stigma, and criminalisation, that increases their vulnerability to HIV. The policy brief provides key recommendations for service providers and policy makers.

The policy brief urges “a holistic approach to young people who sell sex, centred on improving access to information and health services that enable them to protect themselves and obtain the highest attainable standard of health. In the context of sex work, repressive measures that deny services increase vulnerability to HIV infection. The dominant approach to addressing young people who sell sex has been shown by research to create systematic violations of young peoples’ human rights, including the rights to health and life, and entitlement to self-determination, non-discrimination, and improvement in well-being”.

Table 3.1 **LAWS AFFECTING YOUNG KEY POPULATIONS IN SELECTED COUNTRIES IN THE EECA REGION**
(Note: information is in summary form and is not necessarily a comprehensive account of all aspects of the law)

Sources for Table 3.1

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- Sexual orientation laws in the world – an overview. Website. International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA). <http://ilga.org/what-we-do/maps-sexual-orientation-laws/www.sexualrightsdatabase.org>
- Accessibility of HIV prevention, treatment and care services for people who use drugs and incarcerated people in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: legislative and policy analysis and recommendations for reform. Ashgabat: United Nations Office on Drugs and Crime Regional Office for Central Asia; 2010. www.unodc.org/documents/centralasia/Accessibility_of_HIV_prevention_treatment_and_care_eng.pdf,
- Trans legal mapping report 2016: recognition before the law. Geneva: ILGA; 2016. <http://ilga.org/what-we-do/gender-identity-and-gender-expression-program/trans-legal-mapping-report/>
- Criminalization of HIV transmission. Website. AIDS-Free World. <http://www.aidsfreeworld.org/PlanetAIDS/Transmission.aspx>
- The global database on HIV-related travel restrictions. Website. <http://www.hivtravel.org/Default.aspx?pagelD=142>
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¹⁷ / Policy brief: Young sex workers. Edinburgh, UK: Global Network of Sex Work Projects; 2016.

	ALBANIA	BOSNIA AND HERZEGOVINA	GEORGIA	KYRGYZSTAN	SERBIA	TAJIKISTAN	FYROM	UKRAINE
LEGAL AGE OF MAJORITY	18	18	18	18	18	18	18	18
LEGAL AGE OF CONSENT FOR SEX	14-15	14-15	16-17	18	14	16	14-15	16
SEX WORK ILLEGAL?	yes	partially	buying sex only	brothel-keeping and forcing into sex work	unknown	partially “brothel keeping and pandering”	partially	yes
MANDATORY REPORTING TO PARENTS OF UNDER-18s WHO SELL SEX?	yes	yes	no	no	no	yes	no	yes
HOMOSEXUAL SEX ILLEGAL?	no	no	no	no	no	no	no	no
DRUG USE ILLEGAL?	yes	yes	yes	not criminalized	yes	yes	no	yes
TRANSGENDER IDENTITY LEGALLY RECOGNIZED?	no restriction	name yes; gender marker yes, but requirements are prohibitive	name yes; gender marker yes	name yes; gender marker yes, but requirements are prohibitive	no	no	name yes; gender marker yes	name yes; gender marker yes, but requirements are prohibitive
PARENTAL CONSENT REQUIRED FOR HIV TEST FOR UNDER-18S?	yes	yes	until age 14	yes	until age 15	yes	yes	until age 14
OTHER LEGAL CRITERIA FOR HIV TESTING	no	no	no	mandatory testing if ordered by police and courts	no	mandatory for people getting married	no	no
CRIMINALIZATION OF HIV TRANSMISSION?	yes	yes	yes	yes	yes	yes	yes	yes
PARENTAL CONSENT REQUIRED FOR OTHER MEDICAL SERVICES FOR UNDER-18S?	yes	yes	yes, but ages 14-18 can access SRH services without parental consent	yes	yes	access to all medical interventions restricted under the age of 15	yes	until age 14
CONTRACEPTIVES AVAILABLE FOR UNDER-18S?	yes	yes	parental consent required until age 14	yes	yes	access to all medical interventions restricted under the age of 15	yes	parental consent until age 14
MANDATORY REPORTING TO PARENTS OF PREGNANT GIRLS UNDER 18?	yes	yes	until age 14	no	until age 16	yes	no	only if under 16
MANDATORY PRE-MARITAL HIV TESTS?	no	no	no	no	no	no	no	no
ENTRY RESTRICTIONS FOR PEOPLE LIVING WITH HIV?	no	In Republika Srpska only	no	no	no	no	no	no
LEGAL STATUS OF CIVIL-SOCIETY ORGANIZATIONS	no restrictions	no restrictions	no restrictions	no restrictions	no restrictions	NGOs are under government audit	no restrictions	no restrictions

In addition to the legal barriers to services and information listed in Table 3.1, other issues faced by young people include:

Expectations of confidentiality: Providers with mandatory reporting obligations may experience a conflict between their obligations and the child’s expectation of confidentiality. Even if these laws are intended to protect young people from harm, they may in practice deter them from obtaining the health and social services they need, and further expose them to harm.

Bias and discrimination: Service-providers may discriminate against young key populations or refuse to treat them, either for reasons of personal bias or because the service-provider is uncertain of what services they are legally permitted to provide. The UNAIDS 2016-2021 strategy states that “countries are encouraged to work with service-providers in health-care, workplace and educational settings to eliminate HIV-related stigma and discrimination, including against people living with HIV and key populations.”

Sex work: Young sex workers experience sexual, physical and emotional violence at the hands of law-enforcement officers. Even when sex work is not illegal, police may use other laws to harass or arrest sex workers, such as laws against vagrancy, loitering or causing a public nuisance, in addition to bribery, extortion and entrapment.

Men who have sex with men and transgender people: Homosexuality is legal in most countries in the region. However, in all countries, young MSM and young transgender people experience sexual, physical and emotional violence, entrapment and extortion at the hands of law-enforcement officers. Even in countries where some cultural tolerance of lesbian, gay, bisexual, transgender and intersex (LGBTI) people exists, communities routinely report stigma and other forms of violence and live in fear of their lives, their freedom and their confidentiality. A common threat by law-enforcement officers is societal exposure of homosexuality—informing parents, friends, schools and places of employment. There is little or no protection for these highly vulnerable young people, and family and social exclusion is common.

Criminalization of drug use in EECA region: Punitive laws deal harshly with those found in possession of drugs, including young people. Alternative ways to address drug use, other than imprisonment, must be advocated for.

Weak laws or enforcement of laws: Anti-discrimination laws may not be strong enough to be effective, or may be poorly enforced, e.g. there is no systematic monitoring of human-rights violations, or the human rights Ombudsman does not fully resolve cases that are presented. Laws may offer insufficient protection to young key populations against all forms of violence—whether within the home and family, intimate partner violence, stigma as violence or sexual and physical violence. Young key populations may have limited or no access to legal services and legal aid. Furthermore, the lack of community mobilization among young key populations means they may have few support mechanisms for constructing and documenting cases of human-rights violations sufficient to warrant attention from human-rights institutions and Ombudsmen. In this way they suffer multiple levels of marginalization and lack of access to justice.

Civil-society organizations under threat: Legislation may restrict the activities of nongovernmental organizations (NGOs), e.g. by prohibiting “gay propaganda” or foreign funding, or there may be other political discrimination against organizations working with young key populations. Additionally, the law may prohibit civil-society organizations from receiving government money, which may undermine their ability to function as donor investment decreases.

OVERVIEW OF LAWS RELATING TO DRUG POSSESSION AND SALES IN SOME BALKAN COUNTRIES

ALBANIA

In Albania, drug use is not specified as a distinct offence or public misdemeanour, and possession of a small amount or single dose for personal use is not punishable. Because the law does not specify the quantity, this leaves space for misinterpretation by police and justice system agencies. Selling, offering for sale, giving or receiving drugs in any form, and distributing, transporting, delivering and keeping them (except for a small amount for personal use) are punishable by 5–10 years of imprisonment. Harsh penalties (10–20 years’ imprisonment) are applied if the same act is committed in collaboration or more than once. Penalties for personal possession do not vary with the type of drug involved, or with drug dependency or the offender’s previous convictions.

BOSNIA AND HERZEGOVINA

In Bosnia and Herzegovina offences related to drug use are regulated at Federation and entity levels. Possession for personal use is a minor offence (fine of EUR 500–1,000), but supply-related offences are punishable at the Federation and entity level. Penalties do not vary with the type of drug involved, or with drug dependency or the offender’s previous convictions.

In Republika Srpska, use of illegal drugs in a public space and possession for personal use are minor offences, with penalties of up to EUR 250. Penalties for personal possession do not vary with the type of drug involved, with drug dependency or the offender’s previous convictions. At Federation level, production and sale of drugs are punishable by 1–10 years’ imprisonment, with a minimum of three years if organized by a group and up to 15 years if organized or if involving minors.

KOSOVO¹⁸

Possession of illegal drugs for personal use is considered a crime punishable by 1–3 years in prison. In addition, possession of narcotic medications without prescription is considered an administrative violation punishable by a fine of up to EUR 300. Possession of less than 3g of any type of illegal drug for the first time is punishable by up to one year in prison. However, the law dictates a suspended sentence for mandatory treatment/rehabilitation if a first-time offender is dependent on drugs or alcohol. Supply, selling, offering for sale and cultivation of drugs are punishable by up to 10 years’ imprisonment, or up to 15 years if committed in collaboration or a repeat offence.

MONTENEGRO

Use, personal possession or cultivation of drugs for personal use are considered misdemeanour offences punishable with a fine of EUR 30–2,000. However, this penalty may be replaced by up to 30 days in prison. Penalties do not vary with the type of drug involved, or with drug dependency or the offender’s previous convictions. Selling, offering for sale, giving or receiving drugs in any form, and distribution, transporting or importing them are punishable by up to 15 years in prison.

18 / All references to Kosovo shall be understood to be in the context of United Nations Security Council Resolution 1244 (1999).

LEGAL REFORM

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)¹⁹

Countries should work toward decriminalization of behaviours such as drug use/injecting, sex work, same-sex activity and nonconforming gender identities, and toward elimination of the unjust application of civil law and regulations against people who use/inject drugs, sex workers, men who have sex with men and transgender people.²⁰

Laws, legal policies and practices should be reviewed and, where necessary, revised by policy-makers and government leaders, with meaningful engagement of stakeholders from key population groups, to allow and support increased access to services for key populations

Countries are encouraged to examine their current consent policies and consider revising them to reduce age-related barriers to HIV services and to empower providers to act in the best interest of the adolescent.

Countries should work toward developing non-custodial alternatives to incarceration of drug users, sex workers and people who engage in same-sex activity.

The United Nations Political declaration on HIV and AIDS (2016) notes that “laws and policies in some instances exclude young people from accessing SRH care and HIV-related services, such as voluntary and confidential HIV testing, counselling, information and education.” The Global Commission on HIV and the Law has provided evidence-informed, rights-based recommendations for effective responses to the HIV epidemic. Supported by

scholarly research, the commission consulted widely with government, civil society and United Nations partners through a series of seven regional dialogues. The Commission’s final report, HIV and the law: risks, rights and health, published in 2012, contained recommendations for scaling up HIV-related human-rights programmes.

THE LAW, HUMAN RIGHTS AND HEALTH
(from HIV and the law: risks, rights and health)

Key populations (like everyone) are entitled to: the fundamental human rights of dignity, autonomy and freedom from ill treatment, as well as the right to the highest attainable standard of physical and mental health, regardless of sexuality or legal status.

The three elements of legal environments—law, enforcement and access to justice—are interdependent. It is best to pursue all three in simultaneous and coordinated fashion. (...) But where governments are fragile and resources few, it is always worthwhile to work on one or two fronts, creating space to address all three in time. And even where legal reform may be deemed too complex and challenging, governments must protect human rights, punish police violence and support programmes to challenge stigma and discrimination against people with HIV, other key populations and those who are vulnerable.

Among the report’s recommendations to ensure an effective, sustainable response to HIV that is consistent with human-rights obligations are the following:

Countries must reform their approach towards drug use. Rather than punishing people who use drugs who do no harm to others, they must offer them access to effective HIV and health services, including harm reduction and voluntary, evidence-based treatment for drug dependence.

Countries must reform their approach towards sex work. Rather than punishing consenting adults involved in sex work, countries must ensure safe working conditions and offer sex workers and their clients access to effective HIV and health services and commodities.

Countries must reform their approach towards sexual diversity. Rather than punishing consenting adults involved in same-sex activity, countries must offer such people access to effective HIV and health services and commodities.

Countries must reform their approach towards transgender people. Rather than punishing transgender people, countries must offer transgender people access to effective HIV and health services and commodities as well as repealing all laws that criminalize transgender identity or associated behaviours.

Countries must enact and enforce laws ensuring the right of every child, in or out of school, to comprehensive sexuality education (CSE), so that they may protect themselves and others from HIV infection or live positively with HIV.

Sexually active young people must have confidential and independent access to health services so as to protect themselves from HIV. Therefore, countries must reform laws to ensure that the age of consent for autonomous access to HIV and SRHR services is equal to or lower than the age of consent for sexual relations. Young people who use drugs must also have legal and safe access to HIV and health services.

Outlaw all forms of discrimination and violence directed against those who are vulnerable to or living with HIV or are perceived to be HIV positive. Ensure that existing human-rights commitments and constitutional guarantees are enforced.

Enact no laws that explicitly criminalize HIV transmission, exposure or non-disclosure of HIV status, which are counterproductive.

19 / Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2014, updated 2016. - 20 / This recommendation builds upon the WHO, UNFPA and Global Network of Sex Work Projects (NSWP) guidelines on Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries (2012). These guidelines were the first official United Nations document to call for decriminalization of sex work.

A MODEL LAW ON SRH IN TAJIKISTAN

In 2012-2013 the UNFPA EECA Regional Office began designing a model law on reproductive health and reproductive rights for EECA countries. With the advocacy and technical support of the UNFPA Country Office in Tajikistan, the Parliament and Ministry of Health and Social Protection established a working group to review the existing law, and embedded the model law into a national SRH law that now meets international standards. In December 2015 the government produced an order on procedures for providing SRH services to adolescents and young people, including members of key populations. The order gives a detailed definition of vulnerable groups, key populations, informed consent, counselling, confidentiality, personal information and medical services, and it is expected to improve key populations' access to SRH services.

3.2.1 Parental consent

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Countries are encouraged to examine their current consent policies and consider revising them to reduce age-related barriers to HIV services and to empower providers to act in the best interest of the adolescent. It is recommended that sexual and reproductive health services, including contraceptive information and services, be provided for adolescents without mandatory parental and guardian authorization/notification.

Parental consent laws require young people under a certain age to have a parent's or guardian's consent before they can access health services. In some countries, these laws are applied only to certain services, such as HIV testing, emergency contraception, or needle and syringe exchange programmes (see Table 3.1). Parental consent laws apply a blanket approach to all young people, without considering their individual ages, maturity and evolving capacities for making informed decisions relating to their own health.

The rate of physical and emotional maturation of young people varies widely. Article 5 of the CRC recognizes the concept of the evolving capacities of the child, stating that direction and guidance, whether provided by parents or by others with responsibility for the child, must take into account the child's capacities to exercise rights on his or her own behalf. In other words, while a parental consent requirement might be appropriate for a 5-year-old, it might not be for a 15-year-old.

When the consent of parents or guardians is required for a young person to access SRH services, this can pose a barrier to their accessing the full range of services they need. This is even more the case for young key

populations, who may not wish to reveal their identity as a key population to their family, and who indeed may be endangered by doing so.

GOOD PRACTICE FROM UNESCO'S YOUNG PEOPLE AND THE LAW IN ASIA AND THE PACIFIC

Governments should remove age restrictions and parental consent requirements that impede access to SRH and HIV services, including testing for HIV and other STIs, condoms and contraception, needle and syringe programmes and opioid substitution therapy. Consistent with the CRC, national laws should recognize the evolving capacity of adolescents to make independent decisions regarding their health. The consent of a parent or guardian to SRH and HIV services should not be required if a minor is considered to be sufficiently mature. A young person should be able to consent independently if the young person is capable of understanding the nature and consequences of the service and is able to assess their own best interests. If governments prefer to define a minimum age below which consent of a parent or guardian is required in all cases, this should be set at early adolescence. Children above such a minimum age should be able to consent independently if they are assessed by the health professional offering the service as sufficiently mature.

The question of consent also touches upon other issues that directly affect young people and which should also be the subject of advocacy for legal and policy review:

- **The age of consent to sexual activity:** this should be set at an appropriate level that balances the right to protection with the recognition of the evolving capacity and autonomy of adolescents and young people. The minimum should be the same for boys and girls, and for same-sex as well as opposite-sex sexual activity.
- **The age of consent to marriage:** This also should not differ between males and females, and should incorporate the free and personal consent of both partners entering into the marriage.
- **The age of consent to health services and medical treatment** (beyond SRH services).

SUPPORTING ADVOCACY ON AGE OF CONSENT LAWS

An Age of Consent Advocacy Pack developed by the PACT (a global coalition of 25 youth-led and youth-serving organizations and networks working on HIV) and other organizations presents best practices for advocacy on the age of consent, including legislative and policy advocacy relevant to adolescents and young people. The pack focuses on the impact of consent laws on them, and provides practical activities to help audiences understand the information.

As part of the “All In” partnership to end adolescent AIDS, UNAIDS and PACT piloted the pack in Zimbabwe in 2016. The process was facilitated by Youth Engage, a youth-led advocacy organization that brought together 25 youth advocates from diverse backgrounds. Young people, with support from the National AIDS Council of Zimbabwe, are now mobilizing and preparing for a dialogue with parliamentarians to discuss the age of consent laws on marriage, sex and HIV testing in Zimbabwe and young people’s access to SRH services. The manual will also be piloted in other countries.

ALLOWING ADOLESCENT MSM TO BE TESTED WITHOUT PARENTAL CONSENT IN INDONESIA

The Ruang Carlo clinics in Jakarta and Bali, which provide services to men who have sex with men, do not impose any age limitation on who can receive an HIV test. As one key informant remarked: “They engage in very adult behaviours, if they come for testing or treatment we should treat them as adults, too.” A district health centre also found a creative way not to block access to HIV testing for adolescents: they allowed their outreach volunteers to sign off for clients younger than 18 as their guardian. A well-known MSM clinic in Bali also does not ask for parental consent when testing adolescent MSM. As a result of this practice, there are 16-year-old MSM and transgender women already on antiretroviral treatment in Jakarta and Bali; again, for enrolling in treatment, no parental consent is required.

Source: Changing gears: a guide to effective HIV service programming for gay men and other men who have sex with men in Asia. Bangkok: APCOM; 2016.

ADDRESSING STIGMA AND DISCRIMINATION

The **United Nations political declaration on HIV and AIDS** (2016) commits countries to “intensifying national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV, including by linking service-providers in health-care, workplace, educational and other settings, and promoting access to HIV prevention, treatment, care and support and non-discriminatory access to education, health-care, employment and social services, providing legal protections for people living with, at risk of and affected by HIV (...), and promoting and protecting all human rights and fundamental freedoms.”

Besides advocating for legal reform, there are numerous activities that can help to address stigma and discrimination against young key populations, and those living with HIV, at local, regional and national levels.

Sensitize public servants, law-enforcement representatives and police officers on human rights, young key populations and SRHR issues (see also Section 3.5.1).

Work with government bodies, such as the human-rights Ombudsperson. Write alternative/shadow reports to ombudspersons, human-rights commissions or United Nations human-rights processes such as the Universal Periodic Review (UPR) and the Committee on Economic, Social and Cultural Rights (CESCR). It is important to train community members and organizations in how to use these instruments and write shadow reports.

Ensure that young key populations have **access to free-of-charge legal advice and assistance** for protecting their rights when these are violated by law-enforcement or medical personnel. Improve the system of medical examination for filing rape cases with law-enforcement authorities.

Sensitize the media on correct ways to report and discuss SRHR, gender issues, gender-based violence and abuse issues, and relevant international and national events.

Strengthen the capacity of civil-society groups to protect the human rights of key young populations and vulnerable groups, including through the establishment of human-rights defender programmes run and led by communities.

Design a CSE curriculum for primary and secondary schools, addressing SRH, safe behaviour, sexual rights and gender, as appropriate for each age group. The public school system is the single largest public medium for communication with the majority of young people. (See Section 2.4 for more information.)

Design a comprehensive SRHR education programme for out-of-school young people. Many young key populations are not in school and are not reached by school-based programmes. They have little or no access to reliable SRHR information yet are living in circumstances resulting in high rates of unprotected sex with multiple partners, vulnerable to STIs, unintended pregnancies, and lack of access to post abortion care.

THE PEOPLE LIVING WITH HIV STIGMA INDEX

The People Living with HIV Stigma Index is a tool to measure and detect trends in stigma and discrimination experienced by people living with HIV. It can be used by or for people living with HIV, and is primarily driven by people living with HIV and their networks. The tool is designed to be adopted and used by groups to understand experiences of stigma and discrimination in their locality, and to be a catalyst for creating change. The Stigma Index supports the principle of greater involvement of people living with HIV (GIPA) and thus empowers individuals and communities most affected by the epidemic. It is a powerful advocacy tool to support the collective goal of governments, NGOs and activists to reduce the stigma and discrimination linked to HIV.

In each country the research project is different but consistent with the ethos of the Stigma Index. The number of people interviewed varies, as does the outreach and composition of responses from different key population communities. The methodology and research design in each country is built on a core commitment to ethical processes.

Since the project began in 2008, more than 90 countries have completed the study, and the Stigma Index questionnaire has been translated into 54 languages. More than 180 people living with HIV have been trained as interviewers and 100,000 have been interviewed. The information gained from the Index has provided evidence for the success (or failure) of current programmes and has highlighted neglected areas requiring future action. These included improving workplace policies, informing debates about the criminalization of HIV transmission, and promoting the realization of human rights. Country reports showcasing the findings, including reports from countries in the EECA Region, can be found at www.stigmaindex.org/country-analysis.

ADDRESSING VIOLENCE

VOICES OF YOUNG KEY POPULATIONS

"The police often arrest us and beat us at the police station" Young person who injects drugs, Kyrgyzstan

"I was walking with my boyfriend in the park and kissing. Police arrested us and forced us to give them sex. " Young MSM, Ukraine

YOUNG KEY POPULATIONS TECHNICAL BRIEFS (2015)²¹

Work to prevent all forms of physical, emotional and sexual violence and exploitation, whether by law-enforcement officials or other perpetrators, and promote community-led response initiatives.

3.4.1 Types of violence

Young key populations may be subjected to various forms of violence:

Physical violence: Being subjected to physical force which can potentially cause death, injury or harm. It includes, but is not limited to: having an object thrown at one, being slapped, pushed, shoved, hit with the fist or with something else that could hurt, being kicked, dragged, beaten up, choked, deliberately burnt, threatened with a weapon or having a weapon used against one (e.g. gun, knife or other weapon). Other acts that could be included in a definition of physical violence are: biting, shaking, poking, hair-pulling and physically restraining a person.

Sexual violence: Rape, gang rape (i.e. by more than one person), sexual harassment, being physically forced or psychologically intimidated to engage in sex or subjected to sex acts against one's will (e.g. undesired touching, oral, anal or vaginal penetration with penis or with an object) or that one finds degrading or humiliating.

Emotional or psychological violence: Includes, but is not limited to, being insulted (e.g. called derogatory names) or made to feel bad about oneself; being humiliated or belittled in front of other people; being threatened with loss of custody of one's children; being confined or isolated from family or friends; being threatened with

harm to oneself or someone one cares about; repeated shouting, inducing fear through intimidating words or gestures; controlling behaviour; and the destruction of possessions.

Human-rights violations that should be considered in conjunction with violence against young key populations include:

- extortion
- being denied or refused food or other basic necessities
- being refused or cheated of salary, payment or money that is due to the person
- being forced to consume drugs or alcohol
- being arbitrarily stopped, subjected to invasive body searches or detained by police
- being arbitrarily detained or incarcerated in police stations, detention centres and rehabilitation centres without due process
- being arrested or threatened with arrest for carrying condoms
- being refused or denied health-care services
- being subjected to coercive health procedures such as forced STI and HIV testing, sterilization, abortions
- being publicly shamed or degraded (e.g. stripped, uploading photos or videos of the stripped individual on social media, being chained, spat upon, put behind bars)
- being deprived of sleep by force.

21 / For references, see Chapter 1, Section 1.5, Nos. 1–4.

3.4.2 Perpetrators

Perpetrators of violence against young key populations may include representatives of the state, especially law-enforcement or other uniformed officers (e.g. military personnel, border guards and prison guards); non-state groups such as gangs, militias or religious groups;

or institutional representatives such as employers, health-care providers, landlords, teachers or fellow students. Young people who sell sex may suffer violence from clients or from managers. Violence may also be perpetrated by members of the general public; intimate partners or family members; or even by members of young key populations themselves.

THE NEED TO PROTECT REFUGEE AND MIGRANT CHILDREN AGAINST VIOLENCE

Young people who are refugees or migrants face extreme stresses when fleeing countries like Afghanistan, Syria and Iraq and making their way to Europe. They may pass through countries of Eastern Europe that are not well equipped to receive or support them. For example, the tide of refugees and migrants transiting through Serbia has placed great pressure on the country's fragile national child protection capacities. Around 43% of the nearly 8,000 refugees in the country in 2016 were children, and nearly a quarter of these (around 900) were unaccompanied, or had become separated from their families during the journey. Two hundred of them were sleeping rough. There is insufficient accommodation specifically for minors, and the majority of those who are housed are accommodated in regular asylum/transit/reception centres, which can place them at further risk.

Young people on the move face a wide range of risks: from not being recognized as children (either explicitly or implicitly, by restrictions and discrimination in exercising rights and accessing services) to widespread and systematic violence, robbery, illegal detention, and the general ill-treatment that many refugees face. This includes discrimination in access to water, shelter or food; injuries and ordeals during the journey; infectious diseases; and gender-based violence. They are also vulnerable due to the absence of family members who could offer emotional support.

Many unaccompanied and separated minors allege that they have suffered abuse along the route. They are often at the mercy of smugglers and face heightened risks of physical and sexual abuse. In some cases, smugglers agree to take children and youth only in return for sexual favours or on the condition that young people repay the smugglers after arriving at their destination, which often means they are coerced into joining criminal groups. Sometimes young migrants bear the burden of knowing that their family has invested all its money to pay for their journey in the hope that the young migrant will be able to find work and support the family financially from afar. This makes them more vulnerable to abuse.

Most young migrants have not left their country of origin before and must confront new cultural and social norms. This can be very challenging and even risky for them, especially if they are coming from societies with a more conservative culture. For example, the first contact with alcohol and narcotic substances can be very harmful, or even deadly.

Special attention must be paid to members of young key populations who are refugees or migrants, in terms of education on safer sex, sexual identity and gender-based violence. In addition, frontline workers providing services to migrants in general need sensitization and education on how to work with and support young key populations.

3.4.3 Interventions to address violence

Core values for addressing violence against young key populations: Addressing violence should be seen both as a public-health imperative, and as a way of asserting that young key populations, like all people, are entitled to the full protection of their human rights. It follows from this that interventions must not be based on the requirement or belief of reparative therapy for same-

sex sexual behaviour, or of “rescue” or “rehabilitation” from sex work for those aged 18 and above. Community empowerment and sensitization are important so that young key populations understand that violence should not be acceptable to them, and to make reporting violence a norm once systems are established to address it. The right of young key populations to make their own informed choices, consistent with their maturity, should be respected.

PROGRAMMING PRINCIPLES FOR PROGRAMMES TO ADDRESS VIOLENCE

- **Understand local patterns of violence** against young key populations and the relationship of violence to HIV, as the basis for designing programmes.
- **Use participatory methods**, engaging young key populations in processes to identify their problems, analyse causes, identify priorities and develop solutions.
- **Design broad-based programmes** that provide information and holistic health services (including mental-health services) and work with the legal and justice sectors.
- **Use multiple platforms to reach young key populations**, including primary health care, outreach services, mobile counselling, social media, community-led counselling etc.
- **Build capacity of programme staff** to understand and address the links between violence against young key populations and HIV, and to respond sensitively to young key populations who experience violence, without further stigmatizing or blaming them.
- **Network with other groups and providers and establish referral systems:** services can be provided not just by HIV or SRH-related organizations but by key population groups (e.g. LGBTI groups), and referral systems should be established to and from primary health care.
- **Recognize that programmes may have unintended harmful effects** for young key populations, such as retaliatory or “backlash” violence. Prepare for this possibility and monitor programmes for such unintended consequences.
- **Design protocols to ensure the safety of outreach workers** and others responding to violence.
- **Evaluate programmes** to identify strategies that reduce risk factors and levels of violence faced by young key populations, in order to build the evidence base and ensure that resources are directed to the most beneficial strategies.

A **violence response system** should include providing access to immediate medical care, with accompaniment by a peer outreach worker or trained supporter, if requested. Psychological and emotional support should be offered by trained counsellors, and legal support, including assisting the victim with filing police reports as needed. In cases where a member of a young key population has been detained, a programme can advocate for their rights to be respected while in detention, or for their release if the detention is unlawful.

Supplementing this first-line response, programmes can offer sensitization programmes for police and health-care providers (see Section 3.5), as well as specialized training on responding to victims of violence; and evidence-gathering (interviewing witnesses and the person who has experienced the violence) to support legal cases, or for advocacy purposes. It is extremely important that interviews with the person who suffered the violence be conducted only by individuals trained to solicit information without re-traumatizing the individual. It is also important that information not be gathered just to build a documentary record, but that there be the prospect that it will be of practical use. Finally, programmes can also consider offering young key populations practical tips on security and ways to lessen the risk of violence.

WHAT POTENTIAL RESOURCES ARE NEEDED TO PROVIDE LEGAL, PSYCHOSOCIAL AND OTHER SUPPORT SERVICES?

Resource people:

- Designated and trained staff/volunteers (including key population members) to operate helplines or hotlines
- Community outreach workers
- Trained community or professional counsellors for psychological support
- Lawyers or paralegals (could be trained key population members) who can provide legal support

Materials and venue:

- Mobile phones and time credit
- Hotlines
- Internet access
- Print materials to advertise services
- Data collection and reporting forms
- A space to operate hotlines, conduct trainings and meetings
- Drop-in centre or shelter

Costs:

- Remuneration for staff (including lawyers if not working pro bono)
- Start-up and maintenance costs for mobile phones, hotlines
- Advertising the services
- Transport costs
- Training

Source: MSMIT

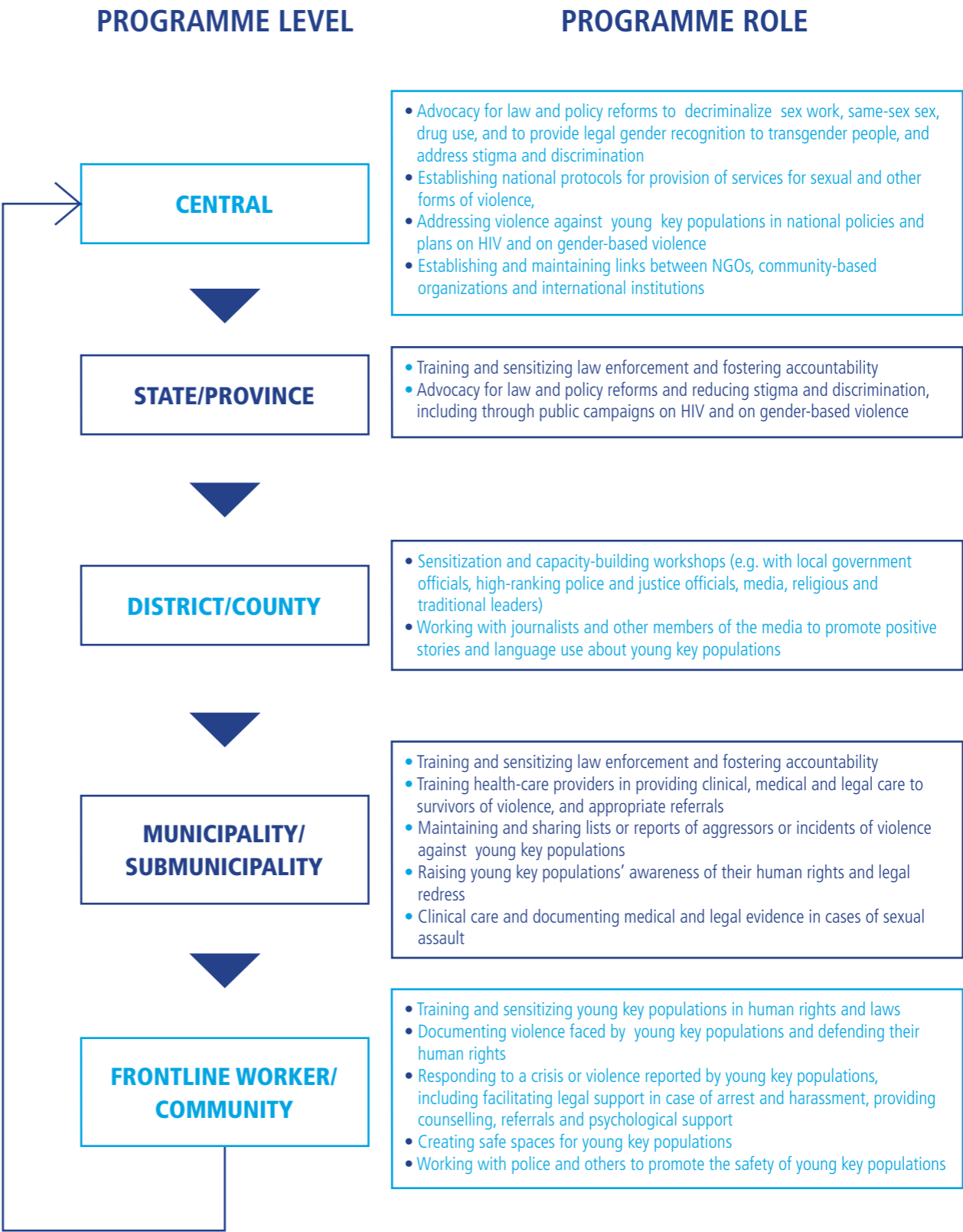


Figure 3.1 ILLUSTRATIVE MULTI-LEVEL APPROACH TO ADDRESSING VIOLENCE AGAINST MEMBERS OF YOUNG KEY POPULATIONS

Source: Adapted from SWIT

WOMEN'S SUPPORT ROOMS IN TAJIKISTAN

In 2012, as part of an integrated response to gender-based violence, the UNFPA Country Office in Tajikistan piloted eight women's support rooms for victims of violence in three regions of Tajikistan. The rooms offer shelter for up to three months, mostly to women who have suffered domestic violence, including young key populations aged 18 and above. Victims can be referred to affiliated facilities for services such as reproductive health, psychosocial and legal support.

The majority of rooms were established under the maternity houses, and in 2014 the Ministry of Health institutionalized the current model. The Ministry of Internal Affairs, committee on women and family affairs, community and religious leaders and local NGOs are involved in supporting the activities of the support rooms.

A MOBILE APP TO REPORT VIOLENCE IN ALBANIA

The "Digital Police Station" is a mobile application created in 2015 by the Ministry of Interior Affairs in Albania to strengthen its response to crime and improve its protection of public safety. Users who download the app can report breaches of the law in real time, including sending photos, videos or text messages. The user can choose not to reveal their identity, and can receive a response from the police about their case. By ensuring privacy, confidentiality and ease of use, it is hoped that the app will allow all citizens, including young key populations, to report incidents of violence or discrimination without being stigmatized themselves.

A department has been set up within the State Police Directorate to collect and analyse data from the app. As of January 2016, 514 cases of violence had been reported and addressed by the police, but the Ministry of Internal Affairs is not yet able to disaggregate this data to show the number of young key populations among these. This is a subject for collaboration between civil-society organizations and the police. Ongoing training and supervision by civil-society organizations is also needed to ensure that police are sensitized not to discriminate against young key populations at any stage of follow-up on reports.

THE CHALLENGES OF WORKING IN A PUNITIVE ENVIRONMENT FOR SEX WORKERS IN KYRGYZSTAN

In 2013 a department to fight human trafficking and crimes against public morality was established in Kyrgyzstan, under the Main Administration of Crime Detection of the Ministry of Internal Affairs. The department conducted mass raids which led to the arrest of 70 sex workers, who were then coerced into being tested for HIV. After this incident, NGOs working with sex workers attempted to negotiate a working relationship with the "moral police" department, through seminars and trainings to which department staff from other oblasts of the country were also invited. The aim was for the staff to understand the NGOs' work, provide assistance and not to impede HIV prevention work with sex workers.

Although good relationships were initially established, the raids continued, accompanied by violations of the human rights of sex workers. In June 2016, there was a "cleansing of sex workers from the city" and many were arrested. Around that time, the first department was disbanded and a similar new one established. These developments made it difficult for HIV prevention programmes to reach sex workers. The experience showed that interventions within a partnership-building framework may not lead to the intended result; trainings, discussions and joint work plans do not always solve problems. Even good subordinate legislation was not helpful in this case. It is crucial for all stakeholders to interact with the management of the Ministry of Internal Affairs to get acknowledgement that raiding sex workers has negative consequences for both law enforcement and the public health-care system, as well as leading to violations of sex workers' rights.

HUMAN RIGHTS DEFENDERS PROGRAMME, SOUTH AFRICA

The Human Rights Defenders programme has been implemented by the Sisonke sex workers movement and the Sex Worker Education and Advocacy Task Force (SWEAT) in South Africa since 2008. It trains sex workers as paralegals in basic rights and how to defend them.

Paralegals document cases of human-rights violations through a toll-free helpline, as well as outreach and weekly community meetings with sex workers. They also offer counselling support to those who report violations. Community meetings with sex workers are used to raise awareness of their rights and how to access justice. Sex workers who need legal services are referred to lawyers accessed through the Women's Legal Centre and weekly legal clinics. They are also offered court support.

SWEAT also undertakes strategic litigation to address the root causes of violence against sex workers.

Source: SWIT

SENSITIZING LAW ENFORCEMENT AND SERVICE-PROVIDERS

Young key populations may experience stigma and discrimination from multiple sources, including family members, community members at large, gangs, religious groups, schools and colleges, government agencies, service-providers and the media. Advocacy with all these groups is needed to achieve changes in policy, procedures, and individual and group behaviours that will reduce stigma and discrimination. This section focuses on the sensitization of police and other law-enforcement officials, and of service-providers.

3.5.1 Sensitizing law enforcement

VOICES OF YOUNG KEY POPULATIONS

“We are often set up. They have their people such as taxi drivers showing them where they dropped us off. When they bring us to a police station they start humiliating us. Laughing, calling us various things. They force us to clean the premises. They blackmail us, threatening to tell our parents and relatives. ”

Sex worker, Tajikistan

“Police officers come regularly to my house. They break down the door, bring their warrant and search my mother, my grandmother, my aunt. There’s no one to protect me. ”

Young person who injects drugs, the former Yugoslav Republic of Macedonia

Around the world, key populations state that violence by law-enforcement officers (gender-based violence, sexual violence, physical violence and stigma as violence), along with entrapment, harassment, arbitrary arrest and detention and extortion, is the single greatest barrier they experience. In all the focus group discussions held with young key populations in the EECA Region, they reported violence in some form from law enforcement. Even when law-enforcement agents act within the law, their treatment of young key populations creates barriers to outreach and to service access for young key populations. Threats of public exposure and humiliation are common. So are cases where the police, for instance, demand unprotected and unpaid sex from young MSM, sex workers and transgender people. In other cases, police insist that young MSM reveal the identities of other men in the local area who also have sex with men. This happens to both adults and children. There are also examples of police forcing health workers to conduct HIV tests on people from key populations.

The appropriate approach (or combination of approaches) to sensitizing police and other law-enforcement officers about key populations and young key populations will depend on the local context, including the legal status of the particular key population, and the other legal issues described in Table 3.1. Possible approaches include.

- stressing the **rights as citizens** of key population members (including young people) under the country’s constitution
- discussing the **human rights** of young key populations and the responsibility of the police to uphold these
- discussing the important role of the police in **supporting public health**, and the benefits of a reduction in HIV and of supporting the welfare of all young people for the sake of security and stability.

Sensitization of police may be most effective when it is presented as a way to benefit the police themselves, e.g. by providing accurate information on HIV, or explaining safe disposal of needles and syringes and ways to avoid needle-stick injuries.

It is valuable to enlist the support of local beat officers when establishing drop-in centres or safe spaces (so that young key populations using these facilities will not be targeted for arrest or harassment). Local police stations may also be willing to identify an officer who will be the liaison for cases involving young key populations.

It is also important to attempt a systematic approach to sensitizing law-enforcement officers, for example through regular in-service sessions, or better still, through sensitization as part of police training at the national level.

Sensitization can be done by members of a local implementing organization or by national trainers. Trainers should include key population members (and young key populations) wherever possible, since sharing of personal stories, combined with the professional competence of the trainer, can help reduce stigma.

SENSITIZING POLICE TRAINEES IN KYRGYZSTAN

Kyrgyz Indigo, an NGO that works with LGBTI people, has worked with law-enforcement bodies in the Kyrgyz Republic to raise awareness of LGBTI human rights, reduce stigma and discrimination, and improve the response of the police to crimes against LGBTI people, in partnership with AIDS Foundation East-West.

It was difficult for a single training programme to cover the full complement of officers due to their busy schedules, staff turnover and rotation between posts. Therefore, in 2014 Kyrgyz Indigo partnered with the Academy of the Ministry of Internal Affairs to offer a series of trainings on harm reduction. The trainings helped to break down the stereotypes of LGBTI people held by the Academy’s students, as well as helping them understand the identities and lives of LGBTI people.

To ensure sustainability of the results, the programme then trained 15 of the Academy’s professors so that they could teach students independently. Two representatives of police were nominated to participate in a Law Enforcement and Public Health Conference in the Netherlands to share experiences and build capacity in protecting the legal rights of LGBTI people. Kyrgyz Indigo’s next step in its strategy was to develop a tutorial, which was approved for 3rd- and 4th-year students, covering information on LGBTI people, focusing on preventing abuses against the community and eliminating stigma and discrimination.

3.5.2 Sensitizing service-providers to work with young key populations

VOICES OF YOUNG KEY POPULATIONS

“When I go to the AIDS centre, they simply hand over the antiretroviral medicines. They are not even concerned about my condition. ” *Young person living with HIV, Kyrgyzstan*

“I had a problem with my general practitioner—with her colleague, to be more precise—who asked me, “Why haven’t you used condoms? Who’s the fag you caught it from?”, and in front of the many people there she shouted out to the nurse to note down the B20 code, that I have HIV. ”
Young person living with HIV, the former Yugoslav Republic of Macedonia

“I don’t go to any doctor I don’t trust. Sometimes they treat us so badly, speaking roughly, saying “You are a so-and-so,” “Why are you engaged in this?” So I don’t want to go to him a second time.”
Sex worker, Tajikistan

“Once I came to a clinic and told them that I am a sex worker. They refused to provide me services.”
Sex worker, Ukraine

YOUNG KEY POPULATIONS TECHNICAL BRIEFS (2015)

Ensure that there is sufficient capacity among professionals, particularly health workers, social workers, and law-enforcement officials, to work with young people and apply rights-based approaches and evidence-informed practice. Stress a human-rights-based approach. Train health-care providers on the health needs and rights of young key populations, as well as on relevant overlapping vulnerabilities. Ensure that services are non-coercive, respectful and non-stigmatizing, that young key populations and health-care providers are aware of their rights to confidentiality, and that any limits of confidentiality are made clear by those with mandatory reporting responsibilities.

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Health-care providers should ensure adolescents from key populations know their rights— to confidentiality, health, protection and self-determination—so that they can advocate for themselves and seek the types of support they are entitled to. Services should provide developmentally appropriate, comprehensive information and education, focusing on skills-based risk reduction.

Services should be safe spaces that increase protection from the effects of stigmas and discrimination, where adolescents can freely express their concerns, and where providers demonstrate patience, understanding, acceptance and knowledge about the choices and services available to the adolescent.

Sensitizing service-providers is important because of the overlapping identities of young key populations and because they must often seek services from facilities that have not been established exclusively for them. Facilities providing HIV services may lack knowledge and experience working with key populations, and if they do work with them, they may not have specific expertise in young key populations. Facilities serving young people may likewise not be experienced working those who are members of key populations, or may be unfamiliar with multiple risk profiles, e.g. young people who sell sex who also inject drugs, or young MSM who sell sex.

At a policy level, issues relevant to young key populations should be included in the basic training of service-providers, i.e. in medical schools, social-work schools, as well as through continuing medical education and other continuing education/training programmes.

At a programme level, in-service sensitization on young key population issues can be offered to service-providers. This should ideally include all staff at service-delivery points who may have contact with young key populations (e.g. receptionists, nurses, counselling staff, doctors). Relevant topics include:

- the principles of youth-friendly/youth-centred services (see Section 5.1)
- the clinical needs of young key populations (for medical service-providers)
- risk-reduction needs of young key populations (for those providing pre-HIV test information and post-test counselling)
- their psychosocial needs
- how stigmatization can affect their ability to use services
- use of appropriate language and terminology (e.g. use “sex work” rather than “prostitution”, do not use disparaging terms for men who have sex with men, transgender people and people who use drugs).

An additional important topic for discussion are the legal and human-rights issues around providing services to those under the age of 18 (see Section 3.2.1).

Programmes can consider working with the health ministry and health-care staff to develop standard operating procedures to help health-care providers deliver services for young key populations competently and consistently.

SENSITIZING SERVICE-PROVIDERS IN ALBANIA

Issues relevant to young key populations should be included in the basic training of health-care providers. One way of doing this is to include information about young key populations in various kinds of training focused on SRH issues. An example is the Minimum Initial Service Package (MISP), a set of priority reproductive-health activities to be implemented at the onset of a humanitarian emergency (conflict or natural disaster). One of the objectives of the MISP is reducing HIV transmission, and planning for comprehensive SRH care (integrated into primary health care where possible). Information on young key populations can be integrated into this topic by trainers, making health-care providers aware of the issues facing young sex workers, young MSM, young people who inject drugs, etc., in order to increase providers’ capacity to offer stigma-free, respectful services for young key populations.

The Albanian Centre for Population and Development (ACPD) an IPPF Member Association, supported by UNFPA, trained trainers and key stakeholders on MISP, after which primary-health providers in three border districts of Albania were trained. The Ministry of Health’s Emergency Platform now includes a reproductive health strategy. Expanding this training in other districts can be an effective way to sensitize health-care providers all over the country on the clinical and psychosocial needs of young key population.

Other good practices include:

- Offer a mechanism for feedback and complaints that ensures follow-up and demonstrates to the community that their suggestions and concerns are heard and addressed.
- Make services low-threshold: confidential, voluntary, comprehensive, with minimal entry/registration requirements.
- Lobby for services to be available to those without residence permits e.g. migrants or non-citizens.
- Offer flexible working hours of SRH and HIV services that are convenient to young key populations.

TRAINING HEALTH PROVIDERS ON THE NEEDS OF YOUNG KEY POPULATIONS IN ASIA AND AFRICA

The International HIV/AIDS Alliance's Link Up project aims to increase young key populations' access to integrated SRH and HIV services by linking community-based peer educators and their clients with community- or clinic-based integrated services. The project is implemented in Bangladesh, Burundi, Ethiopia, Myanmar and Uganda by a consortium of community-based and service-delivery organizations, led by the International HIV/AIDS Alliance.

Consultations with young people from key populations identified stigma by service-providers as one of their main barriers to accessing services. In response, Link Up implemented a five-day training programme for service-providers in each country, to sensitize them to the needs of most-at-risk young people, and so decrease stigma and increase client satisfaction. Young people from key populations were involved at country level to review the training material. Topics included service integration and linkages, as well as gender, sexuality, stigma and discrimination.

Young people participated in the trainings and helped lead different sessions, including a lively panel discussion where they shared their experiences. This session had a great impact on providers, all of whom had worked with young people, but not necessarily with young MSM or young people who sell sex. The participants learned they must take time to hear and understand the experiences of young key populations, and they appreciated the opportunity to address any feelings of discomfort about working with them.

Link Up has organized further capacity-building for peer educators, social workers, midwives, nurse counsellors and clinical officers. All these trainings include components on young people's participation and gender and sexuality to ensure that services are welcoming to young people and key populations and that they are non-stigmatizing.

Website: <http://www.aidsalliance.org/our-impact/link-up>

Source: HIV and young people who sell sex: a technical brief. Geneva: World Health Organization, 2015.

COMMUNITY-LED APPROACHES TO REINFORCE QUALITY OF CLINICAL SERVICES

- Obtain agreement with referral clinics to display patients-rights charters, which are a statement of government policy for all who enter a medical facility.
- Design ways to share information about reliable services in the community, e.g. good doctors to go to for speculum exams, or trustworthy testing and counselling centres and personnel. This information may be posted on a notice board or on a protected Facebook page.
- Schedule regular contact (via visits or letters) with the chief medical officer of a facility to formally report issues and give positive feedback.
- Educate the community on patients' rights and community-based monitoring of services.
- Formally introduce committee members to health-service-providers.

Resources

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<http://www.ippf.org/resource/girls-decide-choices-sex-and-pregnancy>

SERVICES

The connections between HIV and sexual and reproductive health and rights (SRHR) are well established. Linking HIV and SRHR services has numerous benefits, especially since HIV is predominantly sexually transmitted. This is particularly important for adolescents and all young people as they reach an age where they may begin to be sexually active. Comprehensive sexuality education (CSE) is essential to helping young people make informed choices about their sexual, physical, social and emotional health and well-being. But education is insufficient without the availability of clinical and psychosocial services for SRH, and in particular to protect young people against HIV. SRH services include HIV prevention, testing, treatment, care and support; screening and management of sexually transmitted infections (STIs); contraceptive choices; and safe abortion and post-abortion care.

Young key populations, by reason of their marginalization and stigmatization, experience increased vulnerability to STIs, and to violence and other violations of their human rights. This places them at even higher risk of HIV than other young people, and in urgent need of accessible, appropriate, affordable and acceptable services for SRHR and HIV. However, young people often face challenges in accessing SRHR services. These include high cost, inadequate supplies and physical inaccessibility. In addition, young people most affected by HIV face many additional constraints, such as lack of confidentiality, ignorance of the unique issues young people most affected by HIV face, and untrained, inconsiderate or abusive staff.

This chapter describes the package of comprehensive HIV and SRHR services required to adequately address the needs of young key populations (Figure 4.1). All services should be provided in accordance with the principles of high-quality, youth-friendly/youth-centred services described in Chapter 5. High-quality services are those that are accessible, and are designed and able to meet the needs of the person accessing the services. Youth-friendly services are services that young people feel safe and supported to access and use.

The UNAIDS 2016-2021 strategy has a focus on “90–90–90”, meaning that 90% of people living with HIV know their status; 90% of these people are receiving antiretroviral therapy (ART); and 90% of those on treatment have a suppressed viral load (reducing the community HIV viral load). Inherent to the approaches to HIV and SRHR programming among young key populations in this tool is a commitment to support 90–90–90.

It can be challenging for key populations to take an HIV test and know their status because of fear of law enforcement, stigma from health-care providers, fear of living with HIV, and sometimes a lack of interest in HIV because of other issues of concern in their lives. Treatment access remains low in the EECA Region, with just 1 in 5 people living with HIV receiving antiretroviral treatment. Adherence to treatment for young key populations is compromised by their mobility, lack of familial and social support, and fear of disclosure of their HIV status by others. Young key populations need to be

prioritized and supported to test, receive treatment and adhere to treatment. Teenergizer (see Chapter 2, Box 2.1) is one group advocating for all young people living with HIV and at risk of HIV to have access to the services they need.

Figure 4.1 depicts the package of comprehensive HIV prevention, diagnosis, treatment and care services required to address the HIV epidemic among young key populations and the associated services needed to address their wider SRHR.

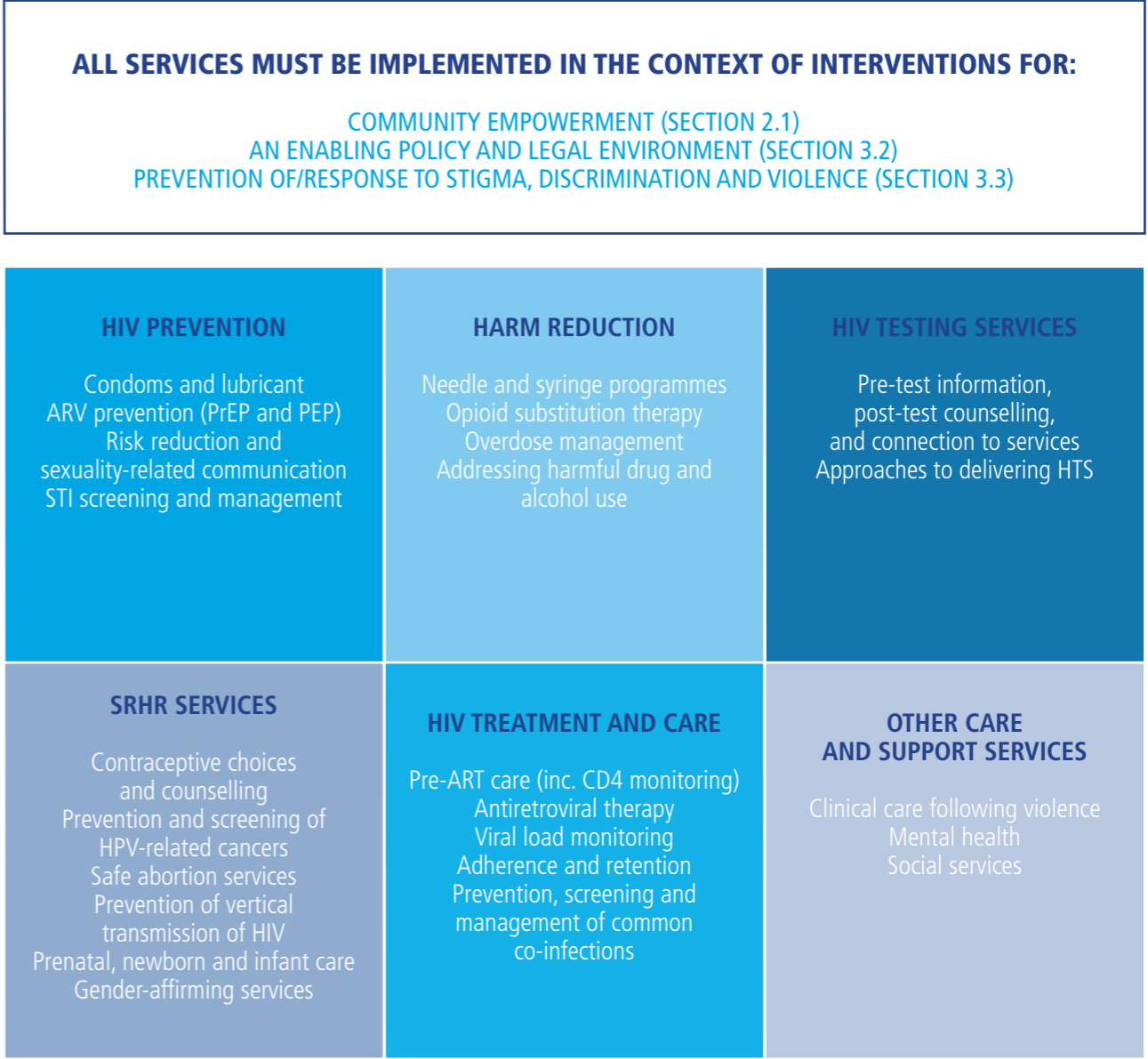


Figure 4.1 **COMPREHENSIVE PACKAGE OF SERVICES FOR YOUNG KEY POPULATIONS**
(Note: information is in summary form and is not necessarily a comprehensive account of all aspects of the law)

HIV PREVENTION

A combination approach to HIV prevention recognizes that any single prevention intervention cannot be effective in isolation. Condoms and lubricant, when used consistently and correctly, remain the cheapest and most effective way to prevent sexual transmission of HIV and STIs, as well as preventing unintended pregnancy (Section 4.4.1). Antiretroviral prevention of HIV through pre-exposure prophylaxis (PrEP) is an approach that is being introduced in some countries in the EECA Region and that is recommended by the World Health Organization (WHO) for all people at substantial risk of HIV (Section 4.1.2). Post-exposure prophylaxis (PEP) should also be available to those who have experienced possible exposure to HIV (Section 4.1.3). These interventions should be offered in tandem with risk reduction communication (Section 4.1.4) and screening and management of STIs (Section 4.1.5). Many of these interventions can be delivered not only in clinical facilities but also by community outreach workers and in other community-based contexts.

4.1.1 Condoms and lubricant

UNFPA and IPPF advocate Triple Protection—the correct and consistent use of condoms with condom-compatible lubricants to prevent sexual transmission of HIV, STIs and unintended pregnancies.

VOICES OF YOUNG KEY POPULATIONS

“If you look 15 years old or younger, no one will sell you condoms in the pharmacy.” *Sex worker, Ukraine*

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)²²

The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and sexually transmitted infections.

Condom programming should be understood to include male and female condoms and condom-compatible lubricants. Male condoms may be used by members of any key population. Female condoms may be used vaginally or anally by women, and by young MSM and transgender people for receptive anal sex.

Barriers to condom and lubricant use by young key populations include general issues of availability, access and affordability, which are discussed below, as well as some that are particular to young people and to the EECA Region:

- In some countries, condoms that are available free of charge are not of acceptable quality.
- There may be a stigma around buying condoms. Young women who sell sex may fear that they will be harassed or arrested by the police if they are found to be carrying condoms.
- Condom use may be stigmatized and it may be difficult for young women or young MSM to insist on condom use with their partner.
- Young key populations may experience power imbalances in sexual relationships that limit their ability to use condoms.

Availability: Condoms and condom-compatible lubricant should be available for all young key populations who request them, in the quantities that they need to protect them consistently from STIs, HIV and unintended pregnancies. Programmes should work with the national HIV or family planning programme to procure and distribute high-quality male and female condoms and lubricants based on users’ preferences. Programmes should also promote condom social marketing and contribute to public–private partnerships for greater condom availability and promotion.

Accessibility: Condoms and lubricant should be distributed or made available at youth health services, drop-in centres, shelters, youth community centres and within sex-work services, as well as by mobile outreach programmes. Community and peer outreach approaches may help to distribute condoms and lubricants, increase knowledge, develop skills and empower young key populations to use condoms and lubricants correctly and consistently.

Affordability: Wherever possible, condoms and lubricant should be provided free of charge. This is the best way to ensure access. Where this is not possible, social-marketing programmes can help to make them affordable to young people. Social marketing can also provide a greater range of condoms (colours, flavours etc.) which may make them more attractive for some users. Programmes can consider working with local pharmacies to make sure that condoms and lubricant are physically easy to access (i.e. they are displayed where they can be reached by the customer without having to ask for them).

POLICIES AND PRACTICES TO PROMOTE CONDOM AND LUBRICANT USE

National

- Revise/remove laws that penalize possession of condoms.
- End the practice of law-enforcement officials using condoms as evidence of sex work, or confiscating them from sex workers.
- Ensure that current laws/policies incentivize owners of sex-work venues to stock condoms and lubricant.

Local

- Train local police to promote and protect the right of young key populations to HIV and STI prevention knowledge, including the need for condom and lubricant promotion and distribution.
- Provide community outreach workers with identification cards signed by local police authorities to prevent them from being harassed while they are conducting outreach work.
- Implement workplace-based programmes with clients of sex workers focused on sexual health, including the reduction of demand for unprotected paid sex.

Working with young key populations to create an enabling environment for condom and lubricant programming: It is essential to involve young key populations in the design of evidence-based promotional and educational strategies and messaging that reflect their experiences of condoms and lubricants, and their needs. Explore messaging that promotes condoms and lubricants in the context of positive, appealing messaging about sexual pleasure, relationships and health.

Condom promotion should go hand in hand with education of young key populations about the importance of lubricant use to prevent condoms from slipping or breaking, and to increase sexual pleasure. Provide information on choosing safe, effective lubricants and avoiding unsafe lubricants. Advocacy training can help young key populations work with programmes to ensure that lubricants are made widely available.

22 / Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2014, updated 2016.

Programmes should offer condom and lubricant skills-building for young key populations and for service-providers. This should be part of group and individual counselling on risk reduction options. Session should address the challenges of using condoms consistently and correctly.

It is also important to discuss the use of the female condom and its potential benefits for young key populations:

- It is stronger than the male condom and may be used for anal sex.
- It is useful for women during menstruation.
- Young women who sell sex can use it when clients cannot maintain an erection.

Condom negotiation: Decisions about whether or not to use condoms during sex are usually made in the context of a specific interaction between two individuals, and navigating this interaction successfully can require particular skills. In order for condom and lubricant promotion programmes to be successful, they should discuss safer-sex negotiation strategies with young key populations, to enable them to negotiate condom use with a variety of types of partners, whether casual or primary. Some young people find it difficult to discuss HIV risk with partners, to suggest condom use with partners, and to refuse sex they do not want, including when partners demand not to use a condom. When discussing condom use with an individual, enquire whether the individual can state: “I am confident I can initiate a discussion about HIV risk with my partners”, and “I am confident I can persuade my partners to use a condom, or refuse to have sex”.

4.1.2 Pre-exposure prophylaxis (PrEP)

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

For all key populations, oral pre-exposure prophylaxis containing tenofovir disoproxil fumarate (TDF) should be offered as an additional prevention choice for key populations at substantial risk of HIV infection, as part of combination HIV prevention approaches.

Oral PrEP is the use of antiretroviral drugs by HIV negative people to block the acquisition of HIV during sexual contact. Trials on the effectiveness of PrEP have been conducted among serodiscordant couples, heterosexual men, women, men who have sex with men, people who inject drugs and transgender women; where adherence has been high, significant levels of efficacy have been achieved, showing the value of this intervention as part of combination prevention approaches.

WHO recommends that PrEP be offered to individuals at substantial risk of HIV (defined as belonging to a population group where HIV incidence is around 3 per 100 person-years or higher in the absence of PrEP). However, the offer of PrEP should be based on the assessment of the individual’s circumstances and behaviours, rather than simply because they belong to a key population.

People at substantial risk of acquiring HIV are often medically underserved, have few other effective HIV prevention options and frequently face social and legal challenges. Providing PrEP may give opportunities for increased access to a range of other health services and social support. Community-based organizations—especially those working with key populations—should play a significant role in the roll-out of PrEP by engaging people at substantial risk, providing information about

the availability and use of PrEP and promoting linkages between PrEP providers and other health, social and community support services.

PrEP should be promoted as a positive choice among people for whom it is suitable and their communities, in conjunction with other appropriate prevention interventions and services, including SRH services.

PrEP should not displace or threaten the implementation of effective and well-established HIV prevention interventions, such as condom and lubricant programming and harm reduction. It should only be offered as a choice, free of coercion, and with access to other prevention strategies that may be preferred by the individual.

PILOTING PREP IN GEORGIA

HIV is growing among men who have sex with men in Georgia, with a prevalence of 25% in 2015 among those in the capital, Tbilisi. These findings led to national consultations with the Georgian lesbian, gay, bisexual and transgender (LGBT) community on introducing evidence-based prevention measures to control and reverse the HIV epidemic among men who have sex with men in Georgia. A pilot PrEP programme for men who have sex with men in Tbilisi began in 2017. LGBT resource centres operating within the Global Fund HIV programme engage high-risk HIV negative men who have sex with men as volunteers for the PrEP programme. Clinical and laboratory monitoring of selected individuals is conducted by the National AIDS Centre. Initially up to 200 men who have sex with men are being engaged in the pilot programme, which is to be replicated in the country’s three biggest cities over the next three years.

4.1.3 Post-exposure prophylaxis (PEP)

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Post-exposure prophylaxis should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV.

PEP is given to reduce the likelihood of acquiring HIV infection after possible exposure, and is currently the only way to reduce the risk of HIV infection in an individual who has been exposed to HIV. This intervention includes prescribing PEP following occupational exposure to HIV, as well as non-occupational situations, including sexual assault, sharing of injection equipment among people who inject drugs, and possible exposure through consensual sex.

The current recommended duration of PEP is 28 days; the first dose should be taken as soon as possible and within 72 hours after exposure. Counselling and other adherence support measures are recommended to ensure that the complete course is taken. PEP should not be considered 100% effective, and it is essential that programmes reinforce the importance of primary prevention and risk-prevention counselling in all settings where HIV could be transmitted.

4.1.4 Risk reduction and sexuality-related communication

RECOMMENDATIONS ON BRIEF SEXUALITY-RELATED COMMUNICATION (2015)²³

Brief sexuality-related communication is recommended for the prevention of sexually transmitted infections among adults and adolescents in primary health services.

Training of health-care providers in sexual-health knowledge and in the skills of brief sexuality-related communication is recommended. Health policy-makers and decision-makers in health-care professional training institutions need to ensure that, where brief sexuality-related communication is introduced, it respects, protects and fulfils their clients’ human rights.

A range of behavioural interventions can provide information and skills that support risk reduction, prevent HIV transmission and increase uptake of services among all key populations.

To reduce the risk of acquiring STIs or HIV, people must understand their risk and have the knowledge, skills and belief in their self-efficacy to reduce that risk. Risk reduction communication can provide information,

motivation, education and skills-building to help individuals reduce higher-risk behaviours and sustain this positive change. It can be delivered to individuals or groups.

One-on-one counselling may focus on awareness of personal risk and risk reduction strategies. For example, counsellors or community workers may discuss risk behaviours, relate a participant's activities directly to HIV risk, and consider strategies to reduce this risk. Counselling should include decision-making skills about when to use various approaches and how to couple these with other HIV prevention tools, such as condoms.

Service-providers should be aware that some clients use adaptive strategies such as serosorting in which a person chooses a sexual partner known to be of the same HIV serostatus, in order to reduce the risk of acquiring or transmitting HIV. Information should be provided about the benefits and risks, and service-providers should make it clear that adaptive strategies are an approach to risk reduction, not risk elimination.

4.1.5 STI prevention, screening and management

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Screening, diagnosis and treatment of sexually transmitted infections should be offered routinely as part of comprehensive HIV prevention and care for key populations.

The presence of an STI such as syphilis, gonorrhoea or herpes simplex virus greatly increases the risk of acquiring or transmitting HIV. The presence of an STI is also an important indicator for higher-risk sexual behaviour. Men who have sex with men, sex workers and transgender people are often at increased risk of STIs. Most of these infections are asymptomatic, especially among women. However, even asymptomatic STIs can cause complications, be transmitted to sexual partners and enhance HIV transmission.

Young key populations should have access to acceptable, effective and high-quality STI services. The basic WHO-recommended STI service package includes:

- provision of condoms and lubricant
- vaccination against human papilloma virus (HPV) and hepatitis B virus (HBV)
- syndromic case management for patients with symptoms
- screening and treatment of asymptomatic STIs:
 - syphilis screening
 - gonorrhoea and chlamydia screening
 - routine STI check-ups
 - referrals to voluntary HIV testing services (HTS)

Services should provide information on the various types of STIs, including transmission, symptoms and prevention techniques. STI services should be rights-based, confidential, accessed voluntarily and without coercion, and provided after informed consent. For more information, see the WHO Global health sector strategy on sexually transmitted infections 2016-2021 (p.36).

An STI services package consists of case management for both symptomatic and asymptomatic STIs. Comprehensive STI case management also includes the promotion and provision of condom use, support for compliance with treatment, risk reduction counselling and partner management. Once established and scaled up, services may be expanded in scope to meet the broader health needs of young key populations.

In some countries effective screening and management of STIs is made difficult by a variety of challenges:

- A lack of comprehensive services offered in one place. For example, HTS centres may provide free STI testing but not treatment, or syndromic treatment is provided free of charge, but other treatment (such as

23 / Brief sexuality-related communication: recommendations for a public health approach. Geneva; World Health Organization; 2015.

antibiotics) is not.

- There may be no active case management or referral to other SRH services.
- NAAT (nucleic acid amplification testing) may be too expensive in countries in the EECA Region.
- Syndromic management of STIs is not allowed in all countries, and relatively few countries have guidelines on syndromic approaches.

Nevertheless, provision of services to young key populations with STI symptoms should be a priority. Symptomatic individuals may be aware they are infected and are more likely to seek care. The specific approach to diagnosis and treatment should be based on national guidelines, where available. Regular screening for asymptomatic infections among young key populations using laboratory tests is often cost-effective, given the high rates of STIs. Where reliable STI diagnostic testing is not feasible, a syndromic approach to manage symptomatic infections is appropriate. Absence of laboratory tests should not be a barrier to screening and treating clients for STIs. By performing genital and anorectal examinations it is possible to look for symptoms of STIs.

Following a positive diagnosis of an STI, it is important to recommend that the client notify their sexual partners, so that they, too, can be tested and treated. Notification can be active (where the facility makes contact with the partner) or passive (where the facility asks the clients to inform or bring their partners). This should be discussed with the client following a positive diagnosis, and support provided. Comprehensive management also includes promoting and providing condoms and compatible lubricants, support for compliance with treatment, and risk-reduction counselling.

Services should consider offering community-based testing for STIs wherever possible, e.g. at organizations that serve young people or key population members specifically. Training of community outreach workers on STIs is an important element of STI prevention and management. Young key populations may have limited knowledge and understanding of STIs. It is important to offer comprehensive STI services wherever possible. Failing that, a strong referral system is needed. For more information on service coordination and integration, see Chapter 5, Sections 5.2 and 5.3.

AN STI TRAINING PACKAGE IN THE EECA REGION

UNFPA EECARO has developed an STI training package for community outreach workers among sex workers and men who have sex with men. The package has been trialled in Georgia, Tajikistan and Ukraine. The community outreach workers contributed to the development and review of the materials and training was undertaken in partnership with community-led organizations among sex workers and men who have sex with men. The community outreach workers acquired sufficient understanding of STIs to provide onwards training to their communities, participate in a referral system with local STI clinics and provide necessary follow-up and support to community members. In Tajikistan STI clinicians were trained on the community outreach approach to increase their capacity to support community outreach workers in STI management.

SENSITIZING PROVIDERS AND KEY POPULATIONS ON STI SERVICES IN TAJIKISTAN

Stigma, the unacceptability and expense of STI services, and punitive laws, policies and practices have made sex workers in Tajikistan wary of seeking out health-care providers. Sex workers and men who have sex with men have low awareness about STIs and HIV and their rights to health care. They often rely on often harmful self-treatment for STIs, based on advice from friends or family.

In response, in 2015 and 2016 UNFPA's Tajikistan Country Office held several national workshops to build awareness about the health needs of sex workers and men who have sex with men, and to familiarize service-providers and community members with the approaches advocated by WHO, UNFPA and the Global Network of Sex Workers (NSWP) for clinical and support services.

A national workshop for local clinicians on improving STI case management among key populations was held. Other workshops helped sex workers and men who have sex with men to increase their knowledge about the basic concepts of STIs and their links with HIV and SRHR. The workshops also helped them understand how the health-care system could provide STI services, and how to communicate accurate STI prevention and treatment messages to other key population members. Other topics included how to choose the best STI prevention commodities (condoms, lubricants etc.) and how to work jointly with service-providers.

The workshops involved 15 clinicians, 37 sex workers and 19 men who have sex with men. They were well received, and there were several requests from community members to continue them. UNFPA remains committed to empowering the key population community on STI case management

INTRODUCING SYNDROMIC MANAGEMENT OF STIS FOR KEY POPULATIONS IN UKRAINE

There is limited access to etiological diagnosis and treatment of STIs among key populations in Ukraine. Although international and national expert missions have concurred that introducing a syndromic approach to STI case management for key populations would be an effective intervention against the country's HIV epidemic, they have noted a strong bias against treating STIs without laboratory test confirmation (based on post-Soviet traditions of medical service provision rather than on scientific data or international experience). Service-providers often mistakenly believe that even partial implementation of a syndromic STI treatment approach would lead to a complete loss of account of STIs and the development of antibiotic-resistant pathogens. With a lack of proper information and political will, this has resulted in the syndromic approach not being part of the current clinical protocols for STI management, even when it is the only suitable option (for example, with clients who are hard to reach and follow up, such as key populations).

To ensure access and effective STI management in hard-to-reach key populations, UNFPA partnered with the Ministry of Health and local medical institutions to advocate for the introduction of a syndromic approach. STI clinicians from regional AIDS centres and STI clinics, as well as primary health-care practitioners (family doctors), were given up-to-date information and trained on the main principles and methods of a syndromic approach to STI management. This has created a “critical mass” of medical specialists who understand the necessity of using a syndromic approach as one of the effective methods of STI treatment and HIV prevention among key populations. They now act as “change agents” to influence the Ministry of Health to officially introduce the syndromic approach in clinical protocols for STI management.

CREATING AN ENTRY POINT TO SEXUAL-HEALTH SERVICES FOR MEN WHO HAVE SEX WITH MEN IN CAMBODIA

Reproductive Health Association Cambodia implemented a programme to provide primary health care to men who have sex with men as an entry point for strengthened SRH and HTS. One of the key activities was the provision of free hepatitis B vaccinations, during which men who have sex with men were also offered STI services and HTS.

Evaluation showed that free primary health care increased uptake of HBV vaccination among men who have sex with men, but was not by itself sufficient to increase the use of STI services and HTS. Other factors included the widespread information about the availability of services for men who have sex with men, provision of travel support to and from the clinics, a strong referral system, and having a supportive environment at the clinics, including counsellors trained to work with men who have sex with men.

Source: MSMIT

HARM REDUCTION

Harm reduction refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of licit and illicit drugs. The harm-reduction approach is based on a strong commitment to public health and human rights, and targets the causes of risks and harms. Harm reduction helps protect people from preventable health harms and death from overdose, and helps connect marginalized people with other social and health services.

WHO, the United Nations Office on Drugs and Crime (UNODC) and UNAIDS defined an evidence-based public-health response for people who inject drugs with a comprehensive package of interventions (in the *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. 2012 revision*). This harm reduction package was expanded in the Key Populations Consolidated Guidelines (2016) to include the following interventions:

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing services (HTS)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of STIs
6. Condom and lubricant programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication for people who inject drugs and their sexual partners
8. Prevention, vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis (TB)
10. Community distribution of naloxone for treatment of overdose.

There is increasing provision of harm reduction services in the EECA Region. This contrasts to previous policy approaches that focused on law-enforcement approaches and rehabilitation programmes for people who inject drugs. Most items in the package are relevant to all young key populations. This section of the tool focuses on the first two and the last components—NSPs, OST, and overdose management—which are specific to young people who inject drugs, as well as some additional considerations (Sections 4.2.4 and 4.2.5).

It is important to be aware of the structural challenges, and the particular circumstances of young members of key populations, that can be obstacles to effective services:

- Laws and policies in some countries prohibit some harm reduction activities or make them difficult to implement, such as OST. There are often restrictive regulations on who can prescribe or provide OST (e.g. only a doctor, rather than a nurse or other trained provider). Those under 18 years are often unable to access harm reduction services; for example, many countries do not provide OST to people under the age of 18.
- There is a lack of harm reduction services for people who use or inject drugs who are incarcerated. NSP and OST are especially urgently needed.
- Young people who use drugs may have overlapping vulnerabilities. For example, young women who inject drugs may sell sex in order to fund their drug use. They frequently experience violence, and may require services related to contraceptive choices that take into account their drug use. Likewise, someone who shares unsterile injecting equipment used by a person living with HIV is at significant risk of becoming infected.
- The use of other substances can also increase risk of HIV transmission, including alcohol, methamphetamines, cocaine, MDMA, and amyl nitrite. These substances can affect the ability to make safe choices about sexual behaviour, or may make a person vulnerable to sexual assault. Some also have physiological factors that facilitate HIV transmission.
- Transgender people may use needles to inject hormones, and may do this without medical supervision in places where gender-affirming treatment is not available or accessible in health-care facilities. Needles are also used for tattooing. In both cases, there is a risk of unsterilized needles causing infection.
- When funds are reduced, harm reduction services are often the first to be cut. The Global Fund supports harm reduction programmes, but governments do not. Some other donors do not allow funds to be used to procure needles and syringes.

ESTABLISHING VOLUNTARY COUNSELLING AND TESTING SERVICES IN PRISON SETTINGS IN ALBANIA

HIV prevention programmes in Albanian prisons are small in scale and rarely comprehensive. A pilot programme supported by UNFPA established five voluntary counselling and testing (VCT) centres in prisons (4 male and 1 female prison), and developed guidelines on HIV management and training prison health and security staff. A surveillance reporting system was also instituted. At the end of the project, a survey of 11 prisons and 210 prisoners, including the five where the project was implemented, showed that 150 prisoners had been tested for bloodborne pathogens in the VCT prisons, compared with 29 prisoners in the other prisons. In the prisons with VCT, the level of condom use among inmates involved in a sexual relationship was twice as high as in the prisons without VCT. Prevalence of HIV and hepatitis C virus (HCV) was significantly lower in the VCT prisons, although rates of syphilis were comparable. The study showed that early detection of HIV and other STIs, and access to services, improved in prisons with VCT. This should be part of a multi-pronged HIV and STI reduction strategy in the Albanian prison system.

INVOLVING ADOLESCENTS WHO USE DRUGS IN HARM REDUCTION IN UKRAINE

Although nongovernmental organizations (NGOs) delivered HIV prevention services to two-thirds of the estimated number of people who inject drugs in Ukraine in 2015, less than 1% of these were aged below 20. Nevertheless, most people who inject drugs started using drugs around the age of 15–16 and began injecting at around 18. Adolescents who use drugs mostly use highly toxic synthetic substances which can cause irreversible harm to their health, in addition to the increased risk of HIV. International charitable foundation (ICF) Alliance for Public Health, with support from Elton John AIDS Foundation, launched a Pioneer Harm Reduction Project for adolescents who use drugs in five cities of Ukraine. An essential principle of the project is the active participation of adolescents who use drugs, who are an integral part of project teams. The project offers a range of harm reduction activities, including HIV prevention and care, with complementary activities designed to attract and retain young people who use drugs. Young people are reached and enrolled via peers and through conventional outreach, information and testing events at schools, and social networks.

The programme staff are hired based on their willingness to implement new initiatives and to demonstrate unbiased attitude to adolescents. At each site, two young people work alongside specialists as social work assistants. They are engaged for a few hours a day after school, and are paid for their work. Altogether, more than 5,000 adolescents are involved in prevention efforts under the project, in projects within community organizations, and in leadership-building programmes.

4.2.1 Needle and syringe programmes (NSP)

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

All people from key populations who inject drugs should have access to sterile injecting equipment through needle and syringe programmes. WHO guidance does not specify age restrictions for needle and syringe programmes.

NSPs are cheap, easy to establish and have proven to be highly effective in reducing HIV transmission among people who inject drugs, without increasing injecting behaviour. NSPs are best delivered at the community level and are an important point of first contact with people who inject drugs who are reluctant to use other services for fear of discrimination.

The best-practice characteristics of NSPs are that they:

- are low-threshold, easy to enrol in, and actively attract clients into services
- offer a range of commodities, all free of charge
- use community members to distribute commodities
- do not restrict the number of needles and syringes provided and do not prevent secondary distribution, and do not impose the strict exchange of needles and syringes, i.e. clients are not required to bring in used equipment before receiving new injecting equipment (because this increases the risk of needle and syringe sharing)
- are accompanied by a safe disposal plan to prevent accidental hazards, and to mitigate opposition from the wider community because of discarded used injecting equipment
- offer overdose management, by ensuring all staff are trained in overdose revival techniques, and by providing naloxone to people who inject opioids, their families and members of the wider community
- use all available opportunities to discuss the specific risks of drug use with people who inject drugs, as well as ways to reduce risk, and available risk reduction services
- offer a range of other support and care services by qualified staff, such as on-site medical care and information about health maintenance (e.g. vein care and abscess management)
- are integrated with other services where possible, and offer referrals to drug treatment, legal aid, family and housing advice and safer injection sites, where available, as well as testing for HIV, TB and viral hepatitis
- continually assess their results to understand the changing needs of their clients.

PRISON NSP AND OST IN REPUBLIC OF MOLDOVA

NSPs have been operating in prisons in Republic of Moldova since 1999 through regulations that allow syringes into prison as medical equipment as part of the national HIV programme, and OST was introduced in 2005. The NSPs are run by peer volunteers in collaboration with medical staff, who support the programme as it helps protect them from accidental needle-stick injuries. As a result of the programme, prevalence of HIV and HCV among prisoners decreased by more than 50 percent over a period of 5 years.

Source: IDUIT

USING LOW-DEAD-SPACE SYRINGES IN NEEDLE EXCHANGE PROGRAMMES

When people who inject drugs share conventional needles and syringes (so-called high-dead-space syringes) they increase the risk of HIV and hepatitis B and C transmission, because these items retain fluid (µL84) both in the syringe itself and in the needle, even after rinsing. Low-dead-space syringes, by contrast, are designed in a way which leads them to retain only a comparatively small fraction of the fluid. This makes the risk of HIV or hepatitis transmission via re-used low-dead space syringes much lower than with high-dead-space syringes. Low-dead-space syringes should be introduced to harm reduction programmes quickly, particularly in places with high rates of HIV among people who inject drugs.

COMMUNITY EMPOWERMENT FOR PUBLIC SAFETY IN THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

The “Project Syringe Patrol” was initiated by the community organization Trust, in Skopje, whose members are people who use drugs, with the support of the Global Fund, and over the past 7 years with support from the local municipality of Kisela Voda. The project’s outreach workers are trained to safely collect used injecting equipment from public places such as parks and public areas near methadone treatment centres, in order to ensure that it cannot cause harm to people. The teams conduct patrols four times a week, and the waste material is delivered to methadone treatment centres to be destroyed safely. The project is promoted through websites, leaflets, brochures and posters, and people can contact the outreach teams by phone or email to report public places that need to be cleaned up.

Project Syringe Patrol promotes the social responsibility of the community of people who use drugs, since they are actively involved in contributing to clean public places, a safer environment and the prevention of bloodborne infections.

4.2.2 Opioid substitution therapy (OST)

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

All people from key populations who are dependent on opioids should be offered and have access to opioid substitution therapy. WHO guidance does not specify age restrictions for OST. Treatment should be provided in the best interests of the adolescent concerned and in consultation with them.

OST is an evidence-based intervention for opioid dependence and HIV prevention among people who use and inject drugs. It helps to prevent HIV among people who inject drugs and to increase adherence to ART among eligible people living with HIV.

OST AS A HOLISTIC TREATMENT

- **Offer help with social integration:** Individual or group counselling and self-help groups can help OST clients develop communication and socialization skills. Peer support groups have also been an important emotional resource for people who inject drugs in many settings.
- **Work with peer advocates, so that client feedback informs services:** Local organizations led by people who inject drugs can help OST providers by providing information to people who inject drugs, OST clients, parents and relatives, as well as to doctors and the general public. They can also train local clients to become peer advocates for OST or to staff information hotlines.
- **Work with family and relatives for a supportive environment:** To ensure the effectiveness of OST and the quality of clients’ lives, programmes should offer psychological and social services to families and friends of programme participants (and especially to children, ensuring that they are kept with the parents and family wherever possible). However, it is essential that clients retain their right to confidentiality.
- **Advocate for OST and clients’ rights:** It is important to engage in advocacy for clients’ rights to access high-quality and sustained OST, and expanded programmes. Advocacy by programme providers can be done alongside peer advocacy networks and family groups, who can also help mobilize national campaigns for access to treatment.

DEVELOPING TAKE-HOME OST PROGRAMMES IN UKRAINE

In Ukraine, advocacy efforts by All-Ukrainian OST Patients Association and allies led to service integration and eventual flexibility around take-home OST. This has proven lifesaving for many individuals with complicated diagnoses. Proxies, approved by the treating doctor of the individual on OST, can collect the medication. In the case of intra-institutional delivery, staff communicate with drug-treatment facilities to obtain doses necessary to support patients currently receiving in-patient treatment.

4.2.3 Overdose management

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose. WHO guidance does not specify age restrictions for overdose management.

Drug overdose is the leading cause of preventable drug-related deaths globally. In 2012 the United Nations General Assembly ratified a resolution of the Committee on Narcotic Drugs recommending that overdose prevention and treatment should be included in every country's drug strategy.

Naloxone should be available in conjunction with—not as a substitute for—comprehensive overdose prevention and management training in community settings. Based on the experience of harm reduction organizations, efforts to increase access to naloxone should focus on:

- **Training and providing naloxone directly to non-medical people (lay people):** This includes people at risk of an opioid overdose; friends and families of people who inject drugs; and community/peer outreach workers and others who might be present at an overdose.
- **Ensuring professional responders are equipped with naloxone:** This includes not just hospital, clinic and ambulance workers, but also emergency service workers/first responders such as law enforcement and fire workers.
- **Expanding access through commercial points of sale:** This includes encouraging physicians to prescribe naloxone and making the drug available over the counter in pharmacies without a prescription.

4.2.4 Addressing harmful drug and alcohol use

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

All people from key populations with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice.

The focus group discussions with young key population members in the EECA Region revealed that their use of alcohol and drugs is mostly related to psychological problems, including depression and stress related to their identity and their difficulty becoming integrated into society due to stigma and discrimination. In the case of sex workers, drugs and alcohol help them to relieve the stress caused by serving their clients. Providing psychological support to young key populations who use alcohol and drugs is therefore extremely important.

Screening and brief intervention for alcohol-related problems within services can be an effective and efficient way to reduce alcohol consumption. Brief interventions are those practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it. These are low in cost and have

proven to be effective across the spectrum of alcohol problems.

Harm reduction and peer-based education can also help to reduce drug misuse and empower young people to make healthy, informed lifestyle choices. To help an individual make decisions about whether to take drugs, they require rights-based information with the facts about the drug, and to understand the risks related to taking that drug.

Efforts to assist people with drug dependency should be focused on long-term substitution therapy, medical care and behaviour change therapies as a way to eliminate or reduce symptoms of the dependence and attain a high quality of life.

GENDER-SENSITIVE HARM REDUCTION INTERVENTIONS IN UKRAINE

The ProfiGender project of ICF Alliance for Public Health, which is funded by the Expertise France 5% Initiative, aims to ensure that women, men and other epidemiologically significant segments of the population of people who inject drugs and their sexual partners have equal access to gender-sensitive, high-quality HIV services in Ukraine. From 2017 the project is focusing on young women who use drugs and their sexual partners.

The project trains service-providers to interact in gender-sensitive ways with male and female clients, to enrol new female clients and their sexual partners more efficiently, and to work with them individually on the issues that are most important to them, rather than assuming the standard priorities of harm reduction programmes. This includes developing practical skills for safer sexual and drug-use behaviours. A game, "NewMe", is used to address psychosocial issues.

The project also arranges mentoring support from more experienced OST clients for new female clients, and individual counselling of both male and female OST clients on the topics most important to them, including tailored SRH education and couples counselling.

INCREASING POSITIVE BEHAVIOURS AMONG CLIENTS OF A NEEDLE EXCHANGE PROGRAMME IN ALBANIA

Even though harm reduction programmes are available in Albania and provide a wide range of free services for people who inject drugs, poor adherence to services is a widespread problem. This reduces the individual and public benefit of health interventions. In order to increase service uptake and retention among people who inject drugs, a behavioural intervention was piloted among clients of a needle and syringe exchange programme in Tirana. Contingency management involves positive reinforcement (use of financial or material incentives) to promote adherence to an intervention or behaviour consistent with its goals. Incentives were coupons for food or petrol, prepaid phone cards, etc., and were distributed on a weekly basis in the presence of a programme staff member.

Eighty people who inject drugs (aged 18–40 years) volunteered for a trial: 40 were assigned to the contingency management scheme, while the other 40 took part in the usual harm reduction interventions as a control group. After six months those in the contingency management group were significantly more likely than those in the control group to participate in the NSP, undergo HIV counselling and testing, bring new users to the centre, participate in social activities, and bring family members for testing. The contingency management approach has proved to be an effective tool as part of harm reduction programmes among people who inject drugs in Albania.

HIV TESTING SERVICES (HTS)

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Voluntary HIV testing services should be routinely offered to all key populations both in the community and in clinical settings. Community-based HIV testing and counselling for key populations, linked to prevention, care and treatment services, is recommended, in addition to provider-initiated testing and counselling.

CONSOLIDATED ARV GUIDELINES (2016)²⁴

HIV testing services, with linkages to prevention, treatment and care, should be offered for adolescents from key populations in all settings.

HIV testing for young key populations is an important component of a comprehensive package of services to reach the ambitious 90–90–90 goals. However, young key populations face multiple challenges to testing, including fear of "outing" themselves as key population members; the potential for harassment, stigma and discrimination by health-care providers; and concerns that providers might not keep clients' status confidential. In addition, many countries have a severe shortage of providers, which further serves to reduce access to services.

The WHO "5 Cs" (Consent, Confidentiality, Counselling, Correct test results and Connection) are principles that apply to all models of HTS and in all circumstances.

- **Consent:** People receiving HTS must give informed consent to be tested and counselled. (Verbal consent is sufficient; written consent is not required.) They should be informed of the process for HIV testing and counselling and of their right to decline testing.
- **Confidentiality:** What the HTS provider and the client discuss must not be disclosed to anyone else without the express consent of the person being tested. Confidentiality should be respected, but it should not be allowed to reinforce secrecy, stigma or shame. Counsellors should discuss, among other issues, whom the person may wish to inform and how they would like this to be done.

- **Counselling:** Pre-test information can be provided in a group setting, but all people should have the opportunity to ask questions in a private setting if they request it. All HIV testing must be accompanied by appropriate and high-quality post-test counselling, based on the specific HIV test result and HIV status reported.
- **Correct:** Providers of HIV testing should strive to provide high-quality testing services, and quality assurance (QA) mechanisms should ensure that people receive a correct diagnosis. QA may include both internal and external measures and should receive support from the national reference laboratory. All people who receive a positive HIV diagnosis should be retested to verify their diagnosis before initiation of HIV care or treatment.
- **Connection:** Linkage to prevention, treatment and care services should include effective and appropriate follow-up, including long-term prevention and treatment support. Providing HTS where there is no access to care, or poor linkage to care, including ART, has limited benefit for those with HIV. Linkages should be provided not only for those diagnosed with HIV: continuous re-engagement with HIV negative young key populations is needed, for regular HIV testing and combination prevention, including access to condoms, lubricants, harm reduction and PrEP.

24 / Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization; 2016.

Community-based testing includes a number of approaches, such as door-to-door/home-based testing, mobile outreach campaigns, and testing in workplaces, parks, bars, places of worship and educational establishments. Community-based HTS is important for increasing early diagnosis, reaching first-time testers and people who seldom use clinical services, including young people in high-prevalence settings and young key populations. Linkage to prevention and treatment services is critical and should be emphasized in all community-based HTS. Lay providers who are trained and supervised to use rapid diagnostic tests can independently conduct safe and effective HTS.

ENSURING ACCESS AND SAFETY FOR YOUNG KEY POPULATIONS AND HTS

The Key Populations Consolidated Guidelines (2016) state that in all epidemic settings accessible and acceptable HTS must be available to adolescents, and provided in ways that do not put them at risk. Countries are encouraged to examine their current consent policies and consider revising them to reduce age-related barriers to HTS and to post-test linkages to prevention, treatment and care. Young people should be able to obtain HTS without parental or guardian consent or presence being required. Authorities also should consider the role of surrogate decision-makers in HTS for adolescents without parents or for those unwilling to involve parents. Providers of HTS should be aware of laws and policies governing the age of consent and develop appropriate procedures based on this legal framework to ensure that children and adolescents have access to HTS.

4.3.1 Approaches to delivering HTS

CONSOLIDATED HTS GUIDELINES (2015)²⁵

In concentrated epidemics, community-based HIV testing services are recommended, with linkage to prevention, treatment and care, in addition to provider-initiated testing and counselling for key populations.

Lay providers who are trained and supervised can independently conduct safe and effective HIV testing using rapid diagnostic tests.

Fixed-site services should be convenient and available, through flexible opening hours or walk-in or same-day appointments. Separate hours and special events exclusively for young people may help overcome concerns that older relatives, neighbours or family friends may see them attending HTS.

25 / Consolidated guidelines on HIV testing services. Geneva: World Health Organization; 2015.

MOBILE HTS IN THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

In the course of 2015, the HIV field testing and counselling service in the former Yugoslav Republic of Macedonia conducted a total of 4,086 HIV tests, 89% of which were among key populations most at risk of HIV. In addition, 921 hepatitis C tests were performed. A total of 21% of all the HIV cases registered that year were discovered through the mobile HIV testing clinic. The mobile clinics are managed by the civil-society organization HERA, which carried out its activities in partnership with 14 other civil-society and community-based organizations, the Institute for Public Health and the Ministry of Health in various regions of the country.

Rapid point-of care testing is a way of offering safe and effective testing services. This approach offers the opportunity to expand testing services beyond what can be achieved with lab-based diagnosis, and can be an important component of community-based testing.

RAPID HIV DIAGNOSTIC TESTS BY NGOS IN KYRGYZSTAN

In Kyrgyzstan, until 2012 HIV testing could only be carried out in HIV laboratories at AIDS centres. The United Nations Development Programme worked with the Republican AIDS Centre and the Ministry of Health to get permission for 12 NGOs to conduct oral-fluid-based rapid HIV testing. This was important because the HIV epidemic in Kyrgyzstan is primarily driven by undiagnosed infections among key populations. Following the selection of NGOs working with people who inject drugs, men who have sex with men, and sex workers, NGO staff members were certified and trained to implement rapid HIV tests. To increase participation from key populations, incentives, such as prepaid mobile phone cards, were procured and distributed.

During the first year of the project, 4,500 NGO clients received HIV testing, of whom 226 had a reactive test and were referred to the nearest AIDS centre for additional HIV testing to confirm diagnosis. Although only around a quarter of those with a reactive test result ultimately attended confirmatory testing, and not all of those chose to receive their confirmatory results, the possibility of receiving HIV testing outside the formal health services did integrate some HIV positive key population members into care. The pilot successfully reached men who have sex with men, a group that AIDS centres in Kyrgyzstan had not previously been able to reach.

Source: WHO Consolidated guidelines on HIV testing services (2015)

Self-testing: HIV self-testing enables individuals to test themselves for HIV conveniently and in a private setting, such as their own home. An individual either sends a sample away for diagnostic tests, with results given by a service-provider, or tests the sample with a kit and interprets the results themselves. Expanded use of HIV self-testing can contribute to reaching first-time testers, people with undiagnosed HIV or those at ongoing risk who are in need of frequent retesting. HIV self-testing does not provide a definitive HIV diagnosis. A reactive self-test always requires further confirmatory testing according to relevant national testing algorithms.

HTS as part of harm reduction: Harm reduction programmes should ensure that HTS are integrated in their programmes (see Section 4.2). Oral tests are the most appropriate for people who inject drugs.

Prisons: HTS should also be offered in closed settings such as prisons.

information, see Chapter 2, Section 2.4.) Some service-providers lack information on the specialized needs of young key populations (e.g. anal health care for men who have sex with men), or lack accurate knowledge in general on SRH, contraception or abortion. Services for transgender individuals are frequently non-existent or inadequate. In addition, some providers extort under-the-table payments, or administer counterfeit medications.

Fear of lack of confidentiality can deter young people from seeking services. Young key populations often fear stigmatization if their identity as a key population member is known to health-care providers. For example, young women who inject drugs may be refused abortion services.

In most countries in the region, SRH and HIV services are specialized services and poorly integrated. Integration of SRH services within primary health care is essential wherever possible, for example by offering OST where SRH services are provided, if feasible. For more information, see Section 5.3.

SRHR SERVICES

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

In order to meet the educational and service needs of adolescents, it is recommended that sexual and reproductive health services, including contraceptive information and services, be provided for adolescents without mandatory parental and guardian authorization/notification.

UNFPA and IPPF believe in the importance of addressing the full and specific SRH needs of young people, including young key populations and young people living with HIV. Integrated SRHR and HIV services recognize the importance of empowering people to make informed choices about their SRH, and the vital role that sexuality plays in people's lives.

TAKING A SEXUAL-HEALTH HISTORY

Taking a sexual-health history is an essential part of performing a SRH exam; it is particularly important when determining what parts of the body need to be screened for STIs. When discussing sexual practices, health-care workers should ask open-ended questions and not make assumptions about the anatomy or sexual practices of their clients. It is essential to ask clarifying questions rather than guessing or assuming what the individual means. At the same time, as with other clients, it is important to ask only those questions that are relevant to providing health care (see Figure 4.2).

Young people of all genders and sexual orientations have SRH needs and the same right to reproductive health as all other people. The SRH needs of young people, and especially of young key populations, are often overlooked. It is important to expand clinical services beyond HIV prevention, testing and diagnosis, and treatment of STIs, to address the services described in this section:

- contraceptive choices
- vaccination for HPV and HBV

- safe abortion
- prevention of perinatal transmission of HIV
- pre-natal, newborn and infant care
- gender-affirming services

Young key populations and those trying to provide services to them face numerous barriers to accessing comprehensive SRH care. Information on SRH often excludes issues that are relevant to some young key populations, such as issues of sexual orientation, or safer sex for men who have sex with men. (For more



Figure 4.2 **SEXUAL-HEALTH HISTORY-TAKING**
 Source: TRANSIT

4.4.1 Contraceptive choices and counselling

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

People from key populations, including those living with HIV, should be able to experience full, pleasurable sex lives and have access to a range of reproductive options.

It is important that all women from key populations have the same support and access to services related to conception and pregnancy care, as women from other groups.

IPPF and UNFPA promote the availability of and equitable access to a wide range of contraceptive choices within a basket of options, including condoms and other barrier methods, and short-acting and long-acting reversible contraceptives. For all contraceptive clients, informed choice is key in initiating one method over another. All clients, including young people from key populations, have the right to decide on the method of their choice. All women, men and young people must have a right to choose, and not be compromised by unwarranted intrusion from the law or provider.

The basic steps in effective contraceptive counselling for young women are:

- Provide counselling to determine the individual's pregnancy intention.
- Discuss available methods of contraception, including dual method protection.
- Determine medical eligibility for the desired contraceptive methods.
- Provide or prescribe the contraceptive method.
- Promote and provide condoms.

Some service-providers may lack knowledge and skills to provide objective counselling on contraceptive choices. They may also be biased by a judgemental attitude towards young people's sexual choices or towards members of key populations. In addition, the limited range of contraceptive methods available, and the sometimes poor quality of available (free) condoms, can also be a barrier to contraceptive uptake (see Section 4.1.1).

Young women who sell sex may use condoms less consistently with regular partners than with their clients. Many therefore need dual-method protection against pregnancy as well as against STIs and HIV. This may be achieved by using a highly effective contraceptive method for pregnancy prevention, and the male or female condom for STI and HIV prevention.

WHO's *Medical eligibility criteria for contraceptive use* – fifth edition (2015) classifies long-acting reversible contraceptives (LARCs) such as intrauterine devices (IUDs) or implants as safe for adolescents. While pills or condoms require daily or pre-sex compliance, and Depo-provera requires injections every three months, LARCs have much higher typical use effectiveness over periods of three to five years. Fertility returns after these devices are removed, which is an important consideration for adolescents. LARCs allow the adolescent to control her own fertility with a relatively simple technology, as long as options are available for removal. The pregnancy rate for those using the copper IUD is 2% over 10 years.

It is important to inform young women using hormonal contraceptives that they do not protect against HIV or other STIs; only condoms (male and female) can do so. Women using hormonal contraceptives must therefore also use a condom or take other measures to protect themselves against HIV.

Young transgender men (female-to-male) with child-bearing reproductive organs may also require access to contraception.

4.4.2 Prevention and screening of HPV-related cancers

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

It is important to offer cervical cancer screening to all women from key populations; screening can also be performed for anal cancer for people who are likely to engage in anal sex.

HPV vaccination does not replace cervical cancer screening. In countries where the HPV vaccine is introduced, screening programmes may need to be developed or strengthened. The WHO recommended target group for HPV vaccination is girls ages 9–13 years who have not yet become sexually active, including those living with HIV.

Women living with HIV are at increased risk for HPV infection and HPV-related tumours. HPV is mainly transmitted through sexual contact and can lead to sexually related cancers. Non-cancerous types (6 and 11) can cause genital warts, which are very common and infectious, and respiratory papillomatosis. HPV vaccines have been approved in many countries and are recommended before the onset of sexual activity to prevent genital cancers and genital warts.

Cervical cancer screening leads to early detection of precancerous and cancerous cervical lesions that will prevent serious morbidity and mortality. All women living with HIV should therefore be screened for cervical cancer, regardless of age, whether they are taking ART, and their CD4 count or viral load. Immediate management for precancerous and cancerous lesions should be provided.

HPV has a significant impact among men, but there are no well-established guidelines pertaining to HPV and anal cancer screenings. Men who have sex with men are at a higher risk than heterosexual men for anal, penile and oropharyngeal cancers associated with HPV. Attention to anal health care among men is relatively recent. Health-care providers should be trained to provide and normalize an anorectal examination as part of a routine, comprehensive history and physical exam. Health-care providers should discuss:

- consistent and correct use of condoms and lubricants
- proper use of rectal douches or enemas
- use of foreign objects and other insertive practices (e.g. dildos, fisting etc.)
- previous anorectal health problems
- use of drugs and other substances during anal sex.

4.4.3 Safe abortion services

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Abortion laws and services should protect the health and human rights of all women, including those from key populations.

[Where abortion is legal,] ensure linkages to safe abortion services for women from key populations, and access to appropriate post-abortion care to reduce morbidity and mortality.

Where abortion is restricted, unsafe abortion may be common and present serious health risks. Women from key populations should be informed about these risks.

VOICES OF YOUNG KEY POPULATIONS

“I had an abortion in the state health institution. When the doctor performing the abortion found out that I am a sex worker, she hit, insulted and cursed me.” *Sex worker, Kyrgyzstan*

“I had to take my wardrobe out of the house and sell it to pay for an abortion. ”
Sex worker, the former Yugoslav Republic of Macedonia

Within or outside marriage, adolescent pregnancy risks derailing girls’ healthy development. It can prevent them from achieving their full potential and exercising their rights to education and the social support they need for healthy development and a safe and successful transition to adulthood. Respecting the rights of adolescent girls and preventing pregnancy are therefore crucial to helping girls achieve their goals.

Access to SRH services has a positive impact on young people’s ability to obtain contraception, which in turn reduces unplanned adolescent pregnancies. In combination, training and supporting health workers, making health services welcoming, and doing outreach education can increase service uptake by adolescents. Linking pregnancy prevention to post-partum and post-abortion care, and to other primary health care, education and social support services is also important.

But these steps are unlikely to reduce adolescent pregnancy rates unless combined with CSE.

Adolescents may be deterred from accessing abortion services if they think their parents will be notified; this can increase the likelihood that they will go to providers of unsafe abortion. In some countries in the region, women who self-medicate with abortion drugs from the black market suffer complications.

Young women should have access to appropriate post-abortion care, and care for post-abortion complications should be provided. Where appropriate, they should be offered counselling on contraceptive choices to prevent future unintended pregnancies.

It is important to protect and respect girls’ rights, engage them in informed decision-making and address the needs

of the most vulnerable as a priority. Adolescent boys, whether they are regarded as fathers, adolescents or men, should not be seen simply as part of the problem, but part of the solution. They too are undermined by harmful gender norms and attitudes.

4.4.4 Prevention of perinatal transmission of HIV

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

All pregnant women from key populations should have the same access to services for prevention of mother-to-child transmission (PMTCT) and follow the same recommendations as women in other populations.

Prevention of perinatal transmission of HIV refers to interventions to prevent transmission of HIV from a mother living with HIV to her infant during pregnancy, labour and delivery, or during breastfeeding. Prevention of perinatal transmission also focuses on early initiation of ART in the mother and assuring the mother's health. A comprehensive strategy for prevention of perinatal transmission includes four elements:

- **Primary prevention of HIV infection among women of reproductive age:** This includes services such as information/counselling on HIV, treatment as prevention for women; STI screening and management; condom promotion; PrEP; HTS for women of childbearing age, including pregnant and breastfeeding women not living with HIV.
- **Preventing unintended pregnancies in women living with HIV:** Information and counselling to support SRHR, including rights-based contraceptive choices and access to a variety of contraceptive methods to prevent unintended pregnancies.

- **Preventing perinatal transmission of HIV from women living with HIV to their infants:** Initiating ART for all pregnant women living with HIV (or providing facilitated referrals); treatment literacy; adherence support during pregnancy and breastfeeding; nutrition support during early ART uptake and breastfeeding; advice on breastfeeding and nutrition; HIV prophylaxis for infants exposed to HIV as per guidelines; facilitating or providing institutional delivery.
- **Providing care, treatment and support for mothers with HIV and their children:** For infants exposed to HIV this includes early infant diagnostic test as per guidelines; initiating ART for infants diagnosed with HIV as per guidelines. For mothers and their partners who are HIV positive, this includes couple counselling on contraceptive choices, and adherence support throughout treatment.

Stigma, lack of male involvement, and gender-based violence are three important areas that must be addressed to improve quality and outcomes of all the services outlined above for prevention of perinatal transmission.

4.4.5 Prenatal, newborn and infant care

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

It is important that all women from key populations have the same support and access to services related to conception and pregnancy care as women from other groups.

Worldwide in 2012, 1 out of 20 adolescents aged 15–19 had a live birth. In the developing world, 23 per cent of adolescent girls are currently married or in a union, and 3 per cent are unmarried but sexually active. In the EECA Region the adolescent birth rate is 30 per 1,000 adolescents. Although this is lower than the global rate (51 per 1,000 adolescents), it is a cause for concern. Women giving birth under age 20 face higher risks of maternal mortality, obstructed labour and obstetric fistula, and have lower chances of receiving an education and obtaining employment. Children born to adolescent mothers face higher risks of mortality, undernourishment and school dropout compared with their peers. Expanding access to family planning services to adolescents is therefore of critical importance given great demand.

Prenatal, newborn and infant care services provided to young people and adolescents should be accessible, acceptable and affordable for them. This can be achieved by integrating prenatal services within other programme settings, such as youth health services, drop-in centres, shelters, youth community centres and within sex-work services. Health-care providers should be trained on the health needs and rights of young women and girls from key populations, as well as on relevant overlapping vulnerabilities such as drug and alcohol use.

- **Planning pregnancy:** Youth-friendly clinics should provide appropriate support and accurate advice about preparing for safe pregnancy and delivery and having a healthy child.
- **During pregnancy.** The first antenatal care visit should come early in pregnancy, ideally before week 12. The young person should be counselled about nutrition. Pregnant young women and their babies should be protected from infections (STIs, including syphilis, tetanus etc.). Health specialists should help pregnant young women and new mothers to decide how they can avoid pregnancy after childbirth. Ideally, counselling on family planning should start during antenatal care. Most complications of pregnancies cannot be predicted, but providers can help young women and (where possible) their families to recognize and respond to them, and to arrange for skilled attendance at birth, and ensure that they know how to contact the skilled birth attendant at the first signs of labour.
- **After childbirth:** Breastfeeding recommendations should be given. Family-planning visits should be coordinated with the infant's immunization schedule.

CONSIDERATIONS FOR PRENATAL CARE FOR YOUNG WOMEN WHO INJECT DRUGS

Taking a sexService-providers, including outreach workers, harm reduction services, drug treatment providers and antenatal care services must be adequately informed about drug use and pregnancy, in order to provide appropriate information to pregnant women who inject drugs. Harm reduction services should advocate with obstetric services to provide non-punitive, factual education and care to pregnant women and nursing mothers to protect their health and that of their infants.

It is not uncommon for women who inject drugs to have irregular or absent periods, and they may not realize that they are pregnant until late into their second or even third trimester. Service-providers should therefore educate women who inject drugs on the potential benefits of prenatal care for pregnant women and their babies, and provide home pregnancy test kits.

Women may not be fully aware of the potential impact of drugs on the child during pregnancy and breastfeeding and may have misconceptions about drug use and pregnancy. They should be provided with accurate and relevant information regarding the risks and harms to pregnancy associated with the continuing use of specific drugs, including tobacco and alcohol.

While the use of any drug while pregnant should be avoided, this may not be a realistic option. Given that many women experience heightened stigma if pregnant and using drugs, which can discourage them from seeking services, it is essential that workers provide support in a nonjudgemental manner to women who continue to use drugs.

Heroin users should be advised of the dangers of abrupt opioid withdrawal to the foetus, and referral to OST should be encouraged.

Pregnant women living with HIV should receive ART and syphilis testing/treatment as needed, to maintain their own health and reduce perinatal transmission of HIV and syphilis.

4.4.6 Gender-affirming services

IMAP STATEMENT ON HORMONE THERAPY FOR TRANSGENDER PEOPLE (2015)²⁶

For many transgender people, hormone therapy is part of the affirmation of their gender identity, so providing this service may assist them to realize their sexual and gender rights.

Some transgender adolescents may benefit from medical intervention in the form of puberty suppression until they have the capacity to make their own decisions (which may be regulated by country-specific laws) on whether or not to start hormone therapy and/or whether or not to undergo sex reassignment surgery.

Young transgender or gender-variant people, as well as young people experiencing gender dysphoria, should receive information and counselling on issues related to their gender identity, and support towards gender affirmation, including options for hormone therapy. The goal of hormone therapy, in general, is to align the external appearance of the individual's body with their gender identity. Hormone therapy should therefore produce masculinizing effects in a female-to-male transgender person, and feminizing effects in a male-to-female transgender person. There is evidence that hormone therapy and sex-reassignment surgery can substantially support the psychological well-being of transgender people who choose these treatments, and by improving self-esteem they may also contribute to lowering HIV risk.

Access to hormone therapy in the EECA Region (as elsewhere) is limited, and few health-care providers are knowledgeable about transgender health care. Some transgender people therefore seek hormone therapy in the informal sector, despite the potential harmful side-effects of unmonitored treatment and the risk of HIV transmission through contaminated needles. Sex-reassignment surgery is unavailable in most countries and is prohibitively expensive for many to obtain through private care. Where surgery or hormone therapy is not available for free or at low cost, some transgender people sell sex in order to raise money for it, which may increase their risk of exposure to HIV.

It is important to inform young transgender people about the risks of obtaining hormones from informal settings, and in particular to inform young transgender women about the higher risk of ill-health (including thrombosis) from using estrogens in oral contraceptives (ethinyl estradiol) compared with a recommended regimen of feminizing hormone therapy. Although hormone therapy may significantly reduce fertility, it may not always prevent pregnancy. Fertility and contraception should therefore be discussed with transgender people.

When providing sexual and reproductive health services to transgender persons, it is important to mirror the terms that the individual uses to refer to their body and genitalia. Doing so helps to establish rapport, awareness and trust between the health-care worker and the transgender individual.

Primary care protocol for transgender patient care

²⁶ / International Medical Advisory Panel (IMAP) statement on hormone therapy for transgender people. London: International Planned Parenthood Federation; 2015.

HIV TREATMENT AND CARE

CONSOLIDATED ARV GUIDELINES (2016)

Adolescents with HIV should be counselled about the potential benefits and risks of disclosure of their HIV status and empowered and supported to determine if, when, how and to whom to disclose.

Young key populations (along with other adolescents) are often underserved by HIV services, have high risk of loss to follow-up, suboptimal adherence and special requirements for comprehensive care, including psychosocial support and SRHR care. Young key populations also face significant barriers to accessing and remaining in treatment, care and support services, often due to policy and legal barriers related to the age of consent.

When appropriate, and only with the individual's specific permission, health-care personnel should engage the support of adults—family members, teachers, community members—as the adolescent learns to manage living with HIV. Young key populations who test positive for HIV should be counselled about the potential benefits and risks of disclosure of their HIV status and empowered and supported to determine when, how and to whom to disclose.

4.5.1 Pre-ART care

CONSOLIDATED ARV GUIDELINES (2016)

Following an HIV diagnosis, a package of support interventions should be offered to ensure timely linkage to care for all people living with HIV.

Knowledge of one's HIV positive status is the first step in the continuum of HIV care. Ensuring that young key populations living with HIV are linked to and enrolled in HIV clinical care is necessary to realize the full health and prevention benefits of ART. Intensified post-test counselling combined with follow-up counselling by health workers significantly increases the proportion of people who enrol in HIV care. It is also important to provide information to help young key populations living with HIV to protect their sexual health, avoid other STIs,

delay progression of HIV infection and avoid transmitting it to others. Referrals should be provided to support groups for people living with HIV that are welcoming of young key populations, where these are available.

CD4 cell count testing at the point of care can be used to prioritize patients for urgent linkage to care and ART initiation. CD4 still has an important role to play in assessing baseline risk of disease progression, decisions for starting and stopping prophylaxis for opportunistic

infections, and prioritizing ART initiation in settings where universal treatment is not possible.

For sexual health and well-being, young key populations living with HIV require access to services related to the diagnosis and treatment of STIs, CSE and counselling, and other services integrated into SRHR and HIV-related services, as appropriate.

4.5.2 Antiretroviral therapy

CONSOLIDATED ARV GUIDELINES (2016)

ART should be initiated among all adolescents and adults living with HIV, regardless of WHO clinical stage and at any CD4 cell count.

As a priority, ART should be initiated among all adolescents with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and adolescents with CD4 count ≤ 350 cells/mm³.

Standard ART consists of a combination of antiretroviral drugs to maximally suppress HIV and stop the progression of HIV disease. The potential of ART to reduce HIV transmission by suppression of viral load supports early initiation of ART. It is recommended to directly provide ART to those testing positive for HIV (if possible), or facilitate referral of the client to another ART provider.

4.5.3 Viral load monitoring

CONSOLIDATED ARV GUIDELINES (2016)

Viral load is recommended as the preferred monitoring approach to diagnose and confirm treatment failure.

Monitoring young key populations on ART is important to ensure successful treatment, identify adherence problems and determine whether ART regimens should be switched in case of treatment failure. Measuring viral load can help discriminate between treatment failure and non-adherence. Viral load gives clients a measure of understanding, control and motivation to adhere to treatment and understand their HIV status. Routine viral load testing should be conducted at 6 months after initiation and repeated at 12 months, and every 12 months thereafter, to synchronize with routine monitoring.

4.5.4 Adherence and retention

CONSOLIDATED ARV GUIDELINES (2016)

Programmes should provide community support for people living with HIV to improve retention in HIV care.

Assessment and management of depression should be included in the package of HIV care services for all individuals living with HIV.

As access to ART improves, its continued success will depend on sustaining high adherence. Interventions that can improve adherence to ART include individual-level interventions and simplifying ART delivery. Young key populations (along with adolescents), in particular, have a high risk of loss to follow-up and suboptimal adherence, and they have a special need for comprehensive care, including psychosocial support and SRHR care.

Community-level interventions have demonstrated benefit in improving retention in care, such as adherence clubs. Interventions that have demonstrated effectiveness in improving adherence and virological suppression include peer counsellors, mobile-phone text messages, reminder devices, and counselling (cognitive behavioural therapy). Adherence counselling needs to address the implications of a detectable or undetectable viral load.

SRH SERVICES FOR YOUNG PEOPLE LIVING WITH HIV IN UGANDA

Link Up, a global consortium led by the International HIV/AIDS Alliance, trained peer educators to provide health education and counselling to networks of new and existing support groups for young people living with HIV, and to link these young people to facility-based HIV and SRHR services. Support groups met once or twice a month. Twelve health facilities, chosen based on their proximity to the peer support groups, provided HIV and SRHR services to young people living with HIV. Peer educators and community health counsellors distributed referral vouchers to the young people. The vouchers entitled them to free care and also included an easy-to-remember universal identity code to monitor service use. Link Up trained doctors and nurses in the health facilities to prioritize the needs of young people living with HIV and deliver services in a respectful and non-stigmatizing manner. A youth-friendly corner was set up at each facility where young clients could collect educational material or meet with peer educators who provided individual or group counselling services.

“Mystery client” audits indicated that preventing commodity shortages, reducing waiting times and modifying hours of operation to accommodate young people’s school and work schedules can make services more accessible to young people living with HIV. Facilities can increase client comfort by ensuring that waiting rooms are clean, well lit, and not too crowded. Confidentiality is critical: young people fear rumours spreading about their HIV status, which increases their desire to seek care at a time or place where they are less likely to be recognized.

Source: Using peers to improve sexual and reproductive health and rights of young people living with HIV in Uganda: findings from a Link Up evaluation. Washington (DC): Population Council; 2016.

4.5.5 Prevention, screening and management of common co-infections

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Key populations should have the same access to tuberculosis (TB) prevention, screening and treatment services as other populations at risk of or living with HIV.

Among people living with HIV, **tuberculosis (TB)** is the most frequent life-threatening opportunistic infection and a leading cause of death. All persons living with HIV should be regularly screened for TB using a clinical algorithm. The screen should contain all four of the following symptoms: cough, fever, night sweats and weight loss. All TB clients who have HIV or live in high-prevalence areas should receive the recommended treatment regimen for TB in addition to prevention, diagnosis, care, support and treatment for HIV.

In many countries TB is highly stigmatized and misunderstood. Talking about TB should therefore be considered as part of a CSE curriculum. The role of NGOs in TB services is crucial, i.e. providing information on where to get tested and treated if necessary, as well as case management when needed.

EARLY DETECTION OF PULMONARY TB IN UKRAINE

ICF Alliance for Public Health has integrated services for detecting pulmonary TB into harm reduction services by training social workers to screen key populations, including young key populations, for TB symptoms during regular outreach work. Individuals with symptoms are referred to a programme nurse who takes a phlegm sample for testing. The social workers train the key populations to recognize symptoms of possible TB and give information about where to get care.

By reducing the time to screen and take a phlegm sample to about 20 minutes, the system helps ensure early access to TB care. About 40 key population members are screened each week, and around 30% are found to have TB symptoms.

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Key populations should have the same access to hepatitis B and C prevention, screening and treatment services as other populations at risk of or living with HIV.

Viral hepatitis is an increasing cause of illness and death among young key populations. Both HBV and HCV are preventable through combined harm reduction interventions. A comprehensive approach includes prevention, HBV and HCV testing, HBV vaccination and treatment, and care for people with HIV who are co-infected with HBV or HCV.

HBV is transmitted by contact with the blood or other body fluids of an infected person. Sexual contact and injecting drug use can transmit the virus. HBV attacks the liver, which can cause acute and chronic disease such as cirrhosis or liver cancer. Hepatitis B is diagnosed using blood tests. Oral treatments are recommended. Fortunately, a cheap, safe and effective vaccine against HBV is available.

Like HBV, HCV is transmitted through contact with the blood or other body fluids of an infected person. Most HCV infections occur through the use of contaminated injection equipment among persons who inject drugs. HCV can also be transmitted by sexual contact. Hepatitis C infection is diagnosed by blood tests. There is no vaccine to prevent it, but for most people chronic hepatitis can be cured with new oral treatment regimens. People who have been spontaneously or medically cured from hepatitis C are not completely protected against a new hepatitis infection.

For young people who inject drugs, high coverage levels of HCV testing and high-quality NSP and OST play an important role in reducing HCV transmission. Since sharing drug-use equipment such as cookers and filters may contribute strongly to HCV transmission, these items should be included in harm reduction sterile kits.

Cervical cancer is a preventable disease and is curable if diagnosed and treated early. Women living with HIV have a higher risk of pre-cancer and invasive cervical cancer. The risk and persistence of HPV infection increases with low CD4 count and high HIV viral load. See Section 4.4.2 for more details.

Co-trimoxazole prophylaxis (CTX) is a fixed-dose combination of two antimicrobial agents (sulfamethoxazole and trimethoprim) used to treat pneumocystis pneumonia, toxoplasmosis and a variety of bacterial infections. CTX prophylaxis is a feasible, well-tolerated and inexpensive intervention to reduce HIV-related illness and death in people living with HIV. Co-trimoxazole prophylaxis should be implemented as an integral component of a package of HIV-related services. It is an off-patent drug and is widely available in resource-limited settings.

Cryptococcal meningitis should also be screened for and treated as necessary.

OTHER CARE AND SUPPORT SERVICES

Other care and support refers to a comprehensive set of services, including psychosocial, physical, socioeconomic, nutritional and legal support. These services are needed from the point of diagnosis throughout the course of

HIV-related illness, regardless of ability to access ART. The following section addresses three further areas of support that are of particular relevance to young key populations.

4.6.1 Clinical care following violence

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Provide primary health-care services including services for survivors of violence, including physical, emotional and sexual violence.

The link between violence and HIV is well documented. Health services, including HIV interventions, serve as an entry point for identifying and responding to experiences of violence and trauma. Training health-care workers who provide HIV services on sexual and gender-based violence, and vice versa, is an effective way to address both HIV and risks related to violence and abuse. Those providing primary care, broader sexual-health services, and harm reduction and psychosocial support can be similarly trained.

It is important to recognize that violence may not always be reported in a primary health-care context, but rather to outreach workers, social-service-providers etc. It is essential to sensitize them so that they can screen for, and respond appropriately to, reports of violence by young key populations.

Where possible, clinical care for survivors of sexual assault should be linked with community-led responses to violence:

- Offer first-line support to survivors of sexual assault by any perpetrator.
- Take a complete history to determine what interventions are appropriate, and conduct a complete physical examination (head-to-toe, including genitalia).

- Offer emergency contraception to women presenting within five days of sexual assault, and ideally as soon as possible after the assault to maximize effectiveness.
- Consider offering PEP for individuals presenting within 72 hours of a sexual assault. Use shared decision-making with the survivor to determine whether PEP is appropriate.
- Survivors of sexual assault should be offered prophylaxis for chlamydia, gonorrhoea, trichomonas, and syphilis depending on the prevalence. The choice of drug and regimens should follow national guidelines.
- Hepatitis B vaccination without hepatitis B immunoglobulin should be offered as per national guidelines.
- Psychological support and care should be offered, including coping strategies for dealing with severe stress.

Individuals who report experiencing trauma—whether through physical violence, sexual violence or psychological victimization—should be assessed for post-traumatic stress disorder. This is true whether the trauma occurred recently or longer ago.

4.6.2 Mental health

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Routine screening and management of mental-health disorders (depression and psychosocial stress) should be provided for people from key populations living with HIV in order to optimize health outcomes and improve their adherence to ART. Management can range from counselling for HIV and depression to appropriate medical therapies.

Young people from key populations have a myriad of health and social problems, yet almost no attention is paid to their mental health and well-being. Young MSM and transgender people in the EECA Region report distress and anguish because of complex family dynamics. Their parents either do not know of or will not accept their sexuality or gender identity, and they face community ridicule, social exclusion, religious rejection and persecution. Young people who sell sex are commonly living in difficult environments as sexually exploited children or sex workers. They commonly lack the knowledge and negotiating skills of older sex workers, and may have to balance being young mothers to small children while selling sex without family support. Similarly, young people who inject drugs often live away from families, in newly created communities among other people who inject drugs. Some live on the streets or in hostels, moving from place to place and working in difficult circumstances to acquire drugs, including selling sex in harsh environments.

The sexual, physical and emotional violence and stigma many experience on a daily basis takes a toll on these young people. Suicide or suicidal ideation are a phenomenon; and alcohol can be a common form of self-medication.

Counselling services for young key populations are poor, and far greater attention needs to be given to meeting their special mental-health needs. Mental-health support should be routinely integrated into primary health care, and mental-health services need to have particular approaches to address young people from key populations. Professionals providing mental-health services (including school psychologists), and outreach staff who counsel young key populations, should be given information and sensitization to enable them to provide counselling free of judgement and based on human rights.

Services for adolescents from key populations should include support to address self-stigma and discrimination, through counselling, peer support groups and networks. Additionally, individual and family counselling can address adolescents’ mental-health co-morbidities. The involvement of supportive parents or guardians can be beneficial, especially for those requiring ongoing treatment and care. It is important, however, to have the adolescent’s express permission before contacting parents or care-givers.

4.6.3 Social services

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Develop or strengthen protection and welfare services that help parents and families to fulfil their responsibilities to effectively protect, care for and support young people.

The EECA Region generally has weak social systems, and young key populations are particularly neglected. Many have difficulties even obtaining health-care insurance. Where possible, programmes should provide access to social services that are particularly important for young people to give them the stability to manage their lives and increase their chances of maintaining their physical and sexual health and well-being. These include:

- for young key populations who are homeless, immediate shelter and long-term accommodation arrangements, as appropriate, including independent living and group housing
- food security, including nutritional assessments
- livelihood development and economic strengthening, and support to access social services and state benefits
- support for young people who sell sex to remain in or access education or vocational training, and foster opportunities to return to school for out-of-school young people.

Resources

General publications mentioned in this chapter

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19. *WHO guidelines for the treatment of Neisseria gonorrhoeae*. Geneva: World Health Organization; 2016.

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Sexual and reproductive health and rights

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SERVICE DELIVERY

ACCESS TO SERVICES FOR YOUNG KEY POPULATIONS

It is often difficult for young key populations to access the care and treatment they need, because of the way service delivery is designed. Adolescent sexual and reproductive health (SRH) services may not meet the specific needs of those who sell sex, practise same-sex sex, are transgender or who inject drugs. At the same time, services designed for key populations may not be fully competent in all areas of sexual and reproductive health and rights (SRHR).

What is needed is an integrated approach to delivering HIV and SRHR services for young key populations (whether adolescents or young adults). Services must be designed and delivered so that they are available, accessible, affordable, appropriate and acceptable. These issues are described in Section 5.1—both the challenges faced by young key populations and some examples of programmes that have tried to address them. Second, services must be well coordinated and, where possible, integrated and decentralized. These approaches are described in Sections 5.2–5.4. Integrating services helps ensure that young key populations can receive as many services as possible at the same location. Decentralization means that they will not have to travel too far to reach services. Community-led service delivery—including by young key populations—is also an essential approach (Section 5.5).

IPPF's YouthHub website provides a range of materials on youth-centred service delivery, as well as comprehensive sexuality education and advocacy. Resources can be downloaded directly from the site: <http://www.ippf.org/youthhub/>

There are multiple barriers affecting young key populations' access to services.

Availability: Even where HIV and SRH services are nominally available, legal barriers make them unavailable in practice to young key populations. Providers sometimes refuse to give testing or treatment because of laws against sex work, same-sex sex, or drug use. They may also refuse to treat people under the age of legal majority without the consent of the young person's parent or guardian. Sometimes young people are required to show identity papers and refused services if they do not do so. In some cases (e.g. the Russian Federation), access to ART is conditional upon joining a national registry of HIV patients. Service-providers do not always know what services they are legally able—or required—to offer.

The system of propiska (registration of place of residence) in many post-Soviet countries limits the access of internal migrants to free or inexpensive health care once they move to other oblasts/provinces within their country. Many young key populations are mobile and thus find they can no longer afford health care. Those who migrate across national borders are often refused public health-care services in the new country.

IMPROVING THE AVAILABILITY OF HIV PREVENTION AND SRHR SERVICES FOR YOUNG KEY POPULATIONS IN GEORGIA

In Georgia, young people's vulnerability is shown by an increasing trend of adolescent pregnancy (much higher than the regional average), child/early marriage practice, and the increasing prevalence of sexually transmitted infections (STIs) and HIV, unsafe abortion and gender-based violence. Guidance is needed for HIV prevention services for adolescents, especially those from key populations, that explicitly considers the range of adolescents' needs and issues.

In 2016 UNFPA worked with the Policy and Advocacy Advisory Council of Georgia's Country Coordinating Mechanism, the Global Fund, and the National Centre for Disease Control and Public Health to elaborate the country's first National comprehensive HIV prevention package standards (Guidelines and Protocols) for young key populations.

The standards are aligned with best international recommendations and practices such as the SWIT and the MSMIT, and include cost calculations for transitioning HIV prevention programmes for key populations to state funding. They aim to catalyse greater national commitment to adequate funding and services for young key populations.

The guidance outlines a comprehensive package of evidence-based HIV-related recommendations for young key populations to improve access, coverage and uptake of effective and acceptable services. It promotes services for young key populations in traditional clinical settings as well as community-based or outreach settings, with a combination prevention package that includes effective, acceptable and scalable behavioural, structural and biomedical interventions.

MAKING SERVICES AVAILABLE TO YOUNG PEOPLE IN DETENTION IN UKRAINE

All-Ukrainian Public Centre Volunteer provides critical HIV prevention services for adolescents in juvenile detention. The programme targets adolescents considered most at risk for HIV infection, with a focus on underage individuals registered with law-enforcement authorities and those who are incarcerated in juvenile detention centres.

One volunteer intervention involves training providers who work with vulnerable and confined adolescents to increase their understanding of and sensitivity to their particular needs, to strengthen communication skills with this age group and to improve referral to appropriate services. A significant area of success was the introduction of courses on working with vulnerable adolescents in conflict with the law into the professional development training plan for the Bila Tserkva Academy of the Criminal Executive Service of Ukraine.

By 2015, 1,300 specialists were trained, including psychologists from juvenile correctional and detention centres and probation officers/staff from all regions of the country. Provider concerns about testing children under the age of 14 (the age of consent in Ukraine) were addressed through consultations with health managers and providers. However, legislative change to address age-related restrictions to services is problematic during political instability.

Accessibility: In many countries in the region, services are available only in regional/provincial centres or in the capital. Transport is frequently limited or too expensive for young key populations to be able to visit service-providers easily or regularly. Frequently, when referrals are made, young key populations are not followed up or

offered accompaniment by a sympathetic professional to their next appointment. This discourages them from accessing these services. The hours that services are available may not suit young people who are at school or college, or who are working. For ideas on how to make services more accessible, see Sections 5.3–5.5.

VOICES OF YOUNG KEY POPULATIONS

“I am a student, and after my studies I go to my work. When do you think I have the time to do HIV test or visit a doctor? They all work until 5pm or close even earlier. I think there has to be a place where the services could be provided after 5pm.” *Young MSM, Tajikistan*

Affordability: If young people find that publicly provided services are inaccessible or unacceptable, privately available services will most likely be too expensive for them to afford. Some services have out-of-pocket costs that are not clearly identified to the people seeking services, and these discourage them from continuing to

receive services. Young key populations are often still in school, without easy access to money, or are unemployed, and they may be impoverished and living on the streets. Whatever money they have may be spent on food or on drugs, which may be more urgent priorities for them than health check-ups.

VOICES OF YOUNG KEY POPULATIONS

“A lot of people do not have money and do not go for testing because of this.” *Young MSM, Tajikistan*

Appropriateness: HIV and SRH services are often not designed for young people, and many staff are not trained to work with key populations and do not understand their needs for specific exams, diagnostic tests or prevention commodities. Conversely, at general clinics or social services designed for young people, staff are frequently unfamiliar with HIV or the SRH needs of key populations, and with the other issues (of stigma, discrimination and marginalization) that particularly affect young key populations.

It may be helpful to map the services available to young key populations and share this information among all service-providers. Services that are specifically youth-friendly/youth-centred, or are designed for key populations, should be highlighted. This information should also be shared in an accessible format with young key populations themselves.

Appropriateness of services is linked to competency and thus to service quality, i.e. having staff who know how to serve young key populations well, and the facilities and infrastructure to provide the needed services (Figure 5.1). Simply put, young key populations have the right to the same range and quality of services as everyone else.

VOICES OF YOUNG KEY POPULATIONS

“When I was giving birth, I told [the doctors] I’m on methadone therapy, and they got all puzzled, they didn’t know what to do. The paediatrician told me the delivery would be at my own risk; the gynaecologist said he was only going to deliver the baby, he didn’t know more than that. I didn’t even see him later.” *Young person who injects drugs, the former Yugoslav Republic of Macedonia*

“Often, when sex workers ask doctors about safe abortions, no answers are provided as doctors themselves are incompetent and hence cannot provide counselling.” *YYoung sex worker, Ukraine*

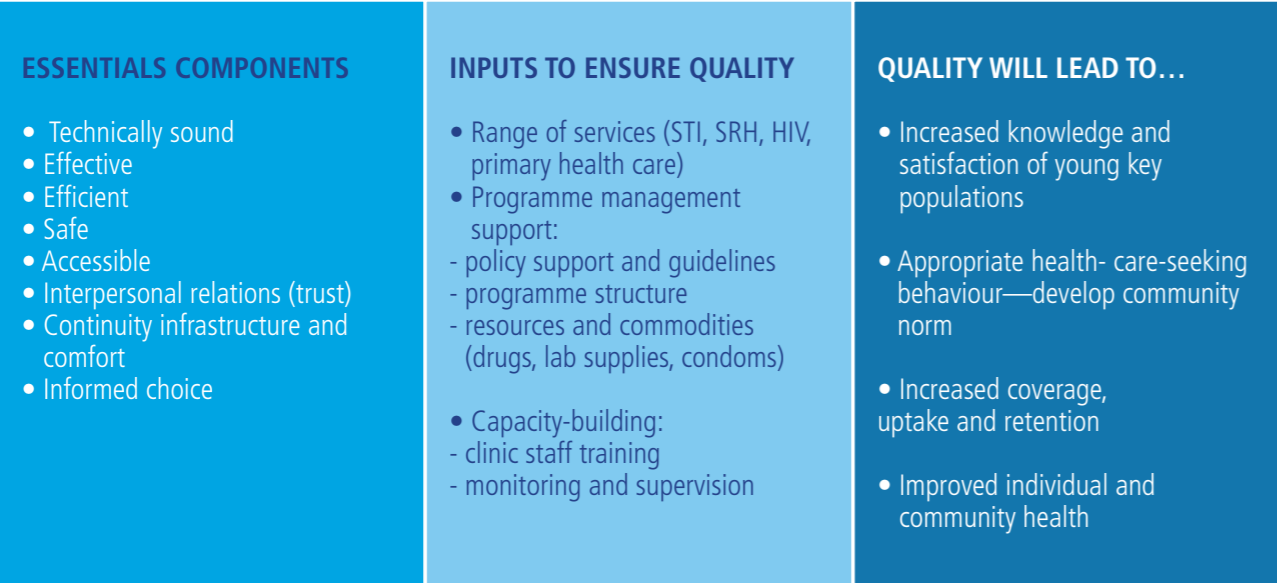


Figure 5.1 ENSURING HIGH-QUALITY STI SERVICES
Source: SWIT

Acceptability: The biggest factor making services unacceptable to young key populations is stigma and discrimination against them by service-providers—whether medical staff, receptionists, youth workers or other staff and volunteers. Discriminatory behaviour or language creates mistrust fear and makes it less likely that the individual will return to seek services when they need them. It can also force them to self-treat and seek other sources of treatment and management. Often, young key populations will seek support from private providers (if available and affordable—Ukraine is an example), where they have greater hopes of confidentiality and of less stigmatizing treatment at the hands of health professionals.

Perceived or actual lack of confidentiality of the individual’s medical and other information is a serious concern for young key populations and young people living with HIV. Sometimes services young key populations are provided in the same room as for the general population, or in the presence of other

doctors. This risks disclosure of personal information to third parties. Service-providers do not always explain clearly the legal boundaries of confidentiality, further undermining trust. In addition, the opinions and autonomy of the young person are frequently not respected.

A practical way to help make services acceptable to young key populations may be having a dedicated space within a clinic where young people can wait separately from adults; or offering services exclusively to young people at certain days/times of the week. Service sites may be more attractive if they offer wi-fi, water/tea or sweets. Services should be monitored to ensure they are respectful of young key populations and acceptable to them. This can be done by conducting accreditation and reports on service sites, as well as supplementary reports based on feedback collected from young key populations. The following case examples show how programmes in several countries have found ways to make services acceptable to young key populations.

YOUNG KEY POPULATION-FRIENDLY SERVICES IN ALBANIA

The Albanian Centre for Population and Development (ACPD), an IPPF Member Association, has established youth-friendly SRH standards in its two clinic centres, enabling stigma-free, rights-based and gender-sensitive services for young people, including young key populations. In collaboration with civil-society organizations that focus on young key populations, public institutions provide youth-friendly services and referrals as needed. Young key populations are also reached through community-based mobile and outreach services for SRH and HIV. With the advocacy efforts of ACPD and its partners, supported by IPPF and UNFPA, the Ministry of Health has established an expert working group to develop standards for youth-friendly services.

TRUST POINTS FOR KEY POPULATIONS IN TAJIKISTAN

Under the Global Fund HIV prevention project, Trust Points have been established in three regions of Tajikistan to deliver services to key populations. These include counselling; distribution of condoms, lubricants, gynaecological kits, informational materials and hygiene kits; STI referrals; and HTS referrals to the Republican AIDS Centre. Outreach workers are based at the Trust Points and offer services to key population members there, or at other locations upon request where appropriate.

Trust Points provide safe spaces for community members where they know they will be welcomed and treated without discrimination. For men who have sex with men, who are mostly married and unable to be open about their sexuality, Trust Points offer the only place where they can be themselves. Some men report that the Trust Points are all that stand between them and suicide.

The Trust Points provide integrated SRH and HIV services, support and referrals to young women who sell sex, use drugs or who are living with HIV. Young mothers are supported through pregnancy to deliver healthy babies. Similarly, a 15-year-old girl who has tested positive for HIV, and whose husband injects drugs and is also living with HIV, knows that she will be accepted and supported by the staff of the Trust Point, and by the hospital staff at the AIDS Centre that they refer her to.

Trust Points are operated by UNFPA implementing partners, in owned premises, rented spaces or within government health facilities. Several are located on the grounds of hospitals, to enable immediate referrals and improve key populations’ access to medical services. This also helps to protect clients from harassment by the police.

DEVELOPING STANDARDIZED YOUTH-FRIENDLY SERVICES IN THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

In 2005 and 2006, two SRH clinics for young people, called “I want to know” centres, were opened by the Ministry of Health and the nongovernmental organization (NGO) Health Education and Research Association (HERA), in partnership with international organizations. These grew out of an IPPF project to promote and improve SRH in five Balkan countries and increase access to high-quality integrated care for youth.

The “I want to know” centres guarantee privacy and confidentiality and ensure an appropriate and welcoming environment for young people. The clinics offer a range of services so that young people do not have to visit several different hospitals or facilities for services. Young key populations know that they will not be discriminated against by the service-providers, and that because the clinics serve young people in general, they are not disclosing their key population status simply by attending the clinic.

Partners designed the programme using IPPF’s self-assessment manual on youth-friendly services. Seventeen primary-health service-providers with backgrounds in medical and social sciences, together with five community and peer educators, and youth volunteers from HERA, conducted the self-assessment, designed the action plan and worked on the renovation and refurbishment of the clinics. The involvement of young people was crucial to encourage use of the centre’s services by young people and to improve communication between clients and service-providers.

The IPPF guidelines on SRH service delivery and peer education are used as standards and protocols. Client files, observation forms and checklists and client satisfaction forms are used to evaluate the quality of service provision and the protection of client confidentiality. Young people, clients and service-providers are involved in the evaluation of services to ensure these remain accessible and continue to meet the needs of young people.

PROVIDING SEXUAL-HEALTH SERVICES TO MSM WITH FEMALE PARTNERS IN INDIA

The Family Planning Association of India (FPAI) provides integrated SRH and HIV services to the general population through a network of 42 branches across the country. Many FPAI clinics have trained service-providers to be sensitive to the needs of men who have sex with men, including those with female partners. MSM with female partners often face real or perceived discrimination from within the community for being bisexual. Other community services for men who have sex with men often refer those with female partners to FPAI clinics for sexual-health services. Because the clinics maintain confidentiality and accessibility for all clients, they allow MSM with female partners to feel comfortable attending with their partners, or to discuss needs related to their sexual behaviour with men with the trained counsellors.

Source: MSMIT

SERVICE COORDINATION

It is important that services be coordinated between different providers, so that people can receive the services they need as smoothly as possible. Well-coordinated services are not only more efficient and more effective, but reduce the chance that people will be lost to follow-up. This is particularly crucial for young key populations, for whom poor coordination may create serious or even insurmountable barriers to accessing services.

Figure 5.2 shows some of the roles played by different levels of community and organizations in providing comprehensive services. In this example, a community-

led organization or an NGO (implementing partner) is working as part of a programme coordinated at a state or national level by a large-scale NGO or a governmental body. Coordination between each of these levels is important, but so also is coordination between the services provided by implementing partners and those provided by other clinics, social-service agencies or other organizations. Since most community-led organizations are not able to provide comprehensive services, a strong referral system must be established. This should go hand in hand with sensitization of other service-providers (see Section 3.5.2) so that young key populations are treated respectfully when they are referred.

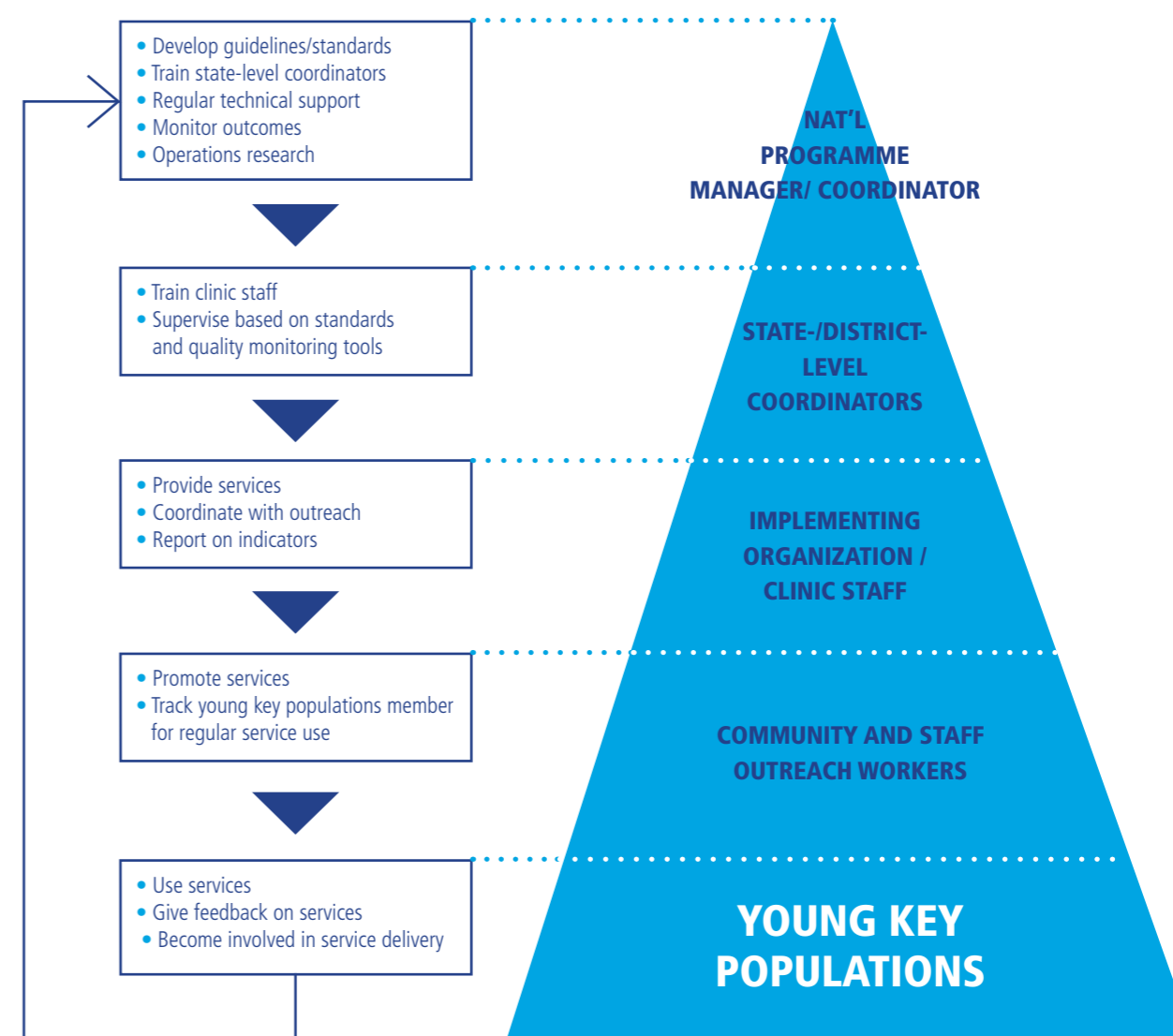


Figure 5.2 ROLES AND RESPONSIBILITIES FOR COORDINATED SERVICES

Source: Adapted from SWIT

In many countries, networks of youth-friendly clinical or social services already exist. (An example is the state network of Centres of Social Services for Family, Children and Youth in Ukraine.) These can be a good resource to deliver services specifically to young key populations, by including in their work plans an obligation to work with young key populations. At a minimum this could include identifying young key populations through appropriate screening, providing social support and referring them to specialist services they need.

It is important for providers to ensure a smooth transition of adolescents from the care of paediatricians to adult physicians, and to consider the mental and emotional needs of the young person during this transition.

Figure 5.3 shows an example of how a referral network from an STI centre or drop-in centre could link young key population members to primary health-care and other services

STEPS TO IMPROVE SRH INFRASTRUCTURE AND QUALITY OF CARE

- Develop guidelines, protocols and standard operating procedures.
- Develop performance indicators.
- Carry out costing and budgeting for youth-friendly services.
- Coordinate the work of NGOs delivering health services with the work of government health-care providers.
- Integrate examples of good practice of NGOs into the work of public health institutions.
- Expand the range of existing services through partnerships between public, civil-society and private providers.
- Include young key populations in monitoring of service quality, including all dimensions of accessibility, affordability, appropriateness, availability and acceptability.

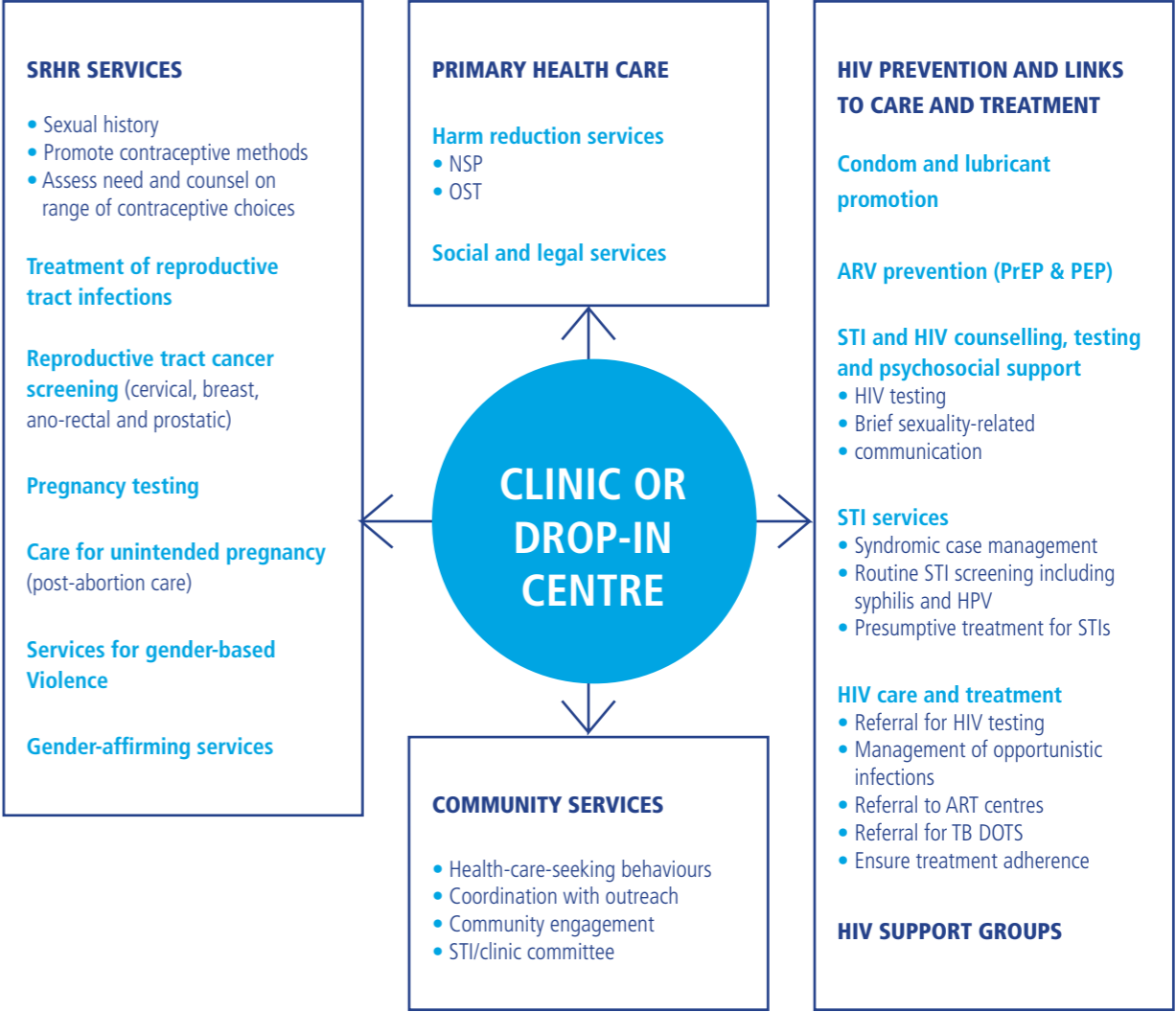


Figure 5.2 ROLES AND RESPONSIBILITIES FOR COORDINATED SERVICES
Source: Adapted from SWIT

The following case examples are instances of promising practices for coordinating referrals for HIV testing services (HTS) and other services.

DROP-IN CENTRE FOR HUMAN RIGHTS IN SERBIA

The Drop-in Centre for Human Rights was established in 2009 in Niš, Serbia's third-largest city, by the Serbian Association for Sexual and Reproductive Health and Rights, an IPPF Member Association. The centre offers a safe, welcoming gathering place for vulnerable populations, especially youth, lesbian, gay, bisexual and transgender (LGBT) people, men who have sex with men, people living with HIV and Roma. It provides psychological, medical, legal and peer counselling, as well as educational and creative workshops and talks on human rights, non-discrimination, preventing STIs and HIV, and rights to social and health-care services.

The centre operates a referral system with local NGOs, primary health centres, public-health institutes and social work centres. Outreach workers and a legal counsellor help clients to submit applications or appeals for the social or health protections to which they are entitled, including appeals to the equality ombudsman in cases of discrimination or stigmatization. Online counselling is offered via Facebook or email, which enables information and services to be offered to young people outside Niš, as well as those who wish to remain anonymous.

"Drop-in Centre is a place where I have met a few people who I can call friends... people you can rely on, who will help you, hear you, understand you, be there for you. That is the only place where I can be myself, and even sometimes, forget about my HIV status and feel 'normal' as a person."

M.N. (32), beneficiary

"The only place where LGBT people can socialize freely in Niš, not hiding their sexual orientation or gender identity, is Drop-in Centre... We feel equal and free to be ourselves there, regardless of the differences among us... I learned a lot about other people's problems, about discrimination and how to prevent/react when being discriminated (against), but also about sexuality, sexual health and rights and, particularly important to me, about self-discrimination. In this environment, I feel really supported and empowered."

S.G. (24), beneficiary

The following example shows how coordination between UNFPA and government institutions made it possible to provide SRH services to extremely vulnerable populations as part of the response to an ongoing social and health crisis.

PROVIDING SRH AND POST-RAPE SERVICES TO REFUGEES IN THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

The Balkans lies on one of the routes into Western Europe for migrants and refugees seeking a safer life. From summer 2015 to the closure of the border in 2016, almost 1 million refugees and migrants transited through The former Yugoslav Republic of Macedonia. Since the country itself has only around 2 million inhabitants, this created huge pressures, including for the health sector. Nevertheless, from the beginning of the migrant crisis, health services for migrants and refugees were made available by deploying mobile gynaecological services at the entry and exit points of the migration route, even prior to the establishment of health units.

At the onset of the migrant crisis, the UNFPA country office in Skopje, in partnership with the Ministry of Health and the NGO HERA, conducted a rapid assessment of the SRH needs of refugee and migrant women and girls. This served as a basis for planning interventions. In addition to the two mobile gynaecological clinics, ultrasound machines, resuscitators, delivery beds, reproductive health kits for STIs treatment, birth delivery and post-rape care kits were donated to maternity wards in the two hospitals at the entry and exit points of the route. This enabled health facilities to provide high-quality SRH services to all migrants and refugees as well as the local population. To ensure standardized quality of services, UNFPA supported the training of service-providers, particularly health-care providers, on the minimum initial SRH service package during emergencies, and on the clinical management of rape. The provision of kits and of training for clinical management of rape were pioneer initiatives for The former Yugoslav Republic of Macedonia, as there had previously been limited knowledge, skills and experience on this subject. Service-providers were particularly interested in understanding the links between gender-based violence and HIV. The interventions were part of a wider initiative to develop multisectoral responses to gender-based violence, and UNFPA conducted similar initiatives in Serbia.

Additional information available at:

<http://www.unfpa.org/news/move-new-mobile-clinic-reaches-refugee-women-balkans>

SERVICE INTEGRATION

Integration means providing a variety of services and resources meeting multiple needs at a single service point (whether a fixed location, or through mobile outreach). This can be done through providers who multi-task, referrals within a health-care institution, or “one-stop-shop” services under a single roof. For example, HIV and SRHR services can be integrated within the basic package of primary health care, so that HIV testing, prevention, treatment and care services are provided alongside services for TB, STI, hepatitis, contraceptive choices and other family planning services, or harm reduction programmes for people who inject drugs.

Integrating services makes them more accessible to young key populations and can increase service uptake, with a beneficial effect for all the services provided, e.g. both HIV testing and TB screening may increase in places where they are offered together. Making HTS more convenient for people coming to health facilities

for other reasons increases the uptake of HIV testing and is an important way of achieving the 90–90–90 targets. Services can also be integrated within programme settings other than primary health-care clinics, such as youth health services, drop-in centres, shelters, youth community centres and within sex-work services. For example, facilities serving young people could consider:

- making available free condoms (male and female) and lubricants
- providing HTS
- providing emergency contraception on demand for young people who sell sex
- providing comprehensive information and counselling on contraceptive methods
- providing free needles and syringes as part of a harm reduction programme for young people who inject drugs.

An important aspect of service integration is providing services for those in prison or detention, including police cells, prisons, juvenile detention centres, immigrant detention centres, and closed rehabilitation shelters. By

definition, those in closed settings will only receive SRH and HIV care if these services can be integrated into the medical services offered in such settings.

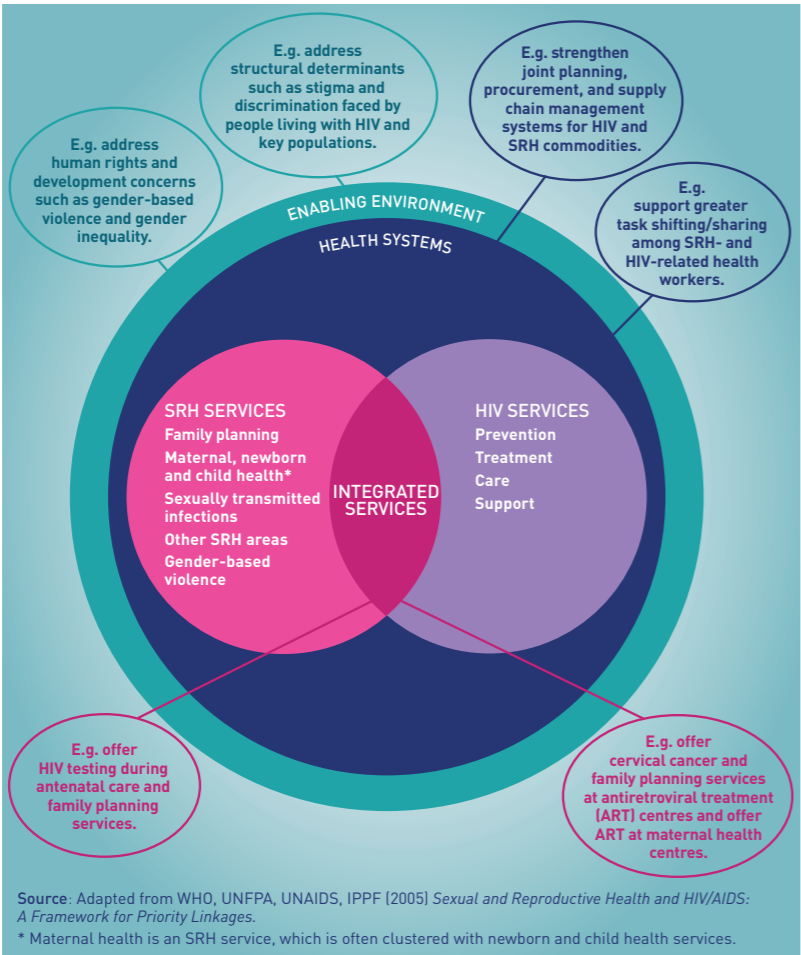


Figure 5.2 INTEGRATION OF HIV AND SRHR SERVICES
Source: WHO and IPPF. SRHR & HIV linkages toolkit. Website. srhhivlinkages.org

INTEGRATING AND STRENGTHENING HIV AND SRH SERVICES FOR KEY POPULATIONS IN KYRGYZSTAN

Kyrgyzstan has made efforts to strengthen the integration of HIV and SRH services for key populations by developing policy documents, regulations, and clinical guidelines and protocols, as well as building the capacity of service-providers and community members. A clinical guideline on support for SRH for people living with HIV was developed and approved by the Ministry of Health in 2015. Training on the guidelines was provided to 40 professors at the Kyrgyz State Medical Institute on Continuous Education, and they have integrated it into the institute’s curriculum. A similar guideline is under development for other key populations.

More than 200 health-care providers at the primary level, as well as oblast and City AIDS Centres countrywide, have been trained on providing integrated HIV and SRH services for people living with HIV and key populations, with a focus on addressing stigma and discrimination. Recommendations from the key population implementation tools will be integrated into these training programmes.

TANDEM TESTING FOR HIV AND HEPATITIS C FOR PEOPLE WHO INJECT DRUGS IN GEORGIA

Since 2015 the government of Georgia has emphasized equal access to hepatitis C treatment for the entire population, with the goal of eliminating hepatitis C in the country by 2020. For many years neither state programmes nor insurance schemes covered the cost of hepatitis C treatment. As people who inject drugs represent the largest population group affected by hepatitis C infection, it is essential to offer screening for hepatitis C virus (HCV) to those using HIV prevention services. Tandem screening for HCV and HIV is therefore offered to all people who inject drugs who use harm reduction services within the Global Fund HIV programme in Georgia. Free access to hepatitis C treatment has considerably increased their interest in testing. In 2016 the number of people who inject drugs screened for both infections increased by 25%. The introduction of mobile testing units has also helped increase the coverage of geographically hard-to-reach people who inject drugs.

ATTEMPTS TO INTEGRATE SRH SERVICES IN TAJIKISTAN

Kyrgyzstan has made efforts to strengthen the integration of HIV and SRH services for key populations. The UNFPA Country Office in Tajikistan found that clients often refuse to visit health facilities because they are too far away, depriving them of adequate access to high-quality SRH services. In 2016 UNFPA began integrating HIV, STI and SRH services, with the ultimate goal of providing integrated services at the primary health-care level.

Coordination meetings were held with directors of the STI Institute, the Republican AIDS Centre and the National Reproductive Health Centre to obtain their political support. The process has been time-consuming and challenging, insofar as it requires reforms to long-established health structures, and funding allocations from the state budget are very limited. To establish and operationalize an intersectoral working group, a decree from the Ministry of Health and other approvals must be obtained. UNFPA is currently working to obtaining the decree.

SERVICE DECENTRALIZATION

Decentralization means delegating or transferring authority and resources from the central ministry of health to other institutions, or to field offices of the ministry at other levels (e.g. provincial, regional, district, subdistrict, primary health-care post and community). Service locations that are easy and safe to reach will significantly improve accessibility and acceptability for young key populations. Where possible, providing ART and OST at decentralized locations will encourage those who are HIV positive to remain on treatment, and those with opioid dependence to adhere to therapy.

Decentralizing service provision means that policies, procedures and approaches can be adapted to the local needs of the communities. This in turn enables highly targeted approaches that use available resources effectively. It means that communities and local governments and other interested and involved parties are able to work constructively together. For example, the municipality may provide a room, a vehicle, health staff, equipment, computers or technical support to community organizations facilitating community-led services, safe spaces and referral mechanisms. Local agreements and action plans enable a level of integration and coordination that national structures are often unable to deliver. They have the potential for lasting positive impact.

Decentralized services require that all staff be properly trained to uphold the highest standards of care in ways that are tailored to, and appropriate for, young key populations. Community-based and community-led services (whether at fixed locations or through mobile outreach) are an important aspect of service decentralization. Established organizations of people living with HIV, key populations, LGBTI organizations, human-rights organizations and youth groups have an important role to play in maximizing the benefits of decentralization. Minimizing potential harm is also crucial, as some local officials may place young people at risk through their prejudice or misapplication of laws and policies.

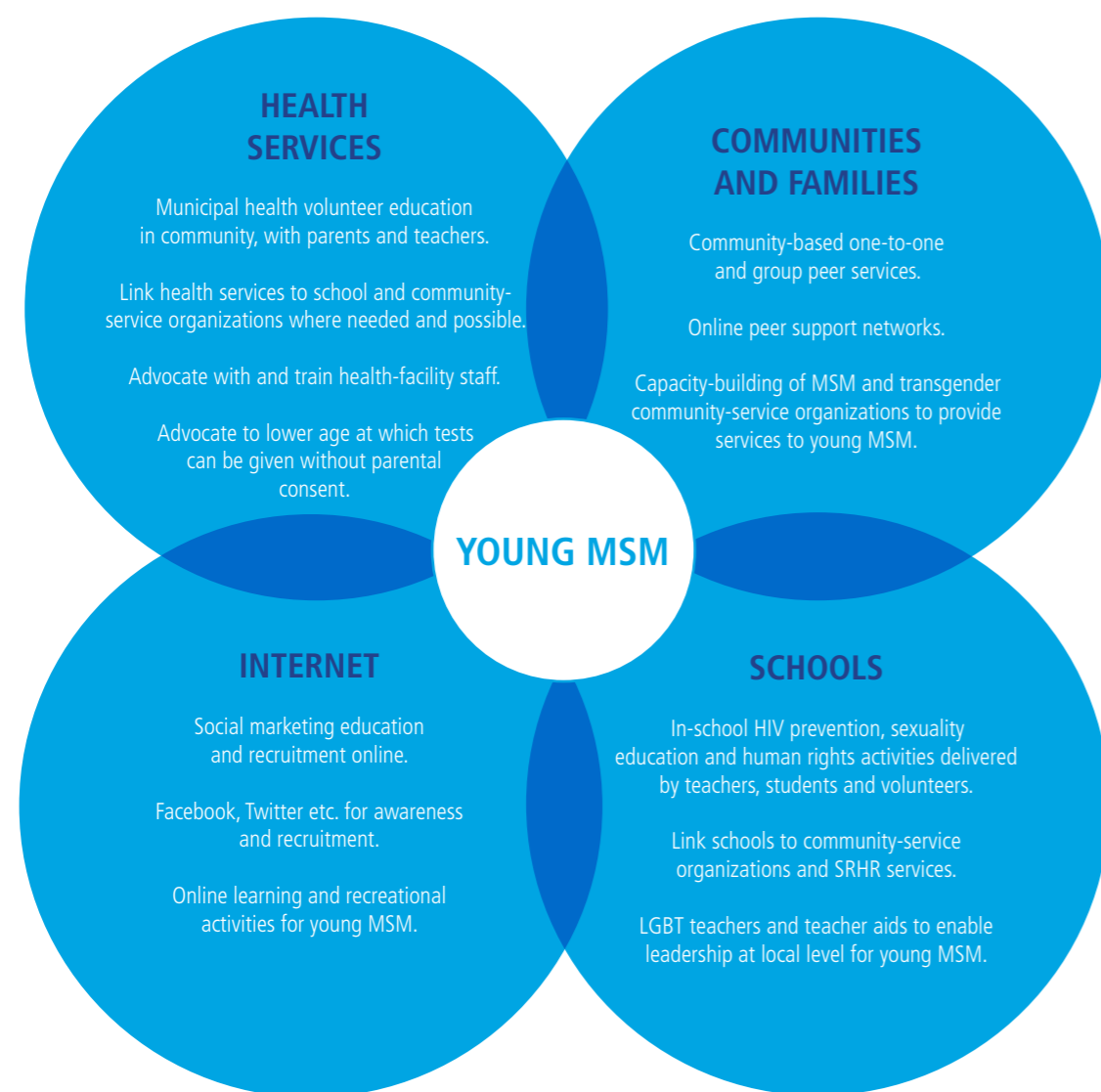
MOBILE OUTREACH TO CHILDREN AND ADOLESCENTS IN UKRAINE

ICF Alliance for Public Health has organized the “Social Patrol”, a mobile team comprised of a social worker, nurse and psychologist. The patrol visits remote areas to provide children and adolescents with counselling on HIV and STI prevention, information materials, testing for HIV, STIs and hepatitis, basic medical care (not requiring a doctor), psychological counselling sessions, and referrals to prevention projects. Services are provided in particular to street children and young people at risk, with access to testing for HIV, STIs and hepatitis from the age of 14. The young people are trained in basic HIV and STI prevention using approaches that take into account their low literacy levels. The service helps to eliminate the practical barriers and the fears that impede adolescents from approaching health-care institutions and NGOs for care.

A PROPOSED PILOT APPROACH LINKING SCHOOLS, COMMUNITIES, HEALTH SERVICES AND THE INTERNET

A study in Thailand proposed a pilot project that incorporates four elements in combination, each linked to an important setting in which young MSM operate: schools, community or family, health services and the Internet (see Figure 5.5 below). Activities could include using school-to-community networks to enhance access to health services, HIV and human-rights peer education and support, online learning, recreational and support activities and the power of web-based social marketing and social media.

Figure 5.5 **PILOT PROJECT MODEL FOR CREATING AN ENABLING ENVIRONMENT FOR IMPROVED SEXUAL-HEALTH OUTCOMES AMONG YOUNG MSM**



1. SCHOOLS: This element of the project would study the feasibility of delivering HIV prevention and sexuality education activities exclusively for young MSM, either in the school setting (via teachers and school clubs) or partly in and partly out of school (via education and support activities implemented by community service organizations, NGOs and health services). This would require buy-in from school authorities and the involvement of teachers, older peer students, community service workers and health volunteers from municipal government sites.

2. COMMUNITIES AND FAMILIES: This would involve a combination of one-to-one and group-based support and education services. The use of older peers was proposed to provide sexual-health education, advocacy, and support for young MSM in their relationships with their families.

3. HEALTH SERVICES: This element of the project aims to improve the quality and youth-friendliness of HIV and SRH services for MSM, via advocacy with health authorities to reduce the age of consent for young MSM to access HIV services or to allow for a health volunteer to sign off as a guardian. Positive attitudes towards regular HIV testing and enrolment in treatment and care services could be fostered by peer- and Internet-delivered information and education. At the same time, staff working in HIV and SRH services require additional training to ensure a nonjudgemental and welcoming attitude towards young MSM clients and to provide services to them using terminology that they can easily understand.

4. INTERNET: Online learning about HIV, partly packaged as recreational activities, could provide a neutral and reliable source of information and complement school-based and after-school activities.

Source: *Changing gears: a guide to effective HIV service programming for gay men and other men who have sex with men in Asia*. Bangkok: APCOM; 2016.

COMMUNITY AND PEER OUTREACH AND SUPPORT

KEY POPULATIONS CONSOLIDATED GUIDELINES (2016)

Community and peer-led and outreach approaches may help to distribute condoms and lubricants, increase knowledge, develop skills and empower adolescents from key populations to use condoms and lubricants correctly and consistently.

Community- or peer-based interventions are an important way to exchange information and increase the health literacy of individuals or networks of young key populations, including their capacity to obtain, process and understand basic health information; explore their options; ask key questions about their choices; and actively participate in decisions concerning their care. This can be done through meetings or in support groups, via tools/devices (e.g. Internet, mobile applications, hotlines), or by providing information and services outside the formal health, education and social care system.

Community-based approaches to service delivery can increase accessibility and acceptability for young key populations. Community-based outreach, mobile services, drop-in centres and venue-based interventions are useful for reaching those with limited access to, or underserved by, formal health facilities. These approaches allow for crucial linkages and referrals between the community and health facilities, and they support service decentralization.

Community-based programmes can also refer to programmes that are led and delivered by members of the key population community. Key population communities, including young people, play a vital role in the response to HIV and the SRHR of young key populations. Peer provision refers to a model in which young people perform functions related to health care for their peers. Based on available evidence, trained young people can implement tasks to prevent, diagnose, treat, maintain or restore physical or mental health, and to increase health literacy among their peers.

Key population members who are trained and knowledgeable about existing local programmes can act as important mentors and guides for others to access and adhere to a programme. They may act as role models and offer nonjudgemental and respectful support that may contribute to reducing stigma, facilitating access to services and improving their acceptability. The vital support these individuals provide might stem from identifying from a particular key population group, being a young person themselves, or first-hand experience of seeking and accessing services.

Often these community members play a critical role in guiding young community members from programmes at community sites to service delivery points that welcome young key populations, where they can access a more comprehensive package of HIV and SRHR services. For example, this could mean supporting a young community member to access HTS for the first time; or accompanying a young person recently diagnosed HIV positive to an appropriate HIV treatment service. The latter is often crucial not only in contexts where all who test positive are required to register with a government clinic or hospital for treatment, but also for supporting case management and adherence more broadly.

Key population community members can have an especially important role at service-delivery sites which are not themselves community-led. They can greet individuals when they arrive and explain the client intake process, including completing medical and client-history forms. Where fear of judgement, discrimination and maltreatment is a major barrier for young key populations seeking HIV and SRHR services, they can answer questions and alleviate the anxiety clients may have about the clinical encounter. In this role, they are more than merely a “friendly face” for young people within health clinics; they are community health professionals who are integral members of programme staff. Any staff, including community members, involved in community-based approaches need to be appropriately supported, in terms of training, supervision and management, as well as incentives and remuneration.

Community members and young peers can also be trained to deliver interventions or steps along the continuum of care, including pre procedure counselling, the procedure itself, and post procedure counselling, as well as follow up visits and referral to other services. Youth performing these functions do not require a formal professional or para professional certificate or tertiary education degree, but must be sensitized, trained, mentored and monitored in the context of the intervention. Table 5.1 outlines some examples of HIV and SRH services that any community member has the capacity to deliver without professional training or qualification, if they have received the necessary training.

Table 5.1 **POTENTIAL FUNCTIONS OF TRAINED PEER PROVIDERS**

HIV PREVENTION

- Information and counselling on safer sex, sexuality, relationships and condom negotiation
- Condom and lubricant distribution and other condom-related services
- Recognize exposure that may have placed the individual at risk of HIV infection, and support access to post-exposure prophylaxis
- Support syndromic management of STIs
- Provide information on harm reduction for young people who use drugs

HIV TESTING AND COUNSELLING

- Support access to HIV testing
- Provide pre-test information and counselling
- Deliver HIV testing using rapid diagnostic test
- Conduct post-test counselling and offer risk reduction information
- Provide counselling and support, and refer to formal psychological counselling as needed

PREVENTION OF PERINATAL TRANSMISSION

- Offer HIV testing to pregnant young women
- Advice and counsel on safer sex, partner and children testing
- Counsel on interventions to reduce the risk of transmitting HIV to infant
- Review strategies to decrease the risk of transmission at the time of delivery
- Advise on contraception

ANTIRETROVIRAL TREATMENT

- Prepare an individual to initiate ART
- Recognize/manage self-limiting drug side-effects and encourage or assist consultation or clinic visit when necessary
- Monitor and support adherence to treatment

SRH SERVICES

- Provide contraceptive counselling
- Provide contraceptive services including condoms, emergency contraception, pills, injectables
- Support confirmation of pregnancy
- Provide pre-abortion/post-abortion counselling
- Provide information on safe abortion, including information on self-care
- Screen, counsel and refer for sexual and gender-based violence
- Provide sexuality and relationship support and counselling
- Promote care-seeking behaviour and antenatal care during pregnancy
- Provide companionship during labour and support post-partum care

SOCIAL AND COMMUNITY SUPPORT

- Advice on where to eat, sleep, bathe
- Assistance with caring for children
- Linkages to literacy classes, out-of-school programmes
- Legal support (paralegal approach)

Source: Adapted from IMAP statement on youth peer provision models to deliver sexual and reproductive health services to young people (2017).

COMMUNITY AND PEER-DRIVEN PREVENTION AMONG ADOLESCENTS AT RISK OF HIV AND STIS IN UKRAINE

ICF Alliance for Public Health operates an outreach model for HIV, STI and hepatitis prevention that is based on a snowball technique: each adolescent client recruits and trains further adolescents. Initially, young people were trained to train their peers; as the project has developed, they now train peers to recruit more peers of their own, and the young people are then given an individual two-hour SRH training session with a social worker. Issues covered include how HIV, hepatitis, other STIs and TB are transmitted, and how to protect oneself against them. There is also information on general personal hygiene. Referrals can be made to HIV prevention projects and social services. The young people receive mobile phone cards as an incentive for their participation. Behavioural changes are tracked using a questionnaire.

By using the snowball technique, this approach is able to reach hard-to-reach subpopulations of children and adolescents. A project using one social worker can reach up to 400 clients in six months.

A COMMUNITY CENTRE IN THE RUSSIAN FEDERATION

ICF Alliance for Public Health operates an outreach model for HIV, STI and hepatitis prevention that is based on a snowball technique: each adolescent client recruits and trains further adolescents. Initially, young people were trained to train their peers; as the project has developed, they now train peers to recruit more peers of their own, and the young people are then given an individual two-hour SRH training session with a social worker. Issues covered include how HIV, hepatitis, other STIs and TB are transmitted, and how to protect oneself against them. There is also information on general personal hygiene. Referrals can be made to HIV prevention projects and social services. The young people receive mobile phone cards as an incentive for their participation. Behavioural changes are tracked using a questionnaire.

By using the snowball technique, this approach is able to reach hard-to-reach subpopulations of children and adolescents. A project using one social worker can reach up to 400 clients in six months.

Source: MSMIT

SEX WORKER-LED OUTREACH TO YOUNG PEOPLE WHO SELL SEX IN MYANMAR

Aids Myanmar Association Countrywide Network of Sex Workers (AMA) is a network of more than 2,000 female, male and transgender people who sell sex which engages in capacity-building and community mobilization to advocate for their health and human rights. Working within a restrictive political environment, sex workers who are part of AMA have had to find innovative ways of reaching out to young people who sell sex to provide peer support and access to information and services, particularly in relation to their health. AMA community mobilization workers are trained to be particularly sensitive to the needs of young people and do not ask for any identifying information, such as their real names or ages, when carrying out outreach.

Community mobilization workers provide STI and HIV prevention tools and strategies, and links to sex worker-friendly health facilities for testing and treatment, as well as follow-up counselling and care for young people who sell sex who are living with HIV. In a context of stigma and discrimination, young people who sell sex are often reluctant to access services for fear of arrest or of being treated badly by health-care professionals. Follow-up care focuses on discussing any barriers to adherence to treatment within a safe and supportive environment, and community mobilization workers offer to accompany young people to their clinic appointments.

AMA provides support to people who sell sex who are imprisoned, particularly ensuring that young people, who are often neglected or abandoned by their families, are given nutritional support while in prison. AMA also works to reconnect young people with their families and friends upon their release to ease the transition back into the community.

Website: www.facebook.com/pages/AMA-Aids-Myanmar-Association/518831108165572?sk=info

Source: HIV and young people who sell sex: a technical brief. Geneva: World Health Organization, 2015.

WORKING WITH REFUGEE SEX WORKERS IN UGANDA

The Cities Project of Reproductive Health Uganda (RHU) aims to increase access to quality SRHR services to refugees engaged in sex work in Kampala. The project started with a mapping exercise from which a pool of female refugee sex workers were identified, 50 of whom were trained as peer educators. They worked with RHU to mobilize their peers, some of whom were young people, to use integrated SRHR/HIV community outreach services in Kampala's slum areas. Recent activities included a refresher/linkages course for the peer educators and a documentation of 50 refugee sex workers in Kampala.

Source: Adapted from Working with refugees engaged in sex work: a guidance note for humanitarians. New York (NY): Women's Refugee Commission; 2016.

USING INFORMATION AND COMMUNICATION TECHNOLOGY TO REACH YOUNG MSM IN THAILAND

Save the Children uses information and communication technologies to enhance HIV prevention outreach to young MSM and transgender people in Chiang Mai, Thailand. The city is a major destination for "sex tourism" and has large numbers of migrants from minority ethnic groups, including from Myanmar. The project provides information on HIV prevention, treatment, care and support by tapping into social media most commonly used by MSM. These include Facebook, Line (a mobile phone application) and other websites and forums frequented by young MSM.

The project's research indicated that non-HIV related content such as personal grooming, religious instruction and topical news would be an effective way to engage young MSM. Content is devised by project staff based on discussions with volunteers and other members of the MSM community, and is changed regularly to keep it fresh and topical. Outreach workers promote Mplus Chat, an app developed by a local NGO working with MSM groups, and this is subsequently used by the educators to establish a relationship with the young MSM. The project provides outreach workers with tablet computers, which help to engage the attention of young MSM and makes communication easier in noisier environments like bars and clubs. The tablet is used to show the young MSM the project's website. It provides content for discussion and can be used to record contact details for later follow-up.

After initial contact is established, outreach workers continue to use ICT platforms to disseminate information on HIV prevention, treatment, care and support. Young MSM value continued online contact as a way to establish a trusting relationship with a counsellor while maintaining a degree of anonymity. This relationship enables outreach workers to promote accompanied referrals to free HIV testing for young MSM.

Source: HIV and young men who have sex with men: a technical brief. Geneva: World Health Organization, 2015.

Most NGOs, community-led organizations and networks in the EECA Region that focus on key populations are currently addressing issues of advocacy, human rights and policy, rather than engaging in direct service delivery. Those issues are very important in order to create an enabling environment for services.

In the meantime, however, it is important to recognize that some services for young key populations are being delivered, or linked to, by young key populations themselves, acting informally, or by other (older) key population members, or other advocates on the ground. Community-led organizations of key populations, and of young people, have a crucial role to play and should be encouraged to offer support and referrals informally now, and to find ways to structure and formalize service delivery.

Resources

Publications mentioned in this chapter

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6. *Working with refugees engaged in sex work: a guidance note for humanitarians*. New York (NY): Women's Refugee Commission; 2016.
<https://www.womensrefugeecommission.org/gbv/resources/1393-sex-work-guidance-note>

Other relevant resources

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 - Introduction
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 - Understanding evolving capacity
<http://www.ippf.org/resource/Evolving-capacity>
 - Obtaining informed consent
<http://www.ippf.org/resource/Obtaining-informed-consent>
 - Adopting a sex-positive approach
<http://www.ippf.org/resource/Adopting-sex-positive-approach>
 - Ensuring confidentiality
<http://www.ippf.org/resource/Ensuring-confidentiality>
 - Celebrating diversity
<http://www.ippf.org/resource/Celebrating-diversity>

ANNEX.

FOCUS GROUP DISCUSSIONS WITH YOUNG KEY POPULATIONS TO DOCUMENT ACCESS AND BARRIERS TO SRHR AND HIV SERVICES

UNFPA EECARO and IPPF EN conducted focus group discussions with young key populations (aged 18–24 years) in Albania, Bosnia and Herzegovina, Georgia, Kyrgyzstan, Serbia, Tajikistan, The former Yugoslav Republic of Macedonia, and Ukraine, following a common methodology. The goal was to document current access, and barriers to access, for HIV and SRHR services, and to understand better the challenges and needs of young key populations in order to support their overall health and well-being, and their recommendations for future programming.

The findings were documented in reports from each country, which were presented and discussed at a working meeting bringing together all eight countries in November 2015. The discussions at this meeting and the country reports provided first-hand information used in the development of this tool.

SOCIAL AND CULTURAL CONTEXT OF YOUNG KEY POPULATIONS:

Questions to gain a sense of the overall health and well-being of young key populations and their social inclusion, how and where they live their lives, the context and texture of their lives. Building resilience and protective factors means we need to understand the lives of young key populations and experience empathy. Questions also covered the cultural context that young key populations live within, and the nature of any stigma they experience due to HIV status, gender, behaviour or sexual orientation.

ACCESS AND AVAILABILITY OF SRH AND HIV SERVICES:

How many services there are, which services are offered and who is providing them, e.g. community-led organizations, NGOs, government services, primary health-care and other local-level service-providers or volunteer services. Questions also focused on whether services are easy to use and convenient (e.g. opening hours, safety, welcoming and qualified staff, affordable), are services integrated, such as SRH/HIV/TB/ drug treatment, or must young people attend many different services.

LEGAL CONTEXT AND VIOLENCE:

Questions exploring national laws, regulations, policies, protocols and guidelines affecting young key populations’ lives and their access to SRHR and HIV services, including discrimination, human-rights violations, police harassment, violence and gender-based violence.

PARTICIPATION AND RIGHTS:

Participants were asked how well they thought their peers were integrated into society, and how they would define social inclusion and integration. They were asked whether they discussed these issues with friends or family, and how well they felt that integration and social inclusion worked in their countries for young key populations as a whole, and what needed to improve so that young key populations could participate fully in society and claim their rights.

RECOMMENDATIONS FOR FUTURE ACTION:

Participants were asked to make recommendations about what should be changed at a policy and practical level to improve their situation in each of the above areas.

A set list of questions was used in order to make the results comparable between countries. However, there was flexibility to change the wording of the questions to make them as relevant, interesting and useful as possible for each country, and to ensure that the questions were easy to understand. Facilitators also had the freedom to choose the sequence in which the questions were asked.

In each country, several focus group discussions were held to ensure the greatest possible participation of young key populations. This meant that groups were held in different locations to make access easier, or that groups were held for different key populations so that they would feel as comfortable as possible. Venues were chosen to ensure that they would be easy for participants to reach, comfortable and safe; where possible, these were venues frequented by young key population members, e.g. an NGO office.

	MEN WHO HAVE SEX WITH MEN	SEX WORKERS	PEOPLE WHO INJECT DRUGS	PEOPLE LIVING WITH HIV	TRANS-GENDER PEOPLE	LGBT	FORMER DE-TAINEES	ORPHA-NAGE GRA-DUATES	TOTAL
ALBANIA	9	16	12			8			45
BOSNIA AND HERZEGOVINA	28								28
GEORGIA	10	8	9				9	10	46
KYRGYZSTAN	34	79	30	26	8				177
SERBIA	34								34
TAJIKISTAN	105	19							124
THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA	10	11	10	4					35
UKRAINE	34	46							80
TOTAL	264	179	61	30	8	8	9	10	569

PARTICIPANTS IN THE FOCUS GROUP DISCUSSIONS

There were generally 8–12 participants in each group. They were asked to sign a consent form confirming that they understood the purpose of the discussion and how the information would be used, and that they would maintain the confidentiality of the other participants. The discussions lasted 2–3 hours and were led by selected facilitators together with a UNFPA/IPPF HIV staff member. An additional person was designated to take notes without participating in the discussion.

The reports that were drafted as a result of this process are available at:

For further information about this report, please contact:



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