

Steady Ready GO!

The meeting

A global consultation held in Talloires, France, 25-28 May, 2004, will contribute to simplifying the difficult decisions that governments, policy makers, programmers, research institutions and funding organisations have to take in order to make the most strategic use of available funds. The meeting focused on decisions relating to priority interventions to achieve the global goals on HIV/AIDS and young people (10-24 years). It reviewed the available knowledge base, in order to provide an evidence-informed focus for activities aimed at decreasing the estimated 5-6,000 young people that continue to become infected with HIV every day.

This global consultation was organised by WHO, UNAIDS, UNFPA and UNICEF, under the aegis of the UNAIDS Inter agency task team on young people (IATT/YP), and in collaboration with the London School of Hygiene and Tropical Medicine, the Liverpool School of Tropical Medicine, and a range of other partners¹. It will provide firm foundations on which to build future policy and programme guidance, and strengthened advocacy and research for young people and HIV/AIDS.

The challenge

The meeting took as its starting point five goals that have particular implications for young people, as outlined in the Declaration of Commitment of the UN General Assembly Special Session on AIDS. These goals and targets have additionally been endorsed during the ICPD+5², and the UN General Assembly Special Session on Children, and they are also reflected in the Millennium Development Goals (MDGs). They provide direction and legitimacy, in addition to having a strong rationale in terms of public health, human rights and social and economic development.

The five goals and targets that provided the focus for the meeting were those that are directed to:

- increasing young people's access to core interventions necessary for the prevention of HIV: **information**, **skills** and **services**;
- decreasing young people's **vulnerability** to HIV/AIDS;
- and decreasing the **prevalence** of HIV among young people

By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the **information** required to reduce their vulnerability

By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 develop the life **skills** required to reduce their vulnerability to HIV infection

By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to youth-specific HIV **services** required to reduce their vulnerability

By 2003, develop and/or strengthen strategies, policies and programmes which ... reduce the **vulnerability** of children and young people by ensuring access of both girls and boys to education, including HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good-quality, youth-friendly information and sexual health education and counselling services; strengthening reproductive and sexual health programmes

By 2005 to reduce HIV **prevalence** among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010

These goals and targets provide a focus for national efforts to prevent HIV among young people: by enabling them to adopt attitudes and behaviours that decrease their, and others' risk of infection; and by ensuring that the environments in which they live, support and do not undermine, young people's ability to prevent the transmission of HIV, including social values and norms.

¹ In addition to the organisers, organisations represented at the meeting included the Alan Guttmacher Institute; Population Services International; American Foundation for AIDS Research; Colombia University; Education, Training, Research Associates, US; Centres for Disease Control and Prevention, US; Department for International Development, UK; the Global Fund; Deutsche Gesellschaft für Technische Zusammenarbeit; Institute of Tropical Medicine, Antwerp; International Labour Organization; International Planned Parenthood Federation; Johns Hopkins; loveLife; Ministry of Finance, Uganda; Medical Research Council, UK; Population Council; United Nations Educational, Scientific and Cultural Organizations; University of Windsor; University of Zimbabwe; US Agency for International Development; the World Bank; YouthNet

² The 5 year Review and Appraisal of the International Conference on Population and Development Programme of Action, the Hague, February 1999

The meeting answered the question: what do we know about interventions to achieve these global goals and targets? Based on the available evidence, can we place interventions into **GO!**, **Ready**, **Steady** categories?

- **GO!**
we have sufficient evidence to recommend widespread implementation NOW, provided that there is careful monitoring of coverage, quality and cost, and operations research to help us better understand how to improve implementation
- **Ready**
there is now good evidence that these interventions can have some impact, we are making progress with understanding the mechanisms of action, and we feel confident that we should be promoting these interventions widely *provided* that they are being carefully evaluated both in terms of impact and process (so that we can begin to develop quality criteria, and better understand how to implement effectively)
- **Steady**
there has been some consolidation of the knowledge base, some research indicating associations, some initial experiences with developing interventions, but there is a need for serious intervention development and research ... these interventions we would NOT recommend for widespread implementation at this stage until more research has been completed
- **Do-NOT-go**
interventions, for which there is strong evidence that they are *not* effective

Being clear about the evidence is all the more important in the light of the fact that HIV/AIDS among young people touches on many sensitive cultural and moral values and opinions, and is often concentrated in groups who are already marginalised and stigmatised.

The process

The meeting participants included researchers, policy makers and programmers, and a range of perspectives, professional backgrounds and organisational networks were represented. Participants brought both global and national view-points, and experiences from different countries and regions.

The meeting started with an overview of the epidemiology of HIV/AIDS among young people, and an assessment of current progress towards achieving the global goals/targets. An overview of what is known, in general, about the effectiveness of prevention interventions and strategies provided an additional backdrop for subsequent discussions.

The next phase was to develop consensus within the group about the criteria for assessing the *evidence of effectiveness* for a range of interventions that were reviewed in a series of background papers, which had been specifically prepared for the meeting by international experts. The criteria that were agreed for assessing the evidence were based on those proposed in another background paper, which were then further refined and developed in working groups.

The interventions background papers were based on the different *settings* where interventions are most frequently implemented for young people, including schools, health services, communities, and the media. They reviewed what is known about the effectiveness of specific interventions implemented in these settings: what works, and what doesn't.

The information presented in these background papers was then synthesised by the working groups in terms of the five global goals and targets, allocating the interventions to the *GO!*, *Ready* and *Steady* categories using the criteria for assessing the evidence that had been elaborated earlier in the meeting.

Based on the assessments of the available evidence, key messages were then crafted for policy makers and funders, programmers and researchers.

The assumptions

Prevention and treatment

The meeting focused primarily on prevention, which remains a key priority in national responses to HIV/AIDS. However, this should in no way imply that young people do not have specific needs for treatment and care, or minimise the importance for young people of the treatment-prevention continuum. Although young people are at the centre of transmission, they are frequently not the group of the population who are the primary focus of the increasing resources available in countries for treatment.

Coverage and quality

For interventions to be more widely implemented and influenced by the evidence, programmers need a clear description of the interventions that are being assessed, their characteristics and the mechanisms underlying their effectiveness. They also need to now of any specific considerations that need to be addressed when delivering the intervention to different target groups or in different contexts. This

will be important when replicating research or taking interventions to scale: coverage, quality and cost will all influence what is do-able, and what is done.

For example, interventions delivered through schools that aim to have an impact on how young people think and act, need to be clear about the age and sex of the target group, the teaching objectives, the content, teaching methods, duration and other factors that are likely to determine whether an intervention is, or is not effective.

Current efforts to develop and use standard national-level indicators, for monitoring the implementation of specific interventions and evaluating their outcomes, will make an important contribution to moving from intervention research to monitoring the coverage and quality of interventions that are being taken to scale¹.

Similarities and differences

Young people have many common characteristics, and the core elements of information, skills and services, outlined in the goals, will be common to all young people, even if the details and strategies for delivering interventions may differ depending on the specific target group, and the circumstances in which they live and learn.

Although young people have many similarities, they are not all the same! Individual characteristics, such as age, sex, marital status and domicile, and a range of contextual factors need to be adequately taken into consideration when developing intervention strategies and assessing the evidence for their success.

The phase and epidemiological characteristics of the HIV/AIDS epidemic also have important implications for defining those young people who need to be the primary focus of interventions for HIV prevention. This will range from all young people in generalised epidemics, to specific groups of young people who are particularly at-risk from HIV in concentrated epidemics.

Preventing and mitigating vulnerability²

Many deep-rooted structural issues underlie the transmission and impact of HIV/AIDS among young people, and it is important to review the evidence in ways that give adequate attention to the structural,

social and other contextual factors that make young people vulnerable to HIV infection, including: gender norms, relations between different age groups, race and other social norms and value systems, location, and economic status and consumerism.

It is clear that the achievement of many other global goals and commitments will make important contributions to decreasing HIV among young people, such as reductions in poverty and gender inequalities, improved employment opportunities, and the protection of human rights, including the *Convention on the Rights of the Child*. Many things will need to be done to decrease young people's vulnerability to HIV/AIDS.

In order to limit the scope of this particular meeting, rather than addressing the broader structural causes of young people's vulnerabilities, the focus was primarily on mitigating the impact of these vulnerabilities in relation to achieving the global goals. This includes making sure that adequate attention is given to gender issues when developing and implementing specific interventions, and that there is a focus on the most vulnerable groups who are frequently at the centre of the epidemic, and who particularly need access to information, skills and services to decrease their vulnerability.

Beneficiaries and a resource

Young people are both beneficiaries of the interventions reviewed during the meeting, and also a key resource in deciding what needs to be done, and how. The importance of involving young people, including young people living with HIV/AIDS, by providing them with opportunities to contribute to intervention development and implementation, was considered to be one of the quality criteria to consider when assessing interventions to achieve the global goals and targets.

The outputs and conclusions

1. Young people remain at the centre of the pandemic in terms of transmission, vulnerability, and potential for change. This is true both for generalised epidemics and for concentrated epidemics where HIV

¹ See the UNAIDS Monitoring and Evaluation Guide for National HIV/AIDS Prevention Programmes for Young People (10-24 years): www.who.int/hiv/pub/epidemiology

² The working definition of vulnerability used during the consultation was: "structural, social and other contextual factors that enhance risk by limiting young people's ability to make healthy decisions and/or increasing the likelihood of negative outcomes".

transmission is primarily restricted to vulnerable groups with behaviours that place them at increased risk from HIV. Young people are *where the virus is* and are also *where the virus is going*, unless action is taken NOW to counter persisting low levels of knowledge and self-efficacy; high rates of STIs, substance use, and gender-based violence; and continuing violations of the human rights of young people. These all create portals of entry for HIV from vulnerable groups to the population at large. Very few young people are infected with HIV during the early years of adolescence, even in the worst affected countries, and the challenge is to protect this new cohort from infection.

2. Progress is being made, but despite the impressive gains that have been achieved in some countries and for some groups of young people towards achieving the global goals, and despite that fact that there is increasing evidence of effectiveness and growing consensus about what needs to be done overall, we are still far from achieving the goals and targets that have been endorsed for 2005, 2010 and 2015.

3. Prevention works, and a range of effective interventions, including risk reduction interventions, need to be taken to scale for many different groups in the community. But young people need to be at the centre of these national prevention efforts.

4. Evidence informs when it is assessed in ways that bring together the rigours of good science with the realities and legitimate demands of policy makers and programmers who need to make tough decisions, today, about how to allocate resources.

HIV/AIDS is not like measles. There is no magic bullet. Many things need to be done through a range of sectors and organisations. The criteria and methods used to assess the evidence must reflect this complex reality, and there is a need to balance the desire to have gold standard experimental evidence with an understanding that just because an intervention has not benefited from such research does not necessarily mean that it doesn't work! Many different sources of evidence need to be taken into consideration.

The meeting concluded that what was most important was to have a set of criteria that would provide a common approach to assessing the evidence, that would ensure transparency about how the assessment is being made, and that provide sufficient flexibility to take different types of interventions and different settings into consideration.

The decision as to whether an intervention should be placed in a *Go!*, *ready* or *steady* category depends on the strength of the evidence. The acceptable strength of evidence (the *evidence threshold*) in turn depends on many factors:

- is the intervention do-able in a sustainable way?
- are there any possible adverse outcomes?
- is it an acceptable intervention to the target group, programmers, and the community at large?
- what is the size of the potential effect?
- does it have other health and social benefits?
- will it raise discussion, and legitimise a wider focus on young people's health and development?

Different interventions are likely to require different thresholds of evidence depending on these factors, and more rigorous evidence may therefore be required to recommend some interventions than others.

A number of criteria, that were discussed and categorised during the meeting, will need to be taken into consideration when assessing the strength of the available evidence relating to a specific intervention. These include the level of evidence, the quality of the intervention, the quality of the outcome measures, the process evaluation of the intervention, and the context.

- **The level of evidence:** informed judgement, associations, plausibility evidence, or probability evidence from randomised controlled trials
- **The quality of the intervention:** is it feasible, are there identified mechanisms of action, is there an experiential base, and has there been careful pilot testing?
- **The quality of the outcome measures:** the robustness and validity of the outcome measures
- **The process evaluation of the intervention:** the reception by target group and practitioners, factors facilitating and inhibiting implementation, and the quality of implementation, in terms of intensity, duration and completeness
- **The context in which the intervention is delivered:** similarities between target groups, the socio-cultural setting, the environment and infrastructure, and historical factors such as the phase of the epidemic

5. Priority interventions in the *GO!*, *Ready* and *Steady* categories were selected for the five global goals/targets. In addition, interventions were identified that should NOT be considered for implementation because the evidence indicates that they are ineffective.

It needs to be stressed that in selecting interventions for these categories, the threshold of evidence differed, in line with the criteria already outlined. The meeting provided a first-cut on the available evidence using these criteria, which will be further refined in subsequent revisions of the background papers for publication. The meeting did not provide the final answers, but made important contributions both to reviewing and synthesising the evidence to guide action and research, and also to influencing how we think about, and assess the evidence.

The following sections provide an overview of the main conclusions of the five goals/targets working groups that were charged with classifying the interventions reviewed in the background papers.

Achieving the information goal

GO! interventions for achieving the information goal were identified in the schools and mass media papers, provided that quality is maintained, and exposure and intensity are adequate (for media interventions there is a dose-response effect).

Ready interventions include programmes for providing information that involve peers, and the provision of information through health services. Additional evidence is also required to support the strong consensus “from the field”, that small scale community interventions play a crucial role in creating a favourable climate for disseminating information about HIV/AIDS prevention.

Achieving the skills goal

GO! interventions include schools-based programmes that model and practice the skills for reducing unprotected sex (delay, reduce and protect) and for safer substance use.

Ready interventions include community-based peer programmes that model the necessary skills to decrease HIV transmission; and media campaigns through a range of channels, including those that increase condom-use self-efficacy.

Steady interventions include programmes that aim to develop generic life skills.

Achieving the services goal

GO! interventions include the provision of an evidence-based package of interventions through health services (information and counselling; risk

reduction through condoms and harm reduction for injecting drug use; testing and treatment of STIs and HIV/AIDS¹); the promotion and marketing of condoms; and outreach services to vulnerable groups, including harm reduction interventions for injecting drug users.

A number of ready interventions were identified, including the addition of health service interventions to other programmes (eg. youth development), the expansion and promotion of HIV testing and counselling services, and non-traditional service delivery approaches (e.g. pharmacies).

Steady interventions include the provision of services through multi-purpose youth centres, interventions through traditional healers, male circumcision and post-exposure prophylaxis for young people who are sexually assaulted.

Achieving the vulnerability goal

The vulnerability goal/target is much more aspirational than operational, and in general requires interventions that are much less defined, developed or evaluated than the other goals. However, it is important to include a focus on vulnerability because it puts the spotlight on the many factors beyond the control of young people themselves that play a key role in how young people think and act, or are able to act; or whether or not different groups of young people have access to, or use the interventions that are available. In terms of mitigating vulnerability, important factors that need to be considered include: *gender disparities; age-differentials; race/ethnicity; norms and values; economic disparities; and residential location.*

A range of interventions were identified in the different background papers as being directed to changing these factors, including: youth-friendly health services and community interventions aimed at decreasing gender disparities; schools, peer programmes and media interventions having an impact on norms and values; schools and health services reaching out to vulnerable groups. However, these promising interventions are mostly in the ready category, and continue to need further evaluation, as do steady interventions such as the potential impact of the development of livelihood skills and opportunities on the achievement of the goals. No interventions were identified that address economic vulnerability, and have been assessed in terms of their effectiveness.

¹ Achieving the global goals: access to services, the technical report of a WHO, UNFPA, UNAIDS Global Consultation, Montreux, Switzerland, 17-20 March 2003, <http://www.who.int/child-adolescent-health/publications>

Achieving the prevalence goal

No one intervention is likely to decrease HIV prevalence among young people. However, the evidence reviewed during the meeting indicated that the following interventions would need to be considered as core components of national efforts to achieve the prevalence goal.

GO! interventions include:

Skill- and norm-based sexual health education in schools, provided that the specified quality criteria for effective programmes are maintained. If these are not adhered to, then interventions in schools are much less likely to be effective.

Youth-friendly health services offering core interventions for the prevention, diagnosis and treatment of STIs and HIV/AIDS, through existing health infrastructures.

Harm reduction to prevent HIV transmission through injecting drug use, and health services targeted to other vulnerable groups at high risk, such as young sex workers.

Mass media interventions that are modelled on the quality criteria of interventions that have demonstrable effectiveness and a dose effect.

Examples of *ready* interventions include activities through *schools* to reduce injecting drug use, encouraging health seeking behaviours (demand creation) and referral to health services, and reducing social vulnerability, for example changing gender norms; interventions through *health services* which provide information and counselling and support individual skills to adopt risk reduction behaviours; and VCT directed to the general population of young people; interventions through *communities* that model skills to reduce unprotected sex (including gender-based violence), and catalyze broader changes in social norms; and interventions through 'modern' communications e.g. internet.

Health education interventions through schools, which only present information, were one example of *Do-NOT-go* interventions for achieving the prevalence goal.

Policies as an intervention

Policies provide the overall context for actions to prevent HIV among young people, and reflect national commitment to create the space for specific interventions to take place. Policies provide direction, and while there are growing efforts to develop policies and strategies that facilitate the achievement of the

global goals on young people, it is important that the policy process is informed by, and supportive of the evidence-based interventions that were outlined during the meeting. Policy development provides important opportunities to raise and discuss the sensitivities associated with HIV and young people, and to promote effective solutions.

6. A research agenda was developed during the meeting that emphasised the need for quantitative and qualitative research, and that highlighted a number of specific areas that require increased attention, for example the collection and analysis of cost data. It also emphasised the need to monitor the coverage and quality of *GO!* interventions, and carry out operations research so that we can better understand how such interventions are best delivered; the need to carefully evaluate the impact and processes of interventions in the *ready* category; and the importance of continued intervention development and research for *steady* interventions. The challenge for research is to help identify effective interventions, and move the up the scale and across the thresholds from *steady* to *GO!*

7. Messages were developed for some key audiences during the meeting, including:

For policy makers

- Effective prevention interventions are available, but these will need to be much more widely accessible and used if the goals are to be attained: this will require commitment, capacity, consensus, coordination and cash!
- Despite the welcome attention being paid to increasing people's access to treatment, prevention among young people will be crucial to "turning off the tap" of HIV transmission
- Give higher priority to evaluation in order to ensure effectiveness, and contribute to the evidence base
- Effective interventions need to be linked whenever possible (eg. schools, services, mass media)
- Schools and media are particularly effective ways of providing young people with information, although alternative interventions will be required for the many young people not in school and without access to the media
- Skill-building contributes to reduced risk of HIV transmission (in terms of delaying sexual debut, reducing partners, and increasing the correct and consistent use of condoms; and in terms of safer injecting drug use)
- Developing and changing norms that contribute to reducing the risk of HIV transmission is very important
- Ensure that young people have access to the known effective health services for the prevention and care of HIV/AIDS, including young people who are particularly vulnerable and at-risk
- There is a continuing need for research, and research capacity development, in resource poor settings

For programmers

- Countries will need to deliver interventions in multiple settings to have any chance of achieving the coverage and prevalence goals/targets, and co-ordination and collaboration will be important for linking these different elements
- Surveillance and national-level monitoring data are increasingly available to support the planning, targeting and implementation of effective interventions
- Programmes should give clear and consistent messages about behaviour change, and a national communication strategy in support of HIV/AIDS programmes can make important contributions to achieving this
- GO! interventions need to be planned to scale
- Information to young people needs to be complete and medically accurate, and the evidence shows that young people are not confused by diverse messages for prevention
- Ensure that young people have access to information and services for STI and pregnancy prevention, in addition to HIV prevention
- Capacity development is urgently needed for those implementing all of the effective interventions described
- Document interventions and work with researchers to evaluate programmes
- Community interventions are important for reaching vulnerable groups, building acceptance and support, and mobilising for specific interventions through schools and health services
- There is no one-size-fits-all intervention, and what is needed and possible will depend on the type of epidemic and the capacity of the resources and infrastructures
- Young people living with HIV/AIDS should be included in planning and implementing interventions for prevention, including prevention-for-positives

For researchers

- More evidence is needed based on biological outcomes
- Better cost data, including total costs, costs per person reached, and costs per HIV transmission averted
- More attention to process evaluations and operations research, in order to be clear about the minimum criteria for effective interventions
- Research on the long-term effects and sustainability of interventions
- More attention to modelling the impact of different interventions, in order to help policy makers and programmers make decisions about the intervention mix
- Research on the long-term protective effect of developing livelihood skills
- Develop approaches to assessing young people's health seeking behaviours
- Develop and use standard outcome measures, including measures for skills and self-efficacy
- Training and capacity-building are needed to carry out research and evaluation of the kind that would produce the evidence needed to move interventions from *steady* to *GO!*

The next steps

That we can even ask the questions that were asked during the Talloires meeting is testimony to the extensive intervention development, programme implementation and research that has taken place around the world, specific to HIV prevention among young people and more widely in relation to adolescent health and development. The meeting was only possible thanks to a number of previous efforts to synthesise the evidence that is needed to inform policies and programmes, and outline a supportive research agenda. It makes an additional contribution, and it is hoped that it can provide some focus for the activities of many other partners, and that many of the individuals and organisations who were not able to participate in the Talloires meeting will contribute to the follow-up activities that were agreed:

The background papers

The meeting provided the opportunity for an extensive peer review of the background papers, and based on this and additional refinements of the criteria that were agreed for assessing the evidence thresholds, the papers will be further developed, including comparable tables for allocating interventions into the *GO!*, *ready* and *steady* categories. Additional papers will also be developed, including a paper that reviews the evidence for policies as an intervention, and the evidence that existing policies are informed by the evidence. The community paper will be developed into two papers: one will focus on interventions that are directed to particularly vulnerable groups of young people (young injecting drug users, young sex workers and young men who have sex with men); and the other will review the evidence for interventions that are provided to geographically defined communities through community organisations and processes. The set of papers will then be published as a Special Supplement in a peer-reviewed journal.

A platform for advocacy

The conclusions and messages developed during the meeting help to make a compelling case and provide clarity about priority interventions. These will form the basis for advocacy materials that will be developed by the UNAIDS IATT/YP, in collaboration with a range of partners, for use at national, regional and global levels. The outcome of the Talloires meeting will additionally inform the 2004 International AIDS Conference, Bangkok, with plans to incorporate the conclusions and messages into plenary presentations and Satellite meetings, and to produce an advocacy publication.

A platform for action

The growing knowledge base about effective interventions, and the characteristics of effective interventions, needs to be much more widely available through a range of channels, including UN Theme Groups on AIDS, and the CCMs that are responsible for overseeing the proposals that are submitted to the Global Fund. Better programme guidance and capacity development will be essential if effective interventions are to be taken to scale and countries are to have a chance of achieving the global goals and targets. An adequate allocation of the available financial resources will also be central to moving from words to action.

A platform for research

The meeting makes an important contribution to ensuring that the research community is well informed about the key questions that would most help policy makers and programmers achieve the global goals and targets. It has helped to identify some of the key questions that create obstacles to the prevention and care of HIV/AIDS among young people, and ways in which research can help to overcome them.

We have goals and targets, we have funds in countries, and we have clarity about effective and promising interventions. The Talloires meeting makes a contribution to providing a focus for global, regional and national level action to achieve the global commitments.

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