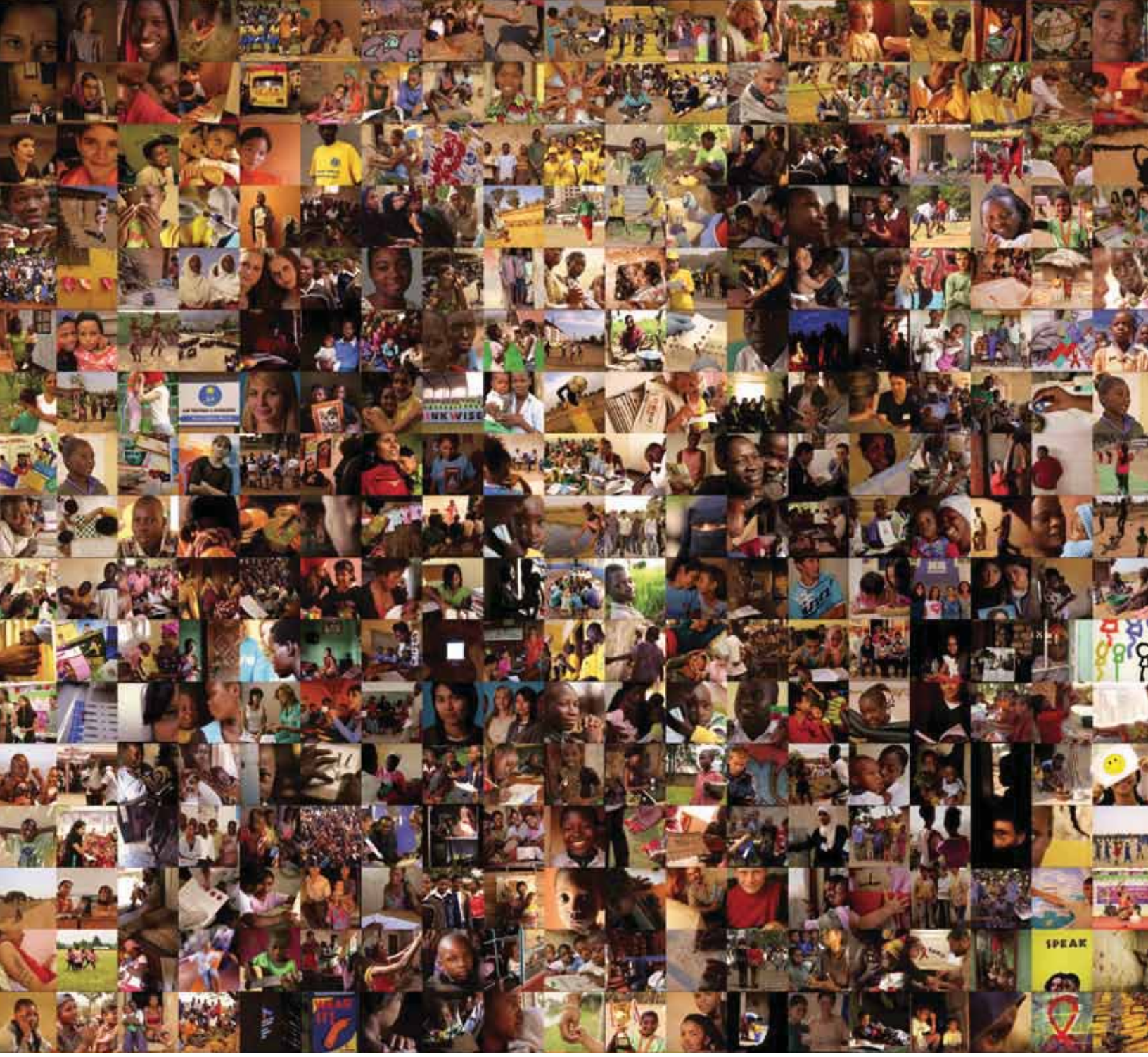

OPPORTUNITY in CRISIS

EMBARGOED
1 June 2011

Preventing HIV from
early adolescence
to young adulthood

Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood

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UNAIDS, the Joint United Nations Programme on HIV/AIDS, brings together the efforts and resources of 10 UN system organizations to the global AIDS response. Co-sponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. Based in Geneva, the UNAIDS secretariat works on the ground in more than 75 countries worldwide.

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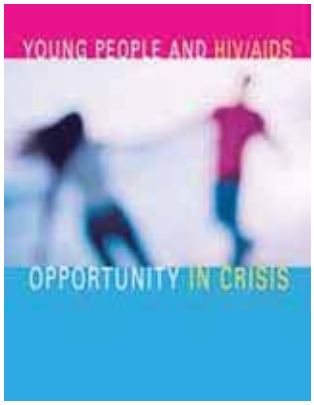
1. INTRODUCTION

The past decade has held high hopes for reducing the rate of new HIV infections among young people. In 2000, world leaders adopted the Millennium Declaration, affirming their collective responsibility to ensure equitable development for all people, especially children and the most vulnerable, in the 21st century. The Declaration was translated into action by eight Millennium Development Goals (MDGs), the sixth of which commits the global community to using every resource possible to halt and reverse the spread of HIV.

Building on that commitment, at the UN General Assembly Special Session on HIV and AIDS in 2001, the world made a promise to reduce the prevalence of HIV in young people globally by 25 per cent by the end of 2010 and to increase young people's access to essential prevention information, skills and services so as to reach 95 per cent of those in need by the same date. The first *Opportunity in Crisis* report, published in 2002, put forward 10 steps to help move countries closer to their prevention goals (*see Then and Now, on page 34*).



Since then, some countries have experienced gains in knowledge and positive changes in the sexual behaviour of their young people, and some countries have achieved declines in HIV prevalence and incidence. Many of these achievements can be attributed to the efforts of young people and their schools, families, health workers and communities, as well as to the efforts of some political leaders. But neither the efforts made nor the progress achieved so far have been sufficient.

Globally, an estimated 5 million [low estimate: 4.3 million – high estimate: 5.9 million] young people aged 15–24 were living with HIV in 2009, a 12 per cent reduction since 2001, when there were 5.7 million [5.0 million–6.7 million] young people living with HIV.[1] Yet the 2010 target – a 25 per cent reduction – is unlikely to be met. The young women and men living with HIV today are the most visible evidence of the world's failure to keep its promise to prevent HIV infection among young people and to empower them to protect themselves and live healthy, AIDS-free lives.

A continuum of prevention can lower young people's vulnerability to HIV

What causes the transmission of HIV among young people is no mystery: unprotected sex with an HIV-positive person or contact with infected blood or other fluids through the sharing of non-sterile injecting equipment.

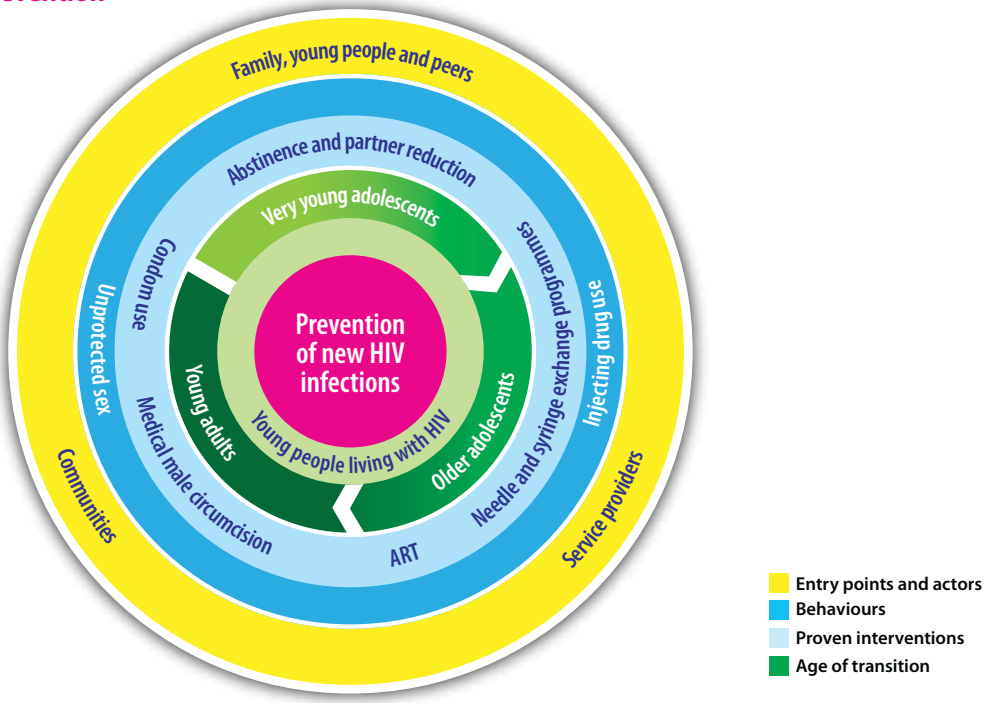
What works to prevent HIV transmission in young people is no mystery either:

- Abstaining from sex and not injecting drugs
- Correct and consistent use of male and female condoms
- Medical male circumcision
- Needle and syringe exchange programmes as part of a comprehensive harm reduction programme
- Using antiretroviral drugs as treatment (which lowers the chance of transmission) or as post-exposure prevention
- Communication for social and behavioural change

In 2009, young people aged 15–24 accounted for 41 per cent of new HIV infections in people aged 15 and older.[2] Reducing this level of incidence requires not a single intervention but a continuum of HIV prevention that provides information, support and services to adolescents and young people throughout the life cycle, from very young adolescents (aged 10–14) through older adolescents (aged 15–19) to young adults (aged 20–24) *(see Figure 1)*.

A continuum of prevention not only helps protect adolescents and young people but ensures that they can access HIV testing and maternal and child health care in response to their needs, including services to prevent mother-to-child transmission of HIV. Ultimately, a continuum of HIV prevention will replace the negative cycle of HIV passing from young people to their partners and the next generation with a positive cycle of HIV-free living.

FIGURE 1: Continuum of prevention



Along with a continuum of HIV prevention, there is a need to address the underlying problems that lead to young people's risk: lack of opportunity, gender inequality and poverty. This is why the MDGs are so crucial to the success of the AIDS response. And while the goal is to prevent new HIV infections in young people, it is also to help those young women and men already living with HIV to manage their chronic illness in a way that gives them as much chance to succeed in life as their HIV-negative peers.

There are opportunities to use proven prevention strategies in all epidemic contexts

In countries with generalized epidemics (a number of countries in sub-Saharan Africa and Haiti and Papua New Guinea), there are opportunities to foster an environment that will encourage healthy attitudes and behaviours, ensure greater gender equality and allow protection against vulnerability to take root and become the new norm. This is particularly important for young women and girls, who in these countries are at greater risk of HIV infection than young men and boys. Here, the same social norms that tolerate domestic violence also prevent women from refusing unwanted sexual advances, negotiating safe sex or criticizing a male partner's infidelity. The silence and complicity around this inequality must, and can, be broken.

In low-level and concentrated epidemics (Central and Eastern Europe and the Commonwealth of Independent States, East Asia and the Pacific, Latin America and the Caribbean, the Middle East and North Africa, and South Asia[3]), where HIV infections among youth are driven by injecting drug use, sex work or male-to-male sex, there are opportunities to reshape a legal and social milieu that compounds vulnerability and marginalization and to reach out in a sustained, effective way to make young people aware of the risk factors and facilitate their access to protection and health care.

Everywhere, young people themselves are central to the success of prevention efforts. In the KwaZulu-Natal province of South Africa and in Kenya, adolescent boys and young men are participating in programmes that offer medical male circumcision.[4] In Malawi, a small study has indicated that girls using cash transfers to stay in school are in the process also reducing their risk of HIV because they are choosing fewer and younger, rather than older, sexual partners.[5] In Romania, nearly 20 per cent of young injecting drug users and sex workers accessing services at a drop-in centre also requested an HIV test.[6]

Communities are integral to successful HIV prevention

Young people's families, peers, elders, teachers and co-workers have a crucial role to play in advocating on their behalf for the services they need to stay healthy and thrive. This community also sets norms for acceptable behaviour and the tone of discussion around issues of sexuality. In Southern Africa, for example, sex with multiple partners and age-disparate relationships are fuelling HIV transmission among young people, and changes in cultural norms related to sexual partnering will be required to sustain people's protection against HIV.[7] Efforts at changing community norms have been effective on a small scale in the United Republic of Tanzania, where the image of men seeking relations with younger women and girls was effectively turned into an image of ridicule,[8] and in Zimbabwe, where the visibility of AIDS-related mortality appears to have been a decisive factor in large-scale behavioural and social change with respect to multiple partnerships.[9]

But many communities turn a blind eye to such common practices as multiple sexual partnerships and age-disparate relationships, and they may also ignore intimate partner violence that limits women's ability to make effective choices for HIV prevention. A recent study in Swaziland documents the threat to young women and girls of a widespread practice of sexual violence: About one third of adolescent girls under the age of 18 had experienced sexual violence, with violence towards all young women, perpetrated by boyfriends, husbands and male relatives, taking place in their homes, in their neighbourhoods, and at school.[10]

Community support is particularly important in times of emergency, when the breakdown of social structures and the adoption of certain behaviours as a means of coping, combined with disruptions in the delivery of HIV prevention services, may increase young people's risk of HIV infection. Particularly in emergencies, food and livelihood insecurity may encourage the practice of sex in return for food, shelter and other necessities.

Governments shape the legal and policy landscapes that can help prevent HIV

Governments and parliaments are front-line actors for revising laws regarding the age of consent for HIV testing and care-seeking. South Africa's Children's Act, passed in 2005, lowered the age of consent for HIV testing and contraceptives to 12 years old, effectively opening up access to full sexual and reproductive health care for adolescents in a country where an estimated 11 per cent of young men and 6 per cent of young women become sexually active before the age of 15.[11] A number of countries in Eastern Europe and Central Asia have recently passed laws lowering the age of consent for testing and treatment in response to extensive advocacy on the part of UNICEF and partners.

The way governments and policymakers address education, training and employment needs in their countries influences young people's ability to navigate HIV risks in their environment and shapes how they see their future. Yet, in many places government action is falling short. Strategies and plans are devised, but money is not allocated, or when it is, efforts are not effectively coordinated, are not at sufficient scale or are not of sufficient quality to ensure the greatest impact from the investment.[12]

Donors must also step up to the challenge. They must work with governments to ensure that money is directed to where the problem is and spent effectively. It will take years before investments in social and behavioural change, systems improvement and community empowerment show results in terms of infections averted. Nonetheless, donors and governments must not shy away from making these investments.

It is time to revitalize prevention efforts for adolescents and young people

The Joint United Nations Programme on HIV/AIDS (UNAIDS) Getting to Zero strategy highlights the need to revolutionize prevention, because progress to date has been inadequate to stop and reverse the epidemic. In order to contribute to a 30 per cent reduction of new infections in young people by 2015, the UN business case on preventing HIV in young people, developed in 2010, asks UN partners to work for three measurable results: In priority countries, at least 80 per cent of young people are to have comprehensive knowledge of HIV; the number of young people using condoms during their last sexual intercourse will have doubled; and the number of young people who know their status through counselling and testing services will also have doubled.

The challenge in achieving these results is on both the supply and demand sides: making HIV prevention services and commodities available and accessible to young people and encouraging those at greatest risk to use the ones that are relevant to them. Using equity as a guidepost will help ensure that those hardest to reach are not last in line, that services are available to them and used by them. Realizing prevention gains among young people and sustaining them will be crucial to achieving "zero new HIV infections, zero discrimination and zero AIDS-related deaths".[13]

2. STATE of the EPIDEMIC among YOUNG PEOPLE

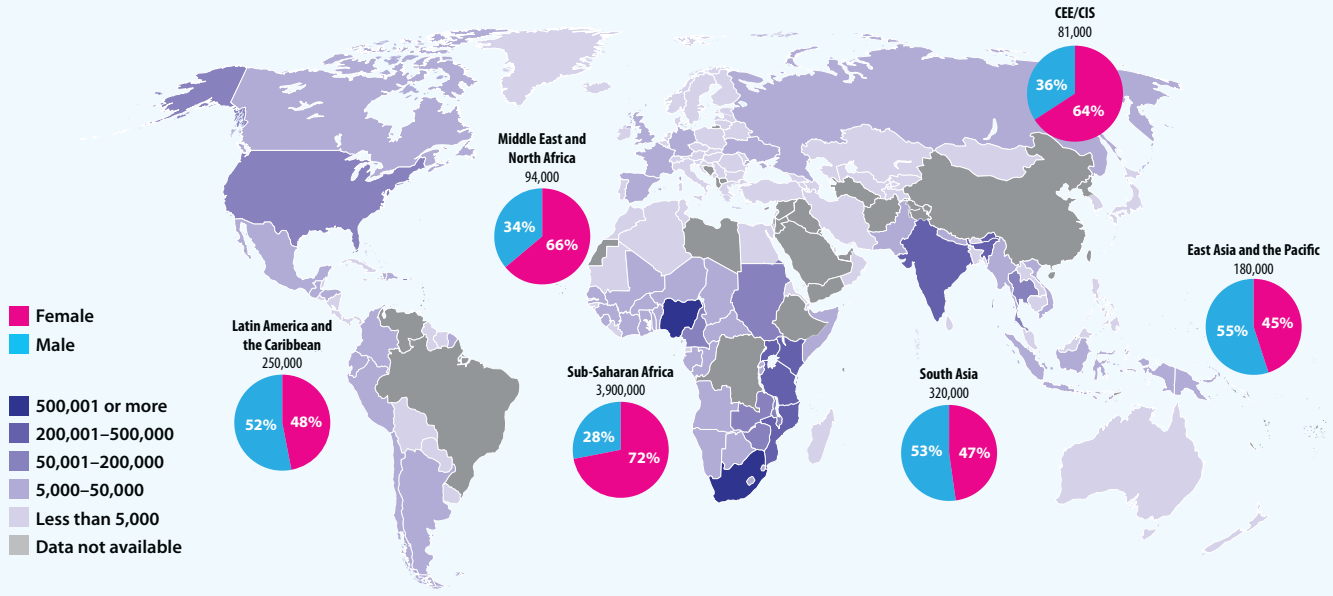
It is estimated that 5 million [4.3 million–5.9 million] young people (aged 15–24) and 2 million [1.8 million–2.4 million] adolescents (aged 10–19) were living with HIV in 2009.[14] Although they could be found in countries on all continents, most of them lived in sub-Saharan Africa *(see Table 1)*.

Globally, young women make up more than 60 per cent of all young people living with HIV; in sub-Saharan Africa their share jumps to 72 per cent *(see Figure 2)*. Thus the overall picture of young people living with HIV is predominantly African and predominantly female. Beyond these dimensions, the epidemic is highly varied.

In many countries, the road from childhood to adulthood is a perilous trajectory for young people, and for young women in particular, and the risk that they will become infected with HIV en route is high. In Swaziland, where HIV prevalence among people aged 15–49 in 2009 was about 26 per cent [25–27 per cent], the highest in the world, the likelihood that a young woman aged 15–19 years old will be infected with HIV is 10 per cent, based on the 2006–2007 Demographic and Health Survey; by age 20–24 it leaps to 38 per cent, and by age 25–29 it rises to 49 per cent.[15]

In sub-Saharan Africa, the lower the household income, the less likely both young men and young women are to have accurate knowledge of HIV and AIDS.[16] Young people are less likely to have accurate knowledge in rural areas than in urban areas.[17] The larger the age gap between sexual partners, the greater the likelihood of being HIV-infected, as is shown by data available in three countries: Swaziland, the United Republic of Tanzania and Zimbabwe.[18]

FIGURE 2: Estimated number of young people aged 15–24 living with HIV, 2009



Source: UNAIDS, unpublished estimates, 2010.

Note: The map is stylized and not to scale. It does not reflect a position on the part of UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the Parties.

TABLE 1: Young people aged 15–24 living with HIV, 2009

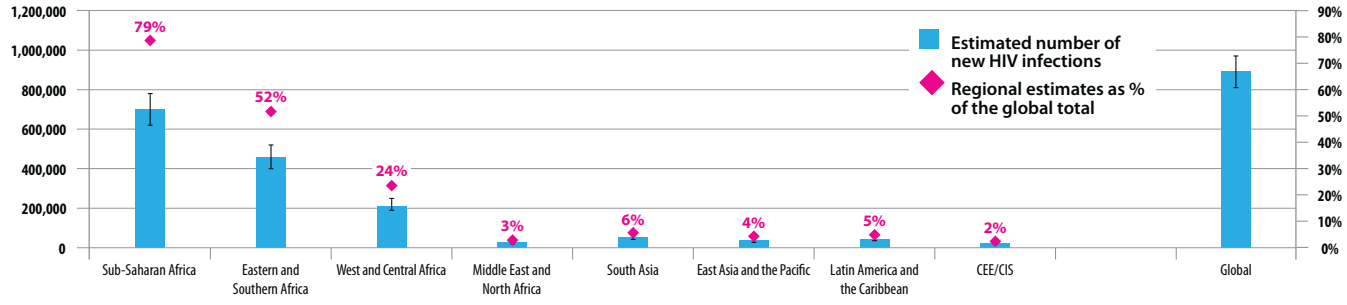
Region	Female		Male		Total	
	Estimate	[low estimate - high estimate]	Estimate	[low estimate - high estimate]	Estimate	[low estimate - high estimate]
Eastern and Southern Africa	1,900,000	[1,700,000 - 2,300,000]	780,000	[670,000 - 930,000]	2,700,000	[2,400,000 - 3,200,000]
West and Central Africa	800,000	[640,000 - 1,100,000]	340,000	[260,000 - 450,000]	1,100,000	[900,000 - 1,500,000]
Middle East and North Africa	62,000	[48,000 - 84,000]	32,000	[26,000 - 41,000]	94,000	[73,000 - 120,000]
South Asia	150,000	[130,000 - 170,000]	170,000	[150,000 - 210,000]	320,000	[280,000 - 380,000]
East Asia and the Pacific	83,000	[49,000 - 107,000]	100,000	[56,000 - 128,000]	180,000	[100,000 - 230,000]
Latin America and the Caribbean	120,000	[94,000 - 150,000]	130,000	[91,000 - 240,000]	250,000	[190,000 - 390,000]
CEE/CIS	52,000	[44,000 - 59,000]	29,000	[25,000 - 33,000]	81,000	[69,000 - 92,000]
World	3,200,000	[2,900,000 - 3,900,000]	1,700,000	[1,400,000 - 1,900,000]	5,000,000	[4,300,000 - 5,900,000]

Source: UNAIDS unpublished estimates, 2010.

HIV prevalence and incidence have declined among young people in many high-burden countries, but these drops are too small

Globally, the number of new infections is thought to have peaked in 1997.[19] The absolute number of young people living with HIV has dropped, from 5.7 million [5.0 million–6.7 million] in 2001 to 5 million [4.3 million–5.9 million] in 2009, and so have prevalence and incidence among young people in many countries.[20] Nonetheless, an estimated 890,000 [810,000–970,000] young people aged 15–24 were newly infected with HIV in 2009 – nearly 2,500 every day – with 79 per cent of these new infections occurring in sub-Saharan Africa *(see Figure 3)*. Globally, young people aged 15 to 24 accounted for 41 per cent of new infections among adults aged 15 and older.[21]

FIGURE 3: Young people aged 15–24 newly infected with HIV: in estimated numbers by region and as per cent of the global total of new infections among that age group, 2009



Source: UNAIDS unpublished estimates, 2010.

Twenty countries in sub-Saharan Africa accounted for an estimated 69 per cent of all new HIV infections globally in young people in 2009. About one out of every three young people newly infected with HIV in 2009 was from South Africa or Nigeria *(see Table 2)*.

TABLE 2: Twenty sub-Saharan African countries with the most new HIV infections among young people aged 15–24, 2009

Country	Total	
	Estimate	[low estimate - high estimate]
South Africa	160,000	[140,000 - 190,000]
Nigeria	120,000	[110,000 - 140,000]
Mozambique	49,000	[41,000 - 56,000]
Uganda	46,000	[38,000 - 53,000]
Kenya	42,000	[27,000 - 56,000]
United Republic of Tanzania	40,000	[31,000 - 52,000]
Zambia	27,000	[22,000 - 32,000]
Malawi	26,000	[18,000 - 33,000]
Cameroon	22,000	[18,000 - 25,000]
Zimbabwe	22,000	[14,000 - 31,000]
Lesotho	9,400	[7,900 - 11,000]
Ghana	8,300	[6,300 - 10,000]
Angola	8,000	[5,400 - 11,000]
Botswana	6,000	[4,300 - 8,800]
Chad	5,900	[3,700 - 21,000]
Swaziland	5,600	[4,600 - 6,600]
Côte d'Ivoire	5,200	[2,600 - 9,100]
Burundi	4,300	[3,200 - 5,100]
Togo	4,000	[2,300 - 5,800]
Rwanda	3,700	[1,400 - 6,600]
World	890,000	[810,000 - 970,000]

Source: UNAIDS unpublished estimates, 2010.

Stigma and discrimination fuel the HIV epidemic and hinder an effective response

In most countries with low-level and concentrated epidemics, infection is spread primarily by people (many of them young) who engage in behaviours that are contrary to accepted cultural norms and that may even be illegal. These groups often experience high levels of discrimination, which impedes their access to services that may also be less available and of less-certain quality.

Young people at high risk of infection often engage in more than one high-risk behaviour, resulting in the rapid spread of HIV among this group. A study in Viet Nam found that in Ho Chi Minh City, where 48 per cent of injecting drug users were less than 25 years old, 24 per cent of them had started injecting within the previous 12 months, and of these, 28 per cent were infected with HIV. Across all cities and provinces in the survey, 20–40 per cent of all injecting drug users also reported having paid for sex within the previous 12 months.[22]

Findings from studies of young men who have sex with other men in urban settings in sub-Saharan Africa illustrate the high odds of infection among these young men and the urgent need to remove barriers to prevention programming and improve access to services for this group. A young man in the suburbs of Cape Town, South Africa, or Lilongwe, Malawi, who has sex with other men has about a 20 per cent risk of becoming infected with HIV by the age of 24, whereas the risk in the general population in either country is much lower: 4.5 per cent in South Africa and 3.1 per cent in Malawi *(see Table 3)*.

In Central and Eastern Europe and the Commonwealth of Independent States (CEE/CIS), HIV prevalence is on the rise, largely because of soaring levels of unsafe injecting drug use.[23] Many of the affected individuals are young: Four out of five people living with HIV in countries of this region are under age 30, and one out of every three new HIV infections occurs among young people aged 15–24.[24]

In some countries of the region, injecting drug use is occurring at younger and younger ages. In a multi-country study of injecting drug users aged 15–24, up to 30 per cent reported their age at first injection as less than 15 years. The mean age of initiation was found to be 15.6 in Albania, 17.5 in the Republic of Moldova, 16.0 in Romania and 18.7 in Serbia.[25] Studies have found that a significant proportion of people who inject drugs become infected with HIV and/or hepatitis C within the first 12 months of initiation.[26] Reaching young people in these settings to prevent initiation and support harm reduction is therefore critical.

TABLE 3: Unmet need for prevention: high levels of HIV infection among young men who have sex with men, 2009–2010

Location	HIV prevalence among young men (15–24) in the general population (%)	Number of young men (18–24) enrolled in study who have sex with men	Number of young men (18–24) testing HIV-positive	HIV prevalence among young men (18–24) enrolled in study who have sex with men (%)
Gaborone, Botswana	5.2	67	8	11.9
Blantyre and Lilongwe, Malawi	3.1	98	19	19.4
Windhoek, Namibia	2.3	124	5	4.0
Cape Town, South Africa	4.5	107	22	20.6

Source: UNAIDS, *Report on the Global AIDS Epidemic 2010*; Baral, S., personal communication based on work cited in Baral, S., et al., 'Bisexual Practices and Bisexual Concurrency among Men Who Have Sex with Men (MSM) in Peri-urban Cape Town, South Africa', Fifth International AIDS Society Conference on HIV Pathogenesis and Treatment, 19–22 July 2009, Abstract No. MOPEC031; and Fay, H., et al., 'Stigma, Health Care Access, and HIV Knowledge among Men Who Have Sex with Men in Malawi, Namibia, and Botswana', *AIDS and Behavior*, December 2010.

With a large proportion of infections transmitted heterosexually in South Asia and East Asia and the Pacific, such factors as high mobility and a well-established sex trade contribute to concentrated epidemics. In India, the epidemic is driven largely by sex work: 4.9 per cent of female sex workers are HIV-positive.[27] In the general population, however, HIV prevalence among both young men and young women was 0.1 per cent [0.1–0.2 per cent] in 2009.

In Latin America, people at risk for HIV are primarily men who have sex with men, transgender people, sex workers, young people in difficult circumstances, injecting drug users and their partners and incarcerated individuals. Most of those affected experience "institutional, social and financial neglect."[28]

Many adolescents living with HIV contracted the virus through perinatal transmission; they are part of a 'hidden epidemic'.[29] In South Africa, for example, modelling suggests that the number of 10-year-olds living with HIV is expected to reach 3.3 per cent by 2020, up from 0.2 per cent in 2000, without a significant acceleration of services for the prevention of mother-to-child transmission (PMTCT).[30] Universal coverage of services to prevent mother-to-child transmission will eventually diminish the number of children infected at birth.

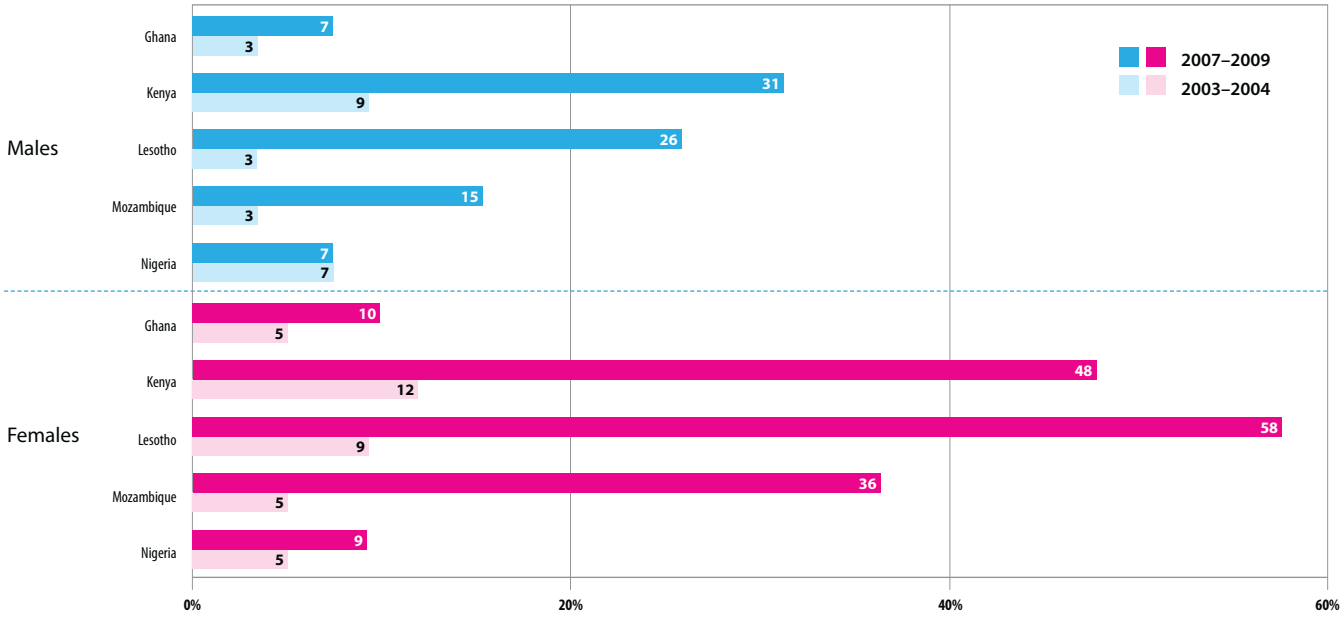
Core interventions are effective when part of a combination prevention approach

Data from selected countries in sub-Saharan Africa show that most young people living with HIV do not know their status,[31] though some are more likely to know than others. As seen in Figure 4, young women, at great risk, are more likely to know they are infected than young men, in part because they have access to antenatal services where HIV testing and counselling are offered more regularly.[32] In some countries where data are available, sex workers (and in some cases, other key populations at high risk of exposure) are more likely to know their status than the general population.

There is evidence that core interventions to prevent infections among adolescents and young people can be effective when used as part of a combination prevention approach that includes behavioural, biomedical and structural components *(see Table 4)*.

The responses described in the following three chapters show promise or have been proven effective by evaluations and other evidence. Together, they contribute to a continuum of HIV prevention that meets the needs of adolescents and young people at various development stages and in various social and epidemic contexts. The types of intervention outlined in each chapter, however, are not exclusive to the age group.

FIGURE 4: Young people aged 15–24 who have been tested for HIV and received their results in selected sub-Saharan countries with the highest number of new infections



Source: AIDS Indicator Surveys and Demographic and Health Surveys, 2003–2009.

Note: Data from Ghana and Nigeria are for 2003 and 2008; Kenya: 2003 and 2008–2009; Mozambique: 2003 and 2009; Lesotho: 2004 and 2009.

TABLE 4: Core HIV prevention interventions

Intervention	Evidence
Abstinence from sex and from injecting drugs	Effective in preventing transmission. Programmes promoting sexual abstinence are effective when abstinence is presented along with condoms and safer-sex strategies as other options. Raising the age of sexual debut and avoiding drug use are important goals for such programmes.
Condom use	Reduces transmission by 90 per cent when used correctly and consistently.
Medical male circumcision	Reduces the risk of HIV infection in men by approximately 60 per cent when conducted by well-trained professionals.
Harm reduction	Needle and syringe exchange programmes reduce the risk of HIV transmission by 33–42 per cent. Integration of opiate substitution therapy in harm reduction programmes reduces drug injecting behaviour, improves adherence to antiretroviral therapy (ART) and reduces mortality.
Antiretroviral treatment	Greatly reduces the risk of HIV transmission per exposure. Reduces transmission 50–90 per cent in sero-discordant couples.
	Is widely used to prevent vertical transmission to newborns and as post-exposure prophylaxis for victims of rape and needlestick injuries. The evidence includes a limited number of successful trials (microbicides and pre-exposure prophylaxis).
Social and behavioural change communication	School-based programmes improve knowledge and self-efficacy, which are important foundations for prevention. Social marketing and the use of mass media influence attitudes and increase uptake of HIV-related services. Many behaviour change efforts, however, show little or no impact if not targeted to those most at risk and if not implemented alongside measures to address norms and structural influences on behaviour and access to prevention commodities and services.

Sources: Abstinence: Underhill, Kristen, Paul Montgomery and Don Operio, 'Sexual Abstinence Only Programmes to Prevent HIV Infections in High Income Countries: Systematic review', *BMJ*, vol. 335, no. 7613, 4 August 2007, p. 1. **Condom use:** Joint United Nations Programme on HIV/AIDS, *Making Condoms Work for HIV Prevention: Cutting-edge perspectives*, UNAIDS, Geneva, June 2004. **Medical male circumcision:** World Health Organization and Joint United Nations Programme on HIV/AIDS, *New Data on Male Circumcision and HIV Prevention: Policy and programme implications*, WHO/UNAIDS Technical Consultation, Montreux, 6–8 March 2007. **Harm reduction:** World Health Organization, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS among Injecting Drug Users*, WHO, Geneva, 2004; World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS, *Interventions to Address HIV in Prisons: HIV care, treatment and support*, WHO, Geneva, 2007. **Antiretroviral treatment:** Cohen, M.S., and C.L. Gay, 'Treatment to Prevent Transmission of HIV-1', *Clinical Infectious Diseases*, 15 May 2010, vol. 50, suppl. 3, pp. S85–S95; Joint United Nations Programme on HIV/AIDS, Getting to Zero: 2011–2015 strategy, UNAIDS, Geneva, 2010, p. 39; World Health Organization, *Antiretroviral Drugs for Treating Pregnant Women and Preventing HIV Infection in Infants: Recommendations for a public health approach*, WHO, Geneva, 2010, p. 11; World Health Organization and International Labour Organization, *Joint WHO/ILO Guidelines on Post-Exposure Prophylaxis (PEP) to Prevent HIV Infection*, WHO, Geneva, 2007. Abdool Karim, Q., et al., 'Effectiveness and Safety of Tenofovir Gel, an Antiretroviral Microbicide, for the Prevention of HIV Infection in Women', *Science*, vol. 329, no. 5996, 3 September 2010, pp. 1168–1174; Grant, R.L., et al., 'Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men, *New England Journal of Medicine*, vol. 363, no. 27, 30 December 2010, pp. 2587–2599. **Social and behavioural change communication:** Shepherd, J., et al., 'The Effectiveness and Cost-Effectiveness of Behavioural Interventions for the Prevention of Sexually Transmitted Infections in Young People Aged 13–19: A systematic review and economic evaluation', *Health Technology Assessment*, vol. 14, no. 7, February 2010, p. 107; Vidanapathirana, J., et al., 'Mass Media Interventions for Promoting HIV Testing', *Cochrane Database of Systematic Reviews 2005*, issue 3, art. no. CD004775.

3. **VERY YOUNG** ADOLESCENTS

Ages 10–14: Protection is crucial; there is a window to develop healthy behaviours

Early sexual debut, early pregnancy and early experiences with drug use all raise risks for HIV infection. They are also signs of things going wrong in the environment of the very young adolescent, the result of multiple failures in protection and care, possibly associated with violence, exploitation, abuse and neglect. Families and communities can change this, by providing a protective environment for children.

The challenge

Globally (excluding China), 11 per cent of adolescent girls are sexually active before age 15 *(see Table 5)*. One result of this early sexual activity is the 16 million births by adolescent girls that occur every year.[33] In some high-prevalence countries, 30–50 per cent of girls give birth to their first child before their 19th birthday.[34]

TABLE 5: Percentage of adolescent girls aged 15–19 reporting to have had sex before age 15

Latin America	**22 per cent**
West and Central Africa	**16 per cent**
Eastern and Southern Africa	**12 per cent**
South Asia	**8 per cent**
World (excluding China)	**11 per cent**

Source: Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other nationally representative household surveys, 2005-2010.

Analysis of data from Ukraine shows that around 45 per cent of injecting drug users began injecting before age 15.[35] The risk that adolescents who use injecting drugs will acquire HIV is related to the circumstances of their first injection, which may involve being given drugs by other drug users and sharing their used injection equipment. During the first few years of injecting drug use, the risk of infection is high.[36]

A 2009 survey of children aged 10–19 living on the streets in four cities in Ukraine showed very high levels of risk behaviours. More than 15 per cent reported injecting drugs (nearly half of these had shared equipment); nearly 75 per cent had experienced sexual debut, most before the age of 15; 17 per cent of boys and 57 per cent of girls had received payment or gifts in exchange for sex; 11 per cent of boys and 52 per cent of girls had been forced to have sex.[37]

Very young adolescents who have sex or inject drugs find themselves at high risk of exposure to HIV infection because they lack knowledge and services and do not see themselves as vulnerable.[38] Young adolescent girls are not only biologically more susceptible to HIV infection; they are more likely to have older sexual and injecting partners and thus greater potential exposure to HIV.[39]

HIV knowledge levels among very young adolescents remain low. In a study in sub-Saharan Africa that looked at knowledge levels among sixth graders (upper primary school, aged 13–14 on average), two thirds did not have the basic knowledge expected of this age group.[40]

Some parents may not appreciate the prevention benefits of accurate, age-appropriate information and support for children aged 10–14 and thus might not offer their children such information. Yet, data from four Southern African countries show that about 60 per cent of parents think children aged 12–14 should learn about condoms for HIV prevention.[41]

Programmes that present abstinence as the only strategy may be thought to be the best option for very young adolescents because of their age. Yet the evidence shows that abstinence-only programmes are not effective at preventing HIV, other sexually transmitted infections or pregnancy, or at changing risk behaviours in the long term.[42] Abstinence 'plus' programmes (which present abstinence as an option along with condoms and safer-sex strategies), however, have been found to be more effective in reducing risk behaviours in the short and long term in North America.[43]

Early adolescence is a window during which to intervene, before most youth become sexually active and before gender roles and norms that have negative consequences for later sexual and reproductive health become well established. Socialization and ensuing attitudes and behaviour around sexuality, including gender norms, occur through families, schools, peers and the mass media, often from a very young age. With a majority of boys and girls aged

10–14 in school in most countries, ensuring that school settings are safe and healthy can be crucial to maintaining the protective environment around children of this age.

Solutions informed by evidence

Sexuality education

Age-appropriate sexuality education can increase knowledge and contribute to more responsible sexual behaviour.[44] Around 50 per cent of such programmes evaluated in a 2006 review of 83 evaluations showed decreased sexual risk-taking among participants.[45] Other evidence shows that sexuality education does not cause harm, nor does it lead children to start having sex at an earlier age than they otherwise would.[46]

In 2007, 88 out of 137 reporting countries included HIV education as part of the primary school curriculum, and 120 included it in secondary schools.[47] The percentage of schools providing life-skills-based HIV education also increased between 2007 and 2009.[48]

However, the teaching of content related to sexual behaviour and HIV prevention practices (including condoms) depends on the existence of a supportive policy, on appropriate teacher training and on the dissemination of clear curricula and teaching materials.

Age-appropriate HIV and sexuality education in a supportive environment is important for developing self-efficacy in young people, a skill that will play a critical role in helping them recognize their HIV risk and reducing their vulnerability in the event of unwanted sexual advances or negative peer pressure.[49] Yet, young people with disabilities are often left out of such programmes.

Young people with intellectual, visual or hearing disabilities may not have access to information because of a lack of materials or poorly designed content, or because of teachers' limited skills; they may be excluded from such programmes because they are believed to be asexual and therefore not at risk. School is where most HIV and sexuality education programmes are delivered, so children with disabilities who are kept out of school are simply unreached by them.[50]

Young people with disabilities are not asexual, and without adequate information and support for prevention, they may be highly vulnerable to sexual exploitation and thus HIV infection, especially in contexts of high HIV prevalence.

SHE GOT INFECTED WITH HIV BECAUSE SHE WAS ABUSED

Rosina (not her real name) is a 13-year-old girl living with her father in a village in Manica Province of Mozambique. Her mother died when she was younger. She currently attends primary school 10 km from her village. Rosina is deaf and cannot communicate verbally, which isolates her from other children.

Rosina went for a school party and did not come home afterwards. In her father's words: "We thought she was at her Auntie's home closer to the school. … She usually stays there to play with her cousin and comes back the following day. … After two days I suspected something was wrong, as she left school material home and her cousin hadn't enough clothes to share."

After not finding his daughter at his sister's house, her father concluded that Rosina was missing. Investigating among her schoolmates, he found that "she was seen with an old woman and two men drinking alcoholic beverages on the party day. With local police we searched through given clues," he continued. "We found her hidden in bedroom of a man [27 years old], sexually abused and in shock." Rosina was treated for her injuries and tested for HIV at a local hospital. The initial result was negative, but "the second confirmation HIV test after three months revealed a positive status," her father said, angrily. Rosina's isolation and inability to shout out for help likely contributed to her abuse. The man who kept Rosina in his bedroom has disappeared. ■

In some parts of the world, regional efforts have given sexuality education a boost. In 2008, on the occasion of the International AIDS Society's 17th International AIDS Conference, held in Mexico City, Ministers of Education and Health from countries in Latin America and the Caribbean pledged in the 'Preventing through Education' Declaration to make quality sexuality education available in their countries.[51] Colombia implemented a large-scale sexuality education programme to be evaluated in 2011; thus far, a qualitative pilot evaluation conducted during the first stage of the project has yielded positive results.[52]

A 2010 evaluation of Jamaica's Health and Family Life Education programme found much greater knowledge of HIV among sixth-grade students in schools that took part in the programme than among students whose schools did not participate. By the ninth grade, these differences in knowledge levels disappeared, but students in the programme were less likely to engage in risky behaviours and more likely to refuse sex.[53]

In India, efforts to provide sexuality education for adolescents have recently overcome an impasse rooted in sociocultural and political opposition, and statewide implementation of a school-based sexuality education programme in Orissa state has now begun. The programme is planned to reach nearly 1 million students by 2014 in Orissa.[54]

In Kenya, the Primary School Action for Better Health programme has shown positive results. Begun in 2002, the programme initially sought to influence the behaviour of adolescents aged 12–14 in the Nyanza and Rift Valley provinces through the delivery of HIV- and AIDS-related education by trained teachers. The first stage of a rigorous evaluation indicates that fewer pupils are having sex and more are delaying their sexual debut, and more girls report that they use condoms.[55] A modified model of the programme has been rolled out to all primary schools in Kenya.

In Europe, a nationwide programme in Estonia that combined school-based sexuality education with youth-friendly sexual and reproductive health services has led to dramatic improvements in reproductive health indicators among young people over the past two decades. The country recorded 59 per cent fewer pregnancies and 61 per cent fewer abortions among 15–19 year-olds between 1992 and 2009. The number of registered new HIV cases in the same age group declined by 95 per cent: from 560 cases in 2001 to just 25 cases in 2009.[56]

A recent comprehensive review of sexuality education covering a broad age range in divergent settings worldwide concluded that programmes that have successfully increased knowledge and improved behaviours can be cost-effective. Programmes that were offered as integral parts of the school curriculum were more cost-effective and had greater potential for scale-up precisely because the design enabled maximum participation and greater geographical coverage.[57] Among the 'levers of success' contributing to the outcome of such programmes in any given country are a commitment to delivering both HIV and AIDS education and sexuality education, a tradition of addressing sexuality in schools, awareness-raising of teachers and community members, the active involvement of 'allies' among decision makers and the availability of appropriate technical support.[58] How the topics are taught also matters: Addressing values and teaching critical-thinking skills, for example, help adolescents question the attitudes and behaviours that can undermine their health.

In HIV-affected countries where large numbers of children are out of school, it is crucial to reach girls and boys – whether through schools, communities or other forums – and provide them with at least a minimum of the information and life skills necessary to help them manage their HIV risk.

Sexuality programmes should combine awareness-raising and skills development with access to services, often in partnership with service providers. Evaluations of such programmes have shown them to be effective in improving knowledge, attitudes and self-efficacy when properly implemented.[59] But in some countries, including those with high HIV prevalence, there is resistance to including information on contraception and condoms within existing life skills and sexuality education curricula.[60]

Children living with HIV also need access to sexuality education, along with health and psychosocial support, as they enter adolescence. *(See Chapter 6 for more details on approaches for young people living with HIV.)*

Mass media

Soul Buddyz, a multimedia 'edutainment' venture for boys and girls in South Africa that includes a television series, has contributed to better knowledge of HIV among its target audience. An evaluation found that 42 per cent of the country's 8- to 15-year-olds had seen most episodes of the series and that, compared to a matched control group, these children were more willing to disclose the HIV status of a family member, were more open to voluntary testing and counselling, and had more positive attitudes towards people living with HIV.[61]

Uganda's Straight Talk Foundation, specializing in social change via print, radio and face-to-face communication, launched *Young Talk*, a newspaper for upper-primary-school-aged children, in 1998, aiming to help children "gain

a more scientific understanding of body changes, resist bad touches, realize their rights, and stay in school." A 2007 evaluation of *Young Talk* and *Straight Talk*, a publication begun in 1994 for youth aged 15–24, found an association with increased knowledge of adolescent sexual and reproductive health, including HIV; more favourable attitudes towards condoms; and a greater likelihood of getting tested for HIV. Girls who knew the programme were four times more likely to abstain from sex with their boyfriends, and boys were also less likely to engage in sex.[62]

Parent-child communication

Studies have shown that increasing communication between very young adolescents and the adults in their lives delays the age at which adolescents start having sex and increases their use of condoms when they do start.[63] Families Matter! was developed by the US Centers for Disease Control and Prevention to improve HIV-prevention knowledge and the communication skills of parents in the United States, then adapted culturally for use with very young adolescents (aged 9–12) and their caregivers in Kenya. An outcome evaluation of the programme conducted in Nyanza Province found increased 'positive parenting' behaviours, better parent-child communication around sexuality and sexual risk reduction, and a positive effect on parents' attitudes towards sexuality education.[64] Families Matter! has reached over 100,000 Kenyan families and been expanded to seven additional African countries (Botswana, Côte d'Ivoire, Mozambique, Namibia, South Africa, the United Republic of Tanzania and Zambia) and translated into 11 languages.[65]

In Nicaragua, the Entre Amigas (Between Girlfriends) project seeks to empower girls aged 10–14 and reduce barriers to their sexual and reproductive health by building friendships among them and providing them with safe environments in which to discuss their problems. The project activities include a soap opera with a 12-year-old girl as the lead, an all-girls soccer team and regular gatherings at community centres and churches for discussions among mothers, teachers and the girls themselves. An evaluation found increased knowledge of sexual and reproductive health among girls and their mothers, as well as changes in behaviour in many girls.[66]

In the Federal Democratic Republic of Nepal, the Choices programme focusing on gender relations is another innovative approach for 10–14-year-old boys and girls.

Enhancing the protective environment

A parent's death – particularly that of a mother – can lead to a child's increased risk of HIV, especially for young girls.[67] A study in Zimbabwe found that children who have lost their mothers are less likely to complete schooling and more likely to start having sex or to marry early, leading to early pregnancy and sexually transmitted infections, including HIV.[68] Improved child protection systems can prevent the abuse and neglect that can make children more vulnerable to such negative outcomes and provide a more effective safety net for the most vulnerable.

Social protection systems that are HIV-sensitive can contribute to greater financial security of affected households (through cash or commodity transfers), improve access to health and social services and ensure that services are delivered to the most vulnerable. Investments in social protection can have an immediate protective impact on young women and girls, and a positive impact on communities overall.

It is time to seize the opportunities to:

- Promote sexuality education and comprehensive knowledge of HIV and other health matters among very young adolescents before they become sexually active
- Strengthen social protection systems and opportunities for economic empowerment to reduce exclusion and vulnerability of HIV-affected households, thus reducing risk behaviours
- Strengthen child protection measures to prevent exploitation and abuse of vulnerable adolescents
- Promote strong communication between early adolescents and their parents, caregivers and families
- Establish legislation and policies that do not exclude very young adolescents (or any adolescents who may be below the legal age of consent in their country) at high risk of exposure from accessing services that are essential for HIV prevention, testing or treatment
- Improve early diagnosis of HIV infection in adolescents living with HIV through increased provider-initiated testing and counselling for adolescents receiving chronic care
- Improve data reporting on HIV prevalence, incidence and service utilization among 10–14-year-olds, including in humanitarian settings, in order to inform estimates of prevention and protection needs for this group

4. **OLDER** ADOLESCENTS

Ages 15–19: As vulnerability increases, so does the risk of HIV infection

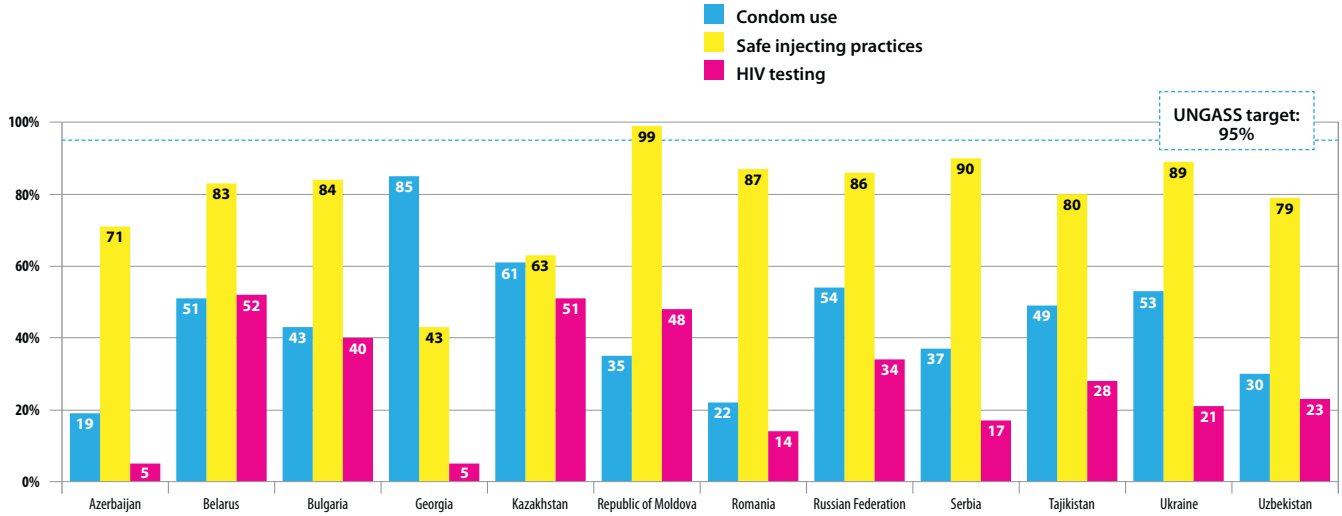
Behaviour in adolescence is greatly influenced by families, peers and service providers, as well as by social values, communities and policies. Where these are absent or send a negative message, risky behaviour can encompass injecting or other drug use, unprotected sex with partners whose HIV status is unknown, paying for sex or selling sex. Vulnerability to HIV infection increases when adolescents' health and development needs are compromised, so there is a need to ensure they have access to information and services, that they live, study and work in safe and supportive environments and have opportunities to participate in decisions that affect their lives. Adolescence is the age at which many people become sexually active and start multiple relationships, so interventions to address these behaviours need to be intensified.

The challenge

Adolescents who sell sex or use drugs are at higher risk of HIV infection than young people who are not engaged in risky behaviours,[69] yet they may find information, sterile injecting equipment and services such as HIV testing and support difficult to obtain.[70] Some of the most vulnerable adolescents are those living and working on the streets, many of whom use injecting drugs, placing them at higher risk of HIV. In St. Petersburg, Russian Federation, HIV prevalence among street youth aged 15–19 is 37 per cent.[71]

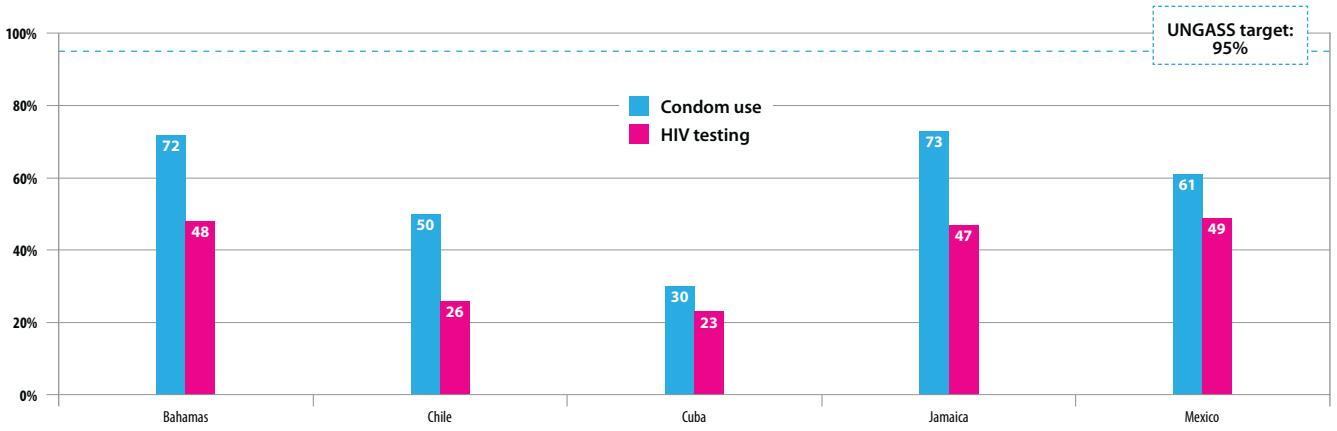
Country data on the provision and monitoring of services in three regions allows for an assessment of progress against the target of 95 per cent access to essential information, skills and services, set in 2001, among young people most at risk of HIV infection, such as those who inject drugs, who sell sex and young men who have sex with men *(see Figures 5–7)*.

FIGURE 5: Condom use, safe injecting practices and HIV testing among injecting drug users below age 25 in CEE/CIS, 2009



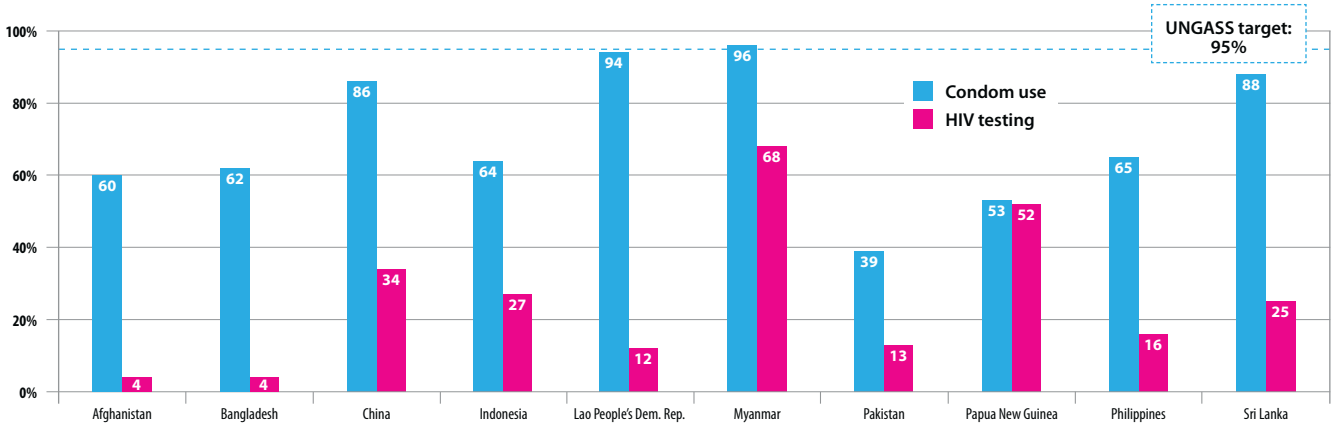
Source: UNAIDS, *Report on the Global AIDS Epidemic 2010,* and UNAIDS online database, <www.aidsinfoonline.org>.

FIGURE 6: Condom use and HIV testing among men below age 25 who have sex with men, Latin America and the Caribbean, 2009



Source: UNAIDS, *Report on the Global AIDS Epidemic 2010,* and UNAIDS online database, <www.aidsinfoonline.org>.

FIGURE 7: Condom use and HIV testing among female sex workers below age 25 in Asia, 2009



Source: UNAIDS, *Report on the Global AIDS Epidemic 2010,* and UNAIDS online database, <www.aidsinfoonline.org>.

Particularly in sub-Saharan Africa, the vulnerability of adolescent girls and young women to HIV is compounded when they agree to relationships with older partners for money or other material gain, and it is heightened by laws and policies that restrict adolescent girls' access to condoms, testing and accurate, comprehensive information. Even when condoms are available, their use, and testing for HIV, can be low.

"A RIGHT TO REFUSE"

Sifuni took part in the Ishi Rural Initiative, a 13-session, curriculum-based course that promotes positive changes in HIV-related knowledge, attitudes, skills and behaviours among young men and women in the United Republic of Tanzania. Funded by UNICEF and USAID and implemented by Family Health International, the Ishi Rural Initiative uses peer volunteers to lead a number of other HIV-prevention activities in their schools and communities, including video presentations, group discussions with classmates and parents, conferences, forums for elders, festivals and other events on topics ranging from health to girls' empowerment. Sifuni was not yet sexually active when she took part in the course. In her own words:

"I learned that I have a right to refuse. I learned how to explain my feelings and show a man that once I say no, you have to understand I mean no. Once you accept one of those gifts, the boy thinks you agree to go with him. If you reject those gifts, you refuse him.

"Nowadays, we are strong," she added. "We can say no regardless of who it is." ■

Sifuni, 18, Makete District, United Republic of Tanzania

Solutions informed by evidence

Sexuality education and sexual and reproductive health

Sexuality and life skills education, particularly around the transmission of HIV, is as important a prevention tool for older adolescents, many of whom have started to have sex, as it is for very young adolescents *(see Chapter 3)*.

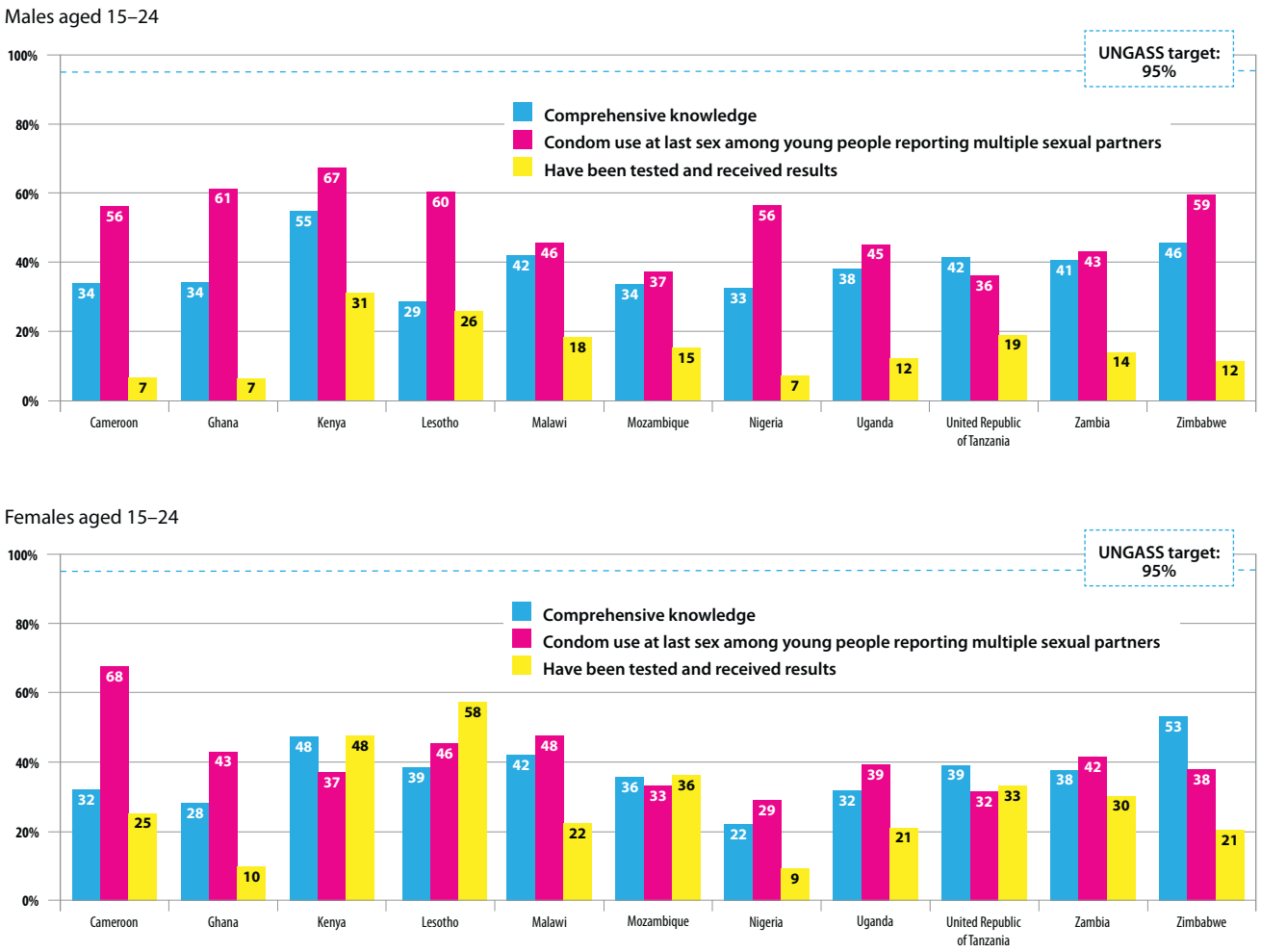
Early motherhood is a reality for many older adolescent girls. Childbirth and parenting, for most adolescent mothers, mean the end of schooling, work or career plans. At a further disadvantage because of their young age and a lack of income, adolescent mothers and their children are particularly vulnerable not only to ill health and poverty but to exploitation, neglect and abuse, which can contribute to their risk of HIV infection.[72] Preventing adolescent pregnancy is a priority in Latin America and the Caribbean, where the proportion of adolescent mothers is the highest in the world: girls aged 15–19 accounted for 18 per cent of all live births in this region in 2007.[73]

Comprehensive, correct knowledge is fundamental to the uptake of HIV services and behaviour change. A closer look at indicators on knowledge, condom use and HIV testing in countries with generalized epidemics shows that more efforts are needed to increase access to testing.

In an analysis of 11 sub-Saharan African countries with the highest numbers of new infections, eight have achieved a reported condom use rate of 45 per cent or greater among males and only three countries among females *(see Figure 8)*. Knowledge levels remain low among both young men and young women, as do levels of access to HIV testing, particularly among young men, for whom there is no entry point comparable to maternal health programmes that provide testing and services for the prevention of mother-to-child transmission (PMTCT) for young women. None of the countries analysed are close to reaching the 95 per cent target set in 2001.

The barriers adolescents often face in accessing sexual and reproductive health services and commodities are explored in Chapter 5.

FIGURE 8: Levels of comprehensive knowledge, condom use at last sex among young people reporting multiple sexual partners and HIV testing among young men and women aged 15–24 in selected sub-Saharan countries with the highest number of new infections, 2004–2010



Source: AIDS Indicator Surveys, Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other nationally representative surveys, 2004–2010.

Note: Data for South Africa were not available for all three indicators. Condom use data for Ghana (male and female) and Zambia and Zimbabwe (female) are based on small denominators (usually between 25 and 49 cases).

Harm reduction

Harm reduction programmes focus on reducing the risk of HIV transmission among people who inject drugs, with needle and syringe exchange programmes and opioid substitution therapy being the centrepiece of such programmes. Because of age restrictions limiting access to medical treatment and other services, adolescents who inject drugs do not usually have recourse to harm reduction services.

Some harm reduction models seek to halt injecting drug use before it begins. The epidemic in Albania, for example, is spread primarily through unsafe sex, followed by injecting drug use, and efforts are being made to 'break the cycle' of new injecting drug use among young people by working with current users. Besides being taught skills, participants in the programme are asked not to help other users initiate injecting drug use, not to inject in front of non-injecting-drug users and not to talk about the 'benefits' of injecting drug use in front of non-users. Preliminary findings show that adolescents who would like to try injecting drugs are

beginning to be rebuffed by older users.[74] Such 'break the cycle' interventions originated in the United Kingdom and have been used in Australia, Kyrgyzstan, the United States, Uzbekistan and Viet Nam.

Meeting injecting drug users on their own ground, through needle-exchange dispensing machines or mobile vans, can particularly help reach 'hidden' or 'hard-to-reach' injecting drug users, many of whom are young. In some countries of CEE/CIS, mobile clinics reach out to young women involved in sex work and young injecting drug users in the communities in which they live; teams provide condoms, needles and syringes and offer counselling and help with behaviour change.

The Korsang organization in Phnom Penh, Cambodia, reaches out to thousands of people, including those who inject drugs, with needle exchange, medical care, meals and other services. Its Kormix programme engages young men living and working on the street through performance and art as a way to express themselves and develop a positive sense of identity. Many young men in the programme have reduced or stopped their risky behaviours.[75]

Mass media and new technologies

Several recent media campaigns have demonstrated the potential of reaching large numbers of adolescents with HIV prevention messages to increase knowledge and change behaviours, especially if the messages are complemented with sexuality education and other communication content used with adolescents. In Kenya and Zambia, the three-part television drama *Shuga* told the stories of several friends as they navigated the turbulent waters of life, love and HIV in a university setting in Nairobi. An evaluation found that 60 per cent of young people in Nairobi saw the drama, and 90 per cent of viewers reported changes in their thinking around HIV testing, concurrent relationships and stigma. Similarly, the airing of *Tribes* in Trinidad and Tobago also produced positive effects.[76] In Ukraine, 1 million people saw the December 2009 television debut of the film *Embrace Me*, which focused on young people and their futures in a context of risky behaviour and drug use. An evaluation showed that 42 per cent of viewers intended to discuss the drama with friends and that messages around unsafe sex were transmitted clearly.[77]

Technological innovations designed to improve HIV services and transmit information are particularly suited to young people, many of them connected through cellphones, the Internet and television. In Brazil, the 'test to take the test' is an Internet-based screening quiz that helps young people recognize risk factors and decide to have an HIV test. Elsewhere in Latin America, Pasión por la Vida (Passion for Life) uses media and technology to place information on HIV prevention, treatment and care at the fingertips of millions of young people, empowering them to act in their own lives and lead changes in their communities. In Uganda, the Text to Change programme rewards teenagers with cellphone airtime for correctly answering questions about HIV and AIDS.

Voices of Youth is an online forum for information and experience exchange that enables young people to explore and take action on issues affecting their rights, such as HIV and AIDS. The Y-Peer network was begun in 2001 to counter the spread of HIV. It now links young people in 50 countries on five continents to information for peer education.

Changing social norms

Engaging communities

There is evidence that changes in social norms have contributed to a decrease in HIV prevalence in some countries of sub-Saharan Africa, where the HIV epidemic spreads largely through heterosexual sex. For example, research suggests that the key factor in the decline in adult HIV prevalence over about a decade in Zimbabwe was widespread behavioural change, driven by fear of infection.[78] In Uganda, research has pointed to the "intensity, depth, breadth and extensiveness" of programming related to behaviour change and the deep involvement of local communities, churches and mosques.[79] (Prevalence in Uganda has since gone up in some areas.[80])

Two key interventions in rural areas appear to have been successful in changing attitudes, although less so in reducing HIV prevalence levels in these communities. The Mema kwa Vijana (Good Things for Young People) programme, begun in 1999 in Mwanza, United Republic of Tanzania, combined several interventions: sexual and reproductive health education and youth-friendly services, community-based condom promotion and distribution, and community activities to create a supportive environment around adolescent sexual and reproductive health.

Evaluations in 2002 and 2008 found improvements in young people's knowledge and attitudes, but no change in their HIV prevalence levels.[81] A subsequent programme now being evaluated, Mema kwa Jamii (Good Things for Communities), more explicitly addresses "underlying patterns of social systems that are beyond an individual's control."[82]

In Zimbabwe, similarly, the Regai Dzive Shiri project sought to change societal norms in 30 communities through the use of peer educators to help adolescents in and out of school gain knowledge and skills, but this intervention also failed to have an impact on HIV levels. There was, however, some positive impact on knowledge and attitudes related to relationships and gender.[83]

Age-disparate sexual relationships in which condoms are not used consistently are instrumental in the spread of HIV among young women in sub-Saharan Africa, and a communication campaign piloted in 2008 in the United Republic of Tanzania seeks to tackle this social norm. It uses a cartoon character named Fataki to effectively turn the image of an older man seeking sexual relations with a younger woman into a negative cultural stereotype. Like the zero-grazing campaign in Uganda in the 1980s and 1990s, the campaign in the United Republic of Tanzania effectively ridiculed the practice of multiple partnerships. Post-campaign surveys showed significant positive changes in attitudes and behaviour.[84] The campaign was expanded nationally in November 2008.

The Sonke Gender Justice Network in South Africa promotes ways to help men and boys work for gender equality and reduce sexual and gender-based violence. Its signature campaign, One Man Can, provides toolkits to men to help them support survivors of gender-based violence, use the legal system to demand justice, educate children ('early and often') and challenge other men to take action. Brothers for Life, an initiative of Sonke Gender Justice, the South African National AIDS Council and Johns Hopkins Health and Education in South Africa geared to men over age 30, addresses the risks of concurrent sexual partnerships, and promotes health-seeking behaviours and HIV testing. The programme also aims to influence social cohesion and traditional notions of manhood.

A 2009 Ubuntu Institute survey of traditional leaders in Botswana, Lesotho, South Africa and Swaziland found that they could take on roles in shaping their communities' responses to HIV and AIDS, yet they often felt marginalized by government and donor efforts. The survey also found that mass-media campaigns often did not reach rural areas. Based on these findings, the Institute has launched a multi-year messaging campaign led by traditional leaders to influence behaviour change.[85]

In the Nairobi informal settlement of Kibera, young people have been mapping the suburb to identify 'hot spots' for HIV risk, as well as safe spaces and health facilities. Community groups are using this information to advocate for measures to eliminate danger points and create a more protective environment.

Cash transfers to change behaviour

Social protection programmes, including modest cash transfers, have had an impact on cross-generational relationships. In Zomba, Malawi, conditional and non-conditional cash transfers to adolescent girls increased school attendance and decreased child marriage, early pregnancy and self-reported sexual activity, including fewer and younger – rather than older – sexual partners. HIV incidence also declined. Among girls enrolled in school at the start of the study who received the cash subsidy, incidence was 60 per cent lower than in the control group, a drop attributed to their decreased need to rely on age-disparate relationships for economic support.[86]

Laws and policies

The stigma surrounding HIV and AIDS combined with legal restrictions on services may cause adolescents to forgo HIV testing, prevention services and treatment.

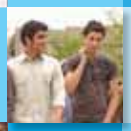
Few countries in some of the most-affected regions have provisions allowing minors to access contraceptives, HIV testing or harm reduction services without parental consent. In Africa, only 4 of the 22 countries that responded to a recent WHO survey had such provisions; in Europe only 5 out of 15 had them, and in South-East Asia only 1 out of 7.

Globally, more countries provided minors access to contraceptives and HIV testing (more than 40 per cent for each) than to harm reduction services (23 per cent).[87] Advocacy has resulted in laws lowering the age at which parental consent is required to use health-related services in Albania, Bosnia and Herzegovina, the Republic of Moldova, Serbia and Ukraine.

Reducing HIV vulnerability also requires special protections for children who are forced into child labour or trafficked due to the death or illness of family members from HIV or AIDS or for any other reason. In Africa, extended families have proved compassionate and resilient in caring for children who have lost parents to AIDS. Nonetheless, without support or oversight, these arrangements can also lead to child abuse and exploitation. All societies should establish mechanisms to prevent child labour and protect vulnerable individuals, including young women and girls, from exploitation by relatives, caregivers and others.

It is time to seize the opportunities to:

- Foster responsibility for HIV prevention in youth within communities and among adolescents themselves
- Examine how economic empowerment of at-risk populations can change risky behaviours
- Ensure that young people have access to reproductive health services including condoms
- Change social norms that encourage or condone risky behaviour among young people and adults
- Promote scale-up of proven interventions targeting individual knowledge, attitudes and behaviour
- Make more extensive use for HIV prevention of the communication pathways and technologies that adolescents and young people are using
- Review laws and law enforcement so they better protect the health and rights of young people, including marginalized young people and those engaged in illegal behaviour that puts them at risk for HIV infection
- Use mapping and community dialogue to help adolescents identify risk and work with leaders to deal with 'hot spots'


5. **YOUNG** ADULTS

Ages 20–24: Young adults realizing their full capacity to prevent infection

In their early twenties, young people begin to assume their adult roles. In many cultures they become more independent; they seek out economic opportunities and provide for themselves; they may marry and start a family, or they may be considering marriage and parenthood in their futures. The labour situation they face and the family planning options available to them are important determinants of their HIV risk. There are multiple opportunities to strengthen HIV prevention for young adults, their partners and their children.

The challenge

Young people aged 15–24 make up 40 per cent of the world's unemployed.[88] The youth labour force continues to grow in the poorest regions, and in recent years, outside industrialized countries, young women have been finding it harder to find work than young men.[89] Such a dearth of decent work drives social exclusion, including drug use, and can fuel the spread of HIV. In all regions, unemployment and poverty are reported as the main reasons young people enter the sex trade.[90]

In CEE/CIS, overall unemployment in 2009 was the highest of any region of the world, 10.4 per cent.[91] HIV epidemics in countries of this region are concentrated among populations that inject drugs, the behaviour that is driving the epidemic in this region.

Living in a country with a generalized HIV epidemic creates its own employment dynamics. A 2005 study suggests that in countries with a high HIV burden, young people participate more in the labour force than they do in less-affected countries.[92]

In many high-prevalence countries, the availability and use of condoms among young people aged 15–24 are improving, but overall condom use remains low.[93] In sub-Saharan Africa, the percentage of young people aged 15–24 with multiple partners who reported using a condom at last sex was 47 per cent of young men and 32 per cent of young women. In Asia (excluding China), 34 per cent of young men and 17 per cent of young women with multiple partners used a condom at last sex.[94]

Low condom use may be linked with low availability, and according to data in countries that have such data, availability may not be in proportion to need. Namibia, for example, has a population of less than 2 million people and distributed 33 million condoms in 2008–2009,[95] whereas in Malawi, with 13 million people, more than 22 million condoms were distributed.[96] In sub-Saharan Africa, only eight condoms are available per adult male per year.[97]

Around 215 million women of reproductive age in developing countries who want to avoid or delay pregnancy, therefore, have to rely solely on traditional methods of contraception, which have a high rate of failure as pregnancy prevention and do not protect against HIV.[98]

Only 26 per cent of an estimated 125 million pregnant women in low- and middle-income countries received an HIV test in 2009.[99] In sub-Saharan Africa, there are an estimated 1,260,000 [810,000–1,700,000] pregnant women living with HIV; in South Asia, around 47,000 [23,000–78,000]; in Latin America and the Caribbean, around 30,000 [19,000–41,000]; and in CEE/CIS, around 15,000 [7,600–22,000].[100]

Only an estimated 53 per cent [40–83 per cent] of HIV-positive pregnant women in sub-Saharan Africa received antiretroviral drugs for prevention of mother-to-child transmission (PMTCT) in 2009. In South Asia the percentage was 24 per cent [15–50 per cent]; in East Asia and the Pacific, 47 per cent [31–68 per cent]; and in Latin America and the Caribbean, 54 per cent [39–83 per cent].[101]

"MY LIFE IS NORMAL"

Maricarmen's story epitomizes the promise – and failures – of HIV prevention efforts. Infected perinatally, she found out she was living with HIV as a teenager and experienced stigma and rejection. She has since received treatment and support, and has grown into a young womanhood that she sees as filled with promise. In her own words:

"I live in the suburbs in Mexico City with my husband and my three-year-old son, and I was born with HIV. Because of the infection, my father died when I was three, and six years later I also lost my mother. Although they knew I had the virus when I was born, I never got any treatment for it. Shortly before age 15, when I was under the care of an aunt, I learned of my illness and began treatment. I started experiencing the rejection of my own family, so I decided to go live in a hostel and a home for girls after that. There I received regular medical consultations.

"About three years later I met the man who today is my husband and the father of my son. He's known of my condition since the beginning of our relationship. During my pregnancy, doctors guided me to take all necessary measures to prevent my child being born with the virus. My child was born by Caesarean section, I did not breast-feed, and he received antiretroviral treatment during his first days of life. Today my son is completely healthy just like my husband. We live a normal life like any other couple. The only difference is that we practise the so-called safe sex.

"My life is normal … and as soon as my son goes to school, I will do the same, so I'll be able to join working life in the future." ■

Maricarmen, 23, Mexico City

Solutions informed by evidence

Biomedical interventions

In places where heterosexual sex is a key mode of HIV transmission, medical male circumcision significantly reduces – by about 60 per cent – a man's risk of infection.[102] A recent analysis of the cost and impact of scaling up adult male circumcision in 14 countries in Eastern and Southern Africa to reach 80 per cent of newborns and males aged 15–49 by 2015 concluded that it would cost $4 billion, but could avert 4 million HIV infections and save over $20 billion in antiretroviral therapy costs by 2025.[103]

Kenya has begun a large-scale roll-out of adult male circumcision, and several other priority countries are in the process of planning the expansion of male circumcision to the national level. To date, boys under the age of 15 represent 45 per cent of participants in the Rapid Results Initiative in Nyanza, Kenya.[104] In South Africa, in a project under way in the Orange Farm township, around 75 per cent of all participants circumcised between January 2008 and November 2009 were aged 15–24, with a particularly high proportion of them aged 15–19.[105] Orange Farm township has a high HIV prevalence, and participation in the project has been high and continues to increase.

In Rwanda, recent cost-effectiveness modelling found neonatal and adolescent male circumcision to be cost-saving over time; the findings suggested that a strategy of neonatal circumcision could be accompanied by a catch-up campaign for adolescent and adult male circumcision until no longer needed.[106] Rwanda's adult HIV prevalence is 2.9 per cent.

Here and elsewhere, circumcision programmes must also emphasize correct and consistent condom use and HIV testing as part of the continuum of prevention.

Condom provision and uptake

The male latex condom is the single most efficient technology available to reduce the sexual transmission of HIV and other infections.[107] There is evidence that promoting condoms to young people leads neither to increased sexual behaviour nor to high-risk behaviour.[108] Yet, social and cultural attitudes pose significant barriers to condom use. A study carried out by the North West Provincial Department of Health in South Africa showed that partnership with actors outside the health sector is key to changing negative attitudes about condom use if it is to reach a level necessary for effective impact.[109]

Female condoms are not as widely promoted as male condoms, although global distribution has increased – from 11.8 million in 2004 to 50 million in 2009.[110] Still, there is little availability, with only 1 for every 36 women worldwide.[111] A media and social marketing campaign in Zimbabwe that focused on understanding the behaviours that brought about risk helped boost public-sector distribution of female condoms from 400,000 in 2005 to 2 million in 2008, and increased sales from 900,000 to 3 million in the same time period.[112]

Many of the successes of HIV prevention in Asia are due to the combination of service delivery with social change models of prevention, accompanied by the mobilization of key populations at high risk of exposure. In India, the Avahan programme demonstrates that intensive programmes for hard-to-reach populations that combine condom promotion with comprehensive services, including sexual and reproductive health services, can be effective in increasing consistent and correct condom use.[113] In Cambodia and Thailand, high availability and uptake of condoms and government-driven '100 per cent' condom policies in sex work were central to a reduction of HIV prevalence in key populations.[114]

Sexual and reproductive health, family planning and PMTCT for young women

Administering a short course of antiretroviral drugs to victims of rape or sexual intercourse for which no condom was available is an effective way to prevent HIV infection.[115] Recent research has also raised the hope that antiretrovirals in the form of pre-exposure prophylaxis dosages, or as the main ingredient in microbicide gels, could protect people who cannot insist on condom use during risky sex or women who wish to become pregnant.[116] Recent trials of a tenofovir-based gel show promise in providing women with a female-controlled prevention option.[117] If proven effective for widespread use, these HIV-specific prevention measures will add significantly to the continuum of prevention.

Young women and men on the cusp of adulthood who choose to become parents have opportunities to help ensure that their children start life HIV-free. For young women, family planning services and access to services for the prevention of mother-to-child-transmission of HIV are crucial opportunities. Young men also have a great opportunity to prevent transmission from man to woman to unborn child, and to encourage their wives or female partners to take advantage of available PMTCT services.

In some countries of Eastern Europe and Central Asia, efforts are being made to promote access to antiretroviral therapy in the context of maternal and child health and PMTCT services for pregnant, HIV-positive women who inject drugs, many of whom are young. At 94 per cent, the level of access to antiretroviral prophylaxis among pregnant women in this region is already high.[118] Inclusion of this extremely marginalized group in such services could help Eastern Europe and Central Asia become the first region to virtually eliminate vertical HIV transmission.

The proven effect of combination regimens of antiretroviral drugs to reduce viral load and thus the risk of mother-to-child transmission of HIV also has implications for preventing the transmission of HIV to youth. Urging all people to be tested, and getting those eligible to start treatment, can have important dividends for prevention. If widely followed, such 'treatment as prevention' initiatives can diminish the AIDS impact of multiple concurrent sexual partnerships and other behaviours that expose young people to high risk.[119]

Reaching young people in their workplaces

Most women and men affected by the HIV epidemic are of working age, so the workplace offers a unique entry point to promote access to HIV prevention, treatment, care and support for young women and men, whether in formal or informal employment or vocational training. Empowering women and men of all ages to engage in productive activities is a priority for reducing HIV-related stigma and discrimination, supporting the livelihood of those affected by AIDS and preventing new infections. Supporting job creation is crucial in addressing the lack of social protection faced by many young workers affected by HIV, especially in the informal economy.[120]

Innovative approaches linked to the workplace that can meet the needs of young people exist. In South Africa, the Techno Girls Career Mentorship Programme focuses on skills development among adolescent girls, particularly in the male-dominated subjects of math, science and technology. The programme seeks out high-achieving or motivated girls in grades 10–12 from disadvantaged backgrounds, particularly in rural areas, and pairs them with companies operating in South Africa. The girls work for one-week periods, three times a year, for three years. Since Techno Girls was launched with support from UNICEF in 2006, more than 2,000 adolescent girls and young women have been placed with companies in four provinces, with the effort now set to go nationwide.[121]

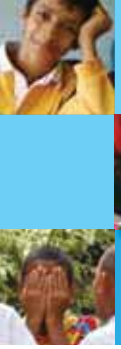
In Cameroon, a micro-finance scheme initiated by the International Labour Office has assisted 112 families in building business skills while facilitating access to HIV counselling and support services and raising awareness about stigma and discrimination among the project stakeholders, including the participating finance institutions. Eleven months after the introduction of the scheme, 98 per cent of the participants were successfully operating their own small businesses, 86 per cent had already repaid part of their loans and 65 per cent had opened savings accounts. Most participants reported increased income, a stronger feeling of self-worth and a sense of empowerment.[122]

The Trade Union Congress of the Philippines has promoted efforts to increase young people's access to sexual and reproductive health services in the workplace since 1995, and it has succeeded in getting thousands of young people to access information and services, negotiating paid leave for young workers to attend sexual and reproductive health events, and helping solidify partnerships to strengthen referral networks, including for gender-sensitive and youth-friendly services. The Congress promotes youth sexual and reproductive health (YSHR) as a human right under the slogan 'YSRH: Good health…our right' and is assisted by the United Nations Population Fund's Work-based Reproductive Health Project for Youth.[123]

Numerous studies have concluded that enhancing a woman's economic stability can help her insist on safer sex.[124] A recent study in South Africa showed that adding a targeted health component to micro-finance programmes increased women's empowerment, reduced their experience of intimate-partner violence and increased HIV protective behaviours, compared to women engaged in the micro-finance activity only.[125]

It is time to seize the opportunities to:

- Promote proven biomedical interventions, such as adult male circumcision, in places of high HIV prevalence and low male circumcision prevalence
- Develop and promote biomedical interventions that can be controlled by most vulnerable women, for example, female condoms, microbicides and post-exposure prophylaxis
- Create livelihood opportunities to give young adults economic sustainability, future prospects and a strong motivation to preserve their health
- Cultivate workplace policies and cultures that respect young people's sexual and reproductive health and rights, reduce stigma and facilitate access to HIV prevention, treatment, care and support services
- Improve access to integrated reproductive health and family planning services, according to national policies
- Recognize and address social norms that make young women highly vulnerable because of gender roles and economic realities



6. ADOLESCENTS and YOUNG PEOPLE LIVING with HIV

Ages 10–24: Most do not know their HIV status; testing and counselling are crucial

There were an estimated 5 million [4.3 million–5.9 million] young people aged 15–24 living with HIV, in addition to the 2.5 million [1.6 million–3.4 million] children under age 15 living with the virus in 2009. Not nearly enough attention has been paid to these adolescents and young people as they transition to adulthood.

The challenge

Globally, there were an estimated 2 million [1.8 million–2.4 million] adolescents aged 10–19 living with HIV in 2009 *(see Table 6)*. An estimated 1.5 million [1.4 million–1.7 million] of these adolescents were in sub-Saharan Africa, and 1.2 million [1.0 million–1.4 million] were in Eastern and Southern Africa alone *(see Figures 9–10)*. The highest numbers of adolescent boys and girls living with HIV are found in South Africa and Nigeria, as well as in India, Kenya, Malawi, Mozambique, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe.

In all developing regions except South Asia and Latin America and the Caribbean, the data clearly show the profound vulnerability of adolescent girls to HIV infection. By the age of 19, the combined impact of many factors – biology, low HIV knowledge and risk perception, such behaviours as early sexual debut and low condom use, structural barriers to access to services and protection, and social norms that perpetuate gender inequality – has already had an effect on adolescent girls, with consequences that will cut short the lives of millions of them or may severely inhibit their ability to achieve their full potential.

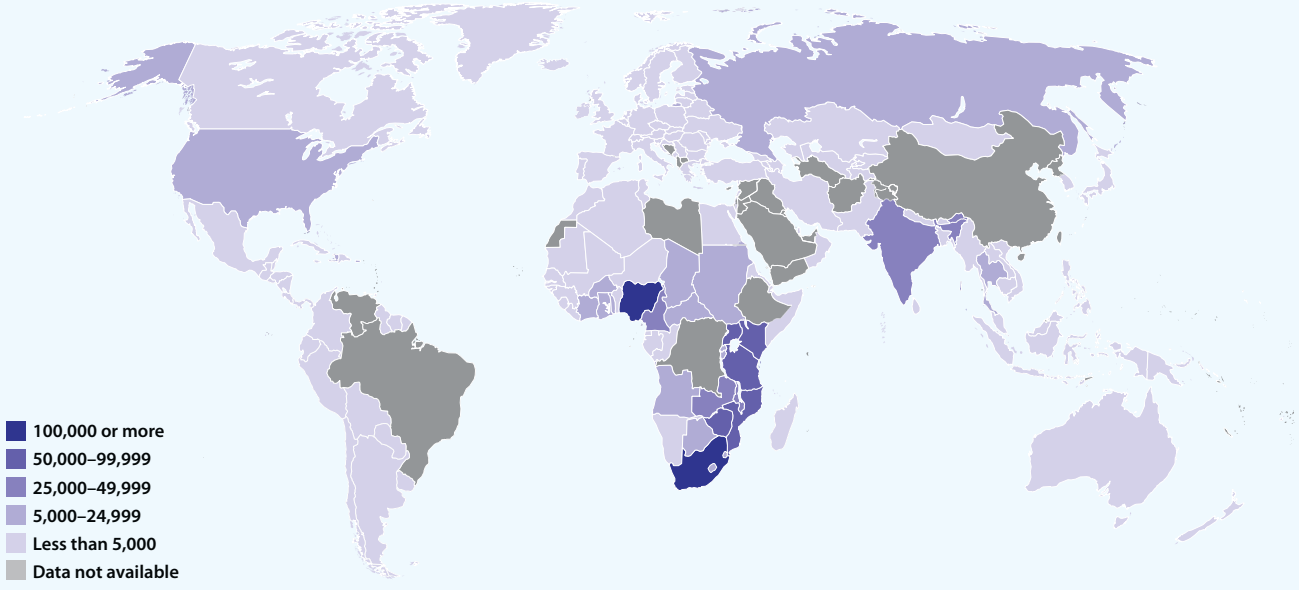
Young people living with HIV contracted the virus either 'vertically', through mother-to-child transmission, or 'horizontally', through unprotected sex (including rape or child abuse) or the sharing of injecting drug equipment with an infected person. For young people who contracted the virus vertically, such circumstances represent a cycle of challenges that were not overcome: PMTCT services were not available to their parents, or their parents did not use these services, and as children they were not tested themselves.

TABLE 6: Adolescents aged 10–19 living with HIV, 2009

Region	Female		Male		Total	
	Estimate	[low estimate - high estimate]	Estimate	[low estimate - high estimate]	Estimate	[low estimate - high estimate]
Eastern and Southern Africa	760,000	[670,000 - 910,000]	430,000	[370,000 - 510,000]	1,200,000	[1,000,000 - 1,400,000]
West and Central Africa	330,000	[270,000 - 440,000]	190,000	[140,000 - 240,000]	520,000	[390,000 - 680,000]
Middle East and North Africa	22,000	[17,000 - 30,000]	9,700	[7,800 - 12,000]	32,000	[25,000 - 40,000]
South Asia	50,000	[44,000 - 57,000]	54,000	[47,000 - 66,000]	100,000	[90,000 - 130,000]
East Asia and the Pacific	27,000	[15,000 - 30,000]	23,000	[14,000 - 34,000]	50,000	[29,000 - 73,000]
Latin America and the Caribbean	44,000	[34,000 - 55,000]	44,000	[31,000 - 82,000]	88,000	[62,000 - 160,000]
CEE/CIS	9,000	[7,700 - 10,000]	3,900	[3,400 - 4,500]	13,000	[11,000 - 15,000]
World	1,300,000	[1,100,000 - 1,500,000]	780,000	[670,000 - 900,000]	2,000,000	[1,800,000 - 2,400,000]

Source: UNAIDS unpublished estimates, 2010.

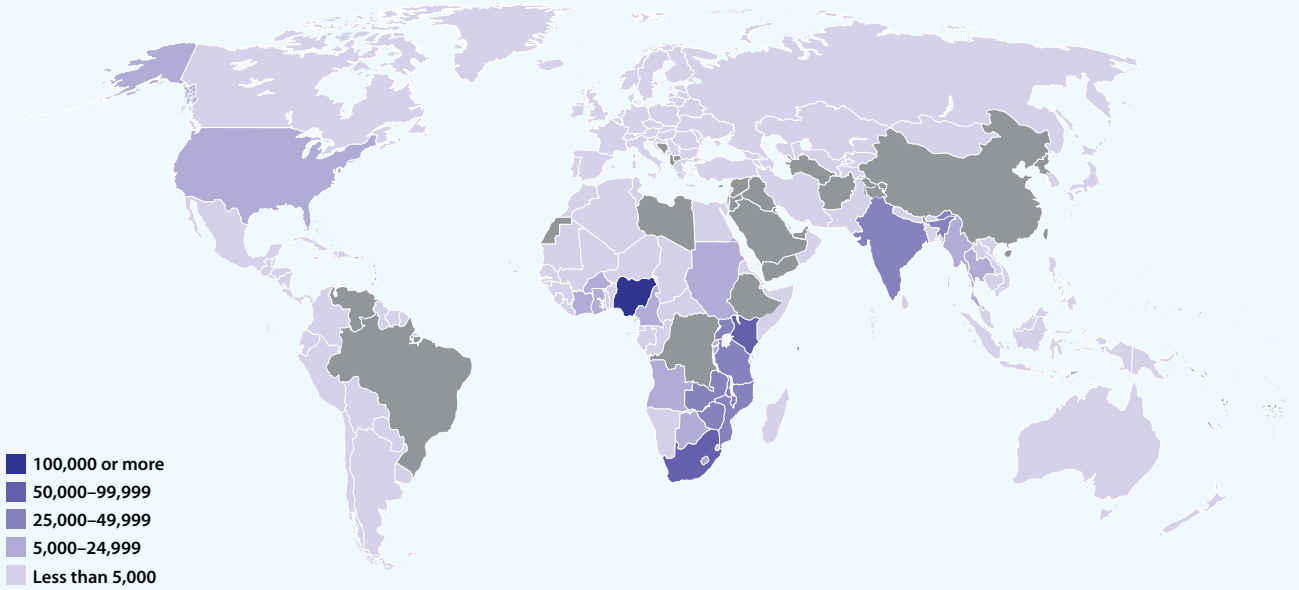
FIGURE 9: Estimated number of adolescent females aged 10–19 living with HIV, 2009



Source: UNAIDS unpublished estimates, 2010.

Note: The map is stylized and not to scale. It does not reflect a position on the part of UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the Parties.

FIGURE 10: Estimated number of adolescent males aged 10–19 living with HIV, 2009



Source: UNAIDS unpublished estimates, 2010.

Note: The map is stylized and not to scale. It does not reflect a position on the part of UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the Parties.

The solutions

Adolescents living with HIV require access to services, beginning with their HIV diagnosis and continuing through services to ensure adherence to treatment, positive health and dignity. Several diagnostic approaches have been developed to suit different contexts – for example, the use of improved classification algorithms to guide recommendations for HIV testing in adolescents presenting at primary health-care facilities in South Africa and Zimbabwe.[126]

In 2010, a global consultation in Kampala, Uganda, arrived at a consensus on the type of services and support adolescents living with HIV require, and it is more than medical care: Adolescents living with HIV need a supportive family and a school and community environment that enables them to reach their full potential and is free of stigma and discrimination. Such an environment is created through awareness-raising and by engaging leaders within the community. At the facility level, adolescents need services including early diagnosis; assistance with disclosure to their families, caregivers and partners; mental health and psychosocial referrals if necessary; sexual and reproductive health and HIV prevention information and services; and treatment and care for themselves. They may need in-home care, depending on their HIV stage of progression; and if they become pregnant they may need PMTCT services.[127]

Support programmes offering services must take into account the other factors affecting these adolescents' well-being. In Brazil according to one study, most adolescents living with HIV were in school when they began treatment; then 29 per cent dropped out of school and half of those remaining failed.[128] In Zimbabwe, a survey of staff at the country's 131 facilities providing HIV care revealed two major concerns for adolescents: psychosocial concerns and adherence to treatment.[129]

The Botswana-Baylor Children's Clinical Center of Excellence works with many HIV-positive children, including many adolescents, offering a broad range of medical, psychological and education services and support. Mildmay International in Uganda uses an integrated approach that reduces stigma and dependency among adolescents and enhances their self-confidence. The Centre for the AIDS Programme of Research in South Africa (CAPRISA) has made promising headway supporting adolescents living with HIV in disclosing their status; disclosure was identified as an extremely difficult area for adolescents as well as for their parents and caregivers.

Despite the gains achieved by such programmes, some of them also highlight the limitations of 'paediatric' programmes, the need to better integrate adolescent services within other existing services, and the unmet needs of adolescents outside of the cities where many programmes are located. There is also a need to develop ways to help adolescents transition from paediatric to adult care.

THE WEDNESDAY GROUP: A PLACE TO SHARE EXPERIENCES AND RECEIVE SUPPORT

The Wednesday Group in Lusaka, Zambia, is a place where adolescents with HIV can meet one another, share thoughts and feelings, talk to counsellors and just relax and hang out. The Network of Zambian People Living with HIV/AIDS already offered group counselling sessions, but for all ages. In 2010 a group of young people asked a counsellor to start a session specifically for young people, so they could focus on issues that mattered to them, such as relationships, sexuality, disclosure and peer discrimination. The stories of some in the group reveal the challenges of navigating adolescence while living with HIV.

Malama (not her real name) lives with her aunt, who has cared for her since both her parents died when she was a baby. Often sick but never told why, Malama found out she was HIV-positive after a bout of hospitalization around age 13. She couldn't understand why she was infected, since she had never had sex. Malama's aunt informed her teacher about her status, and soon the other children at school found out and ostracized her. Her boyfriend, with whom she had just started a relationship, distanced himself. Malama hasn't gone to school for over six months.

Simon, now 18 and also living with HIV since birth, has not told his friends his status, fearing just the kind of discrimination that Malama experienced. He goes out with friends, sometimes drinks beer, and has had sex with girls – but always with a condom.

Common issues emerging in the Wednesday Group's discussion include the lack of transparency, even among family members, lack of support and even open hostility in school, lack of information on how and when to disclose their status, and the lack of peer support and counselling. ■

The 'Positive Health, Dignity and Prevention' agenda propelled by GNP+, the Global Network of People Living with HIV, expresses the broad, holistic needs of people living with HIV beyond just preventing onward transmission: It expresses the need to address their human rights, issues of gender equality, access to services and reproductive and sexual health care, and other areas.[130] Adolescents and young people living with HIV have an equal need for such a broad vision of their physical and mental health and potential, and inputs from this age group will certainly benefit the implementation of the GNP+ agenda.

It is time to seize the opportunities to:

- Improve monitoring and evaluation systems to ensure that the numbers of adolescents and young people living with HIV are known and that their changing needs are acknowledged and met
- Ensure the greater involvement of young people living with HIV in policy and programme development
- Help more adolescents and young people know their status and eliminate stigma in disclosing it
- Expand comprehensive services for adolescents living with HIV in order to meet their medical, emotional and psychological needs
- Treat young people living with HIV as the young people they are: with real lives, real challenges and aspirations for the future

"I DID NOT THINK I COULD HAVE A FUTURE"

Marko never thought he would reach the age of 23. Infected with HIV when he was 2 because of a non-sterile vaccination needle, he struggled through a difficult adolescence of increasing illness after discovering his status at age 12. He was able to access antiretroviral treatment and other support with the help of the National Association of People Living with HIV. In his own words:

"I was completely, completely shocked. I had no information, just a few things here and there…. I was extremely depressed. I would cry at anything. I had wanted very much to become a professional soccer player, but this health deterioration meant I could no longer achieve this goal. Every time I watched a major soccer game, I would be overcome by depression…. I did not think I could have a future.

"At one point, I fell in love. I told the girl that I was HIV-positive. She accepted me for who I was, but her parents and her sister did not agree with her decision.… I felt terrible…. I thought, if I feel like this, how must those other individuals feel who were thrown out of their communities? I would hear all sorts of stories; for example, that a certain HIV-positive individual was thrown out of his community with stones, that the community members did not allow him to drink water from their fountains.

"I really did not believe that I would reach this age and this state of well-being: I go to the gym, I feel okay…. I work, I go to school, I learn, I do 'normal' things as much as possible. Perhaps I do things that an individual with no health problems whatsoever does." ■

Marko, 23, South-Eastern Europe

Since the interview with Marko took place, his health condition has deteriorated significantly as a result of frequent changes in his ARV regimen caused by interruptions in his access to treatment. This is a serious challenge in countries where continued access to effective therapies requires not only financial commitment and support from governments but also adequate planning, procurement and management of medications.



7. OPPORTUNITIES for ACTION

There is great potential to revitalize HIV prevention among adolescents and young people. The many evidence-informed interventions and innovative approaches at our disposal need to be scaled up. Moreover, young people are the population most likely to adopt safer behaviours, so investing in prevention is wise, paying dividends in the short and long terms, from lower rates of adolescent pregnancy and sexually transmitted infections to decreased HIV incidence.

Examples of success and failure in preventing HIV among adolescents and young people point to the need to build a continuum of prevention for them. Such a continuum begins with the needs of an individual as he or she transitions through the various stages of life, from early adolescence, through older adolescence, to young adulthood. As is true for all populations, the response for young people must be tailored to the epidemic among young people, and it needs to be 'owned' by the affected communities.

The continuum of prevention should be reflected in national planning and implementation processes, with sectoral responsibilities spelled out. Prevention strategies depend on 'knowing your epidemic' and who is newly infected and why, so as to adapt the continuum to the identified risks and trends.

For HIV incidence among young people to come down, a combination of actions must be undertaken. They must be started early and delivered in an age-appropriate way, at the right scale and conscious of impact relative to cost.

To build a strong continuum that can help keep children HIV-free as they develop into young adults, *Opportunity in Crisis* recommends renewed attention to key steps:

1. **Provide young people with information and comprehensive sexuality education**

   Avenues for accurate and comprehensive information should include schools, health services, community programmes and faith-based institutions as well as media that engage young people.

2. **Strengthen child protection and social protection measures to prevent exploitation of vulnerable children and adolescents**

   Very young adolescents are at risk for HIV because of failures to protect them. Parents, caregivers and immediate family members aided by social protection programmes, including economic empowerment, can help reduce economic and social exclusion of girls and women, thus reducing risk behaviours. Underlying causes of vulnerability – economic duress, dysfunctional families and exploitation – must be addressed.

3. **Engage young people**

   Young people themselves must own their risks and prevention strategies. Technology can strengthen young people's connection to one another and the world around them, and can improve demand and uptake of effective prevention services and commodities.

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4. Engage communities in shaping a positive social environment that promotes healthy behaviour

Communities must listen to young people, support them and allow them to contribute. Schools, social groups, families and local leaders can further HIV prevention by cultivating 'safer' attitudes and behavioural norms among adults. National programmes can better engage young people through technology, innovation and the effective use of social and broadcast media.

5. Establish laws and policies that respect young people's rights

Legislation and policies need to be adopted and service delivery personnel trained, so that young people get full benefit from existing systems. Barriers to access and uptake of commodities and services must be removed through sustained and well-targeted advocacy involving all key stakeholders. Information on policies and rights must also be made available to young people and service providers.

6. Scale up proven interventions for HIV prevention

Governments should work with civil society organizations and the private sector to ensure better communication about HIV services, such as medical male circumcision where appropriate, and to create effective demand for services and commodities, such as condoms for sexually active young people. Services need to be adapted to reach young people on the margins of society, to prevent the initiation of substance use and to reduce harm from unsafe injection.

7. Increase the number of adolescents and young people who know their HIV status

Too many young people do not know their HIV status. Legal and policy barriers that discourage or deny access to testing should be reviewed and addressed in countries where they exist. There should be investment in antiretroviral therapy for young people living with HIV, in reducing stigma and in improving social protection systems for vulnerable households.

8. Expand comprehensive services for young people living with HIV, paying special attention to adolescents

Adolescents living with HIV are largely missed by services, starting from diagnosis. Existing services that provide care to people living with HIV and AIDS must provide for the health, disclosure, adherence and psychosocial needs of adolescents.

9. Strengthen monitoring, evaluation and data reporting on young people, particularly adolescents

Adolescents and young people are simply not being counted. There is a blank space where data for certain age groups, particularly 10–14 and 15–19, should be. Filling in the missing information will help provide a clear basis for prioritizing action for young people. Evaluation approaches should include young people's perceptions, views and satisfaction regarding the accessibility, relevance and quality of the services provided them.

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THEN and NOW

THEN AND NOW: The ten-step strategy from *Young People and HIV/AIDS: Opportunity in crisis* (2002)		
TEN-STEP STRATEGY (2002)	**PROGRESS AGAINST EARLIEST BASELINE**	
1. End the silence, stigma and shame	**Progress indicator: % of countries with multi-sectoral strategies addressing stigma[1]**	
	Status [earliest available year]	In 2006, 39 of 85 (46%) countries reported having programmes in place to reduce HIV-related stigma and discrimination[2]
	Current status (2010 or latest available data)	In 2010, 78 of 85 (92%) countries reported having programmes in place to reduce stigma and discrimination[3]
2. Provide young people with knowledge and information	**Progress indicator: % of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and reject the major misconceptions about HIV transmission[6]**	
	Status [earliest available year]	According to population-based data available from 20 countries, between 2000 and 2004 (except Congo and Zambia, 2005) a median of 22% of males and 21% of females aged 15–24 had comprehensive knowledge of HIV[4]
	Current status (2010 or latest available data)	According to population-based data available from 20 countries, between 2005 and 2009, a median of 35% of males and 30% of females aged 15–24 had comprehensive knowledge of HIV[4]
3. Equip young people with life skills to put knowledge into practice	**Progress indicator: % of schools providing life-skills-based HIV education within the past academic year[7]**	
	Status [earliest available year]	76 countries reported on this indicator in 2008 (no global figure available)[5]
	Current status (2010 or latest available data)	99 countries reported on this indicator in 2010 (no global figure available)[3]
4. Provide youth-friendly health services	**Progress indicator: % of women and men aged 15–24 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse[6]**	
	Status [earliest available year]	No global aggregates available
	Current status (2010 or latest available data)	No global aggregate is available because not all regions report on this data for young people
		According to population-based data available between 2005–2010, the following proportions of young people aged 15–24 who had multiple partners reported the use of condoms at last sex:[10]
		47% of males and 32% of females in sub-Saharan Africa 33% of males and 17% of females in South Asia
5. Promote voluntary and confidential HIV counselling and testing	**Progress indicator: % of women and men aged 15–24 who have been tested and received their results[9]**	
	Status [earliest available year]	No global aggregates available
	Current status (2010 or latest available data)	According to population-based data available between 2005–2010, the following proportions of young people aged 15–24 had been tested and received their results:[8]
		8% of young women in developing countries (excluding China) 14% of males and 22% of females in Eastern and Southern Africa 6% of males and 9% of females in West and Central Africa 1% of males and 3% of females in South Asia
6. Work with young people, promote their participation	**Progress indicator: Involvement of young people in programmes and planning**	
	Status [earliest available year]	Y-Peer youth-led network established in 2000 to link peer educators in Central Europe with information to support outreach[20]
		Voices of Youth, an online forum for information and experience exchange, re-launched in 2002 to enable young people globally to explore issues affecting their rights and development and take action to address them
	Current status (2010 or latest available data)	Young people in 50 countries on 5 continents now linked to information for peer education through Y-Peer network
		Voices of Youth redesigned in 2011 to reach young people via social media (Facebook, Twitter) and mobile phones for faster, more inclusive global exchange of ideas[21]
7. Engage young people who are living with HIV and AIDS	**Progress indicator: Involvement of young people living with HIV in coordination mechanisms and programmes**	
	Status [earliest available year]	No structured mechanisms to support effective and meaningful engagement of young people living with HIV in national networks or global efforts
	Current status (2010 or latest available data)	Y+ Programme, with an advisory group of young people living with HIV in 6 regions and linking participants from networks in over 65 countries, launched in 2010 by the Global Network of People Living with HIV to support young people in their communication, participation, advocacy and access to tools for a more meaningful role in national responses.[19]

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TEN-STEP STRATEGY (2002)	PROGRESS AGAINST EARLIEST BASELINE	
8. Create safe and supportive environments	**Progress indicator: Number of young women and men aged 15–24 who are living with HIV**	
	Status [earliest available year]	Number of young people living with HIV: **5.7 million [5.0 million–6.7 million] in 2001**[10]
		Per cent of women experiencing sexual abuse before the age of 15 years: **Between 1% and 21%**[11]
		Per cent of women experiencing physical or sexual violence: **Between 15% and 71%**[12]
		Per cent of adolescent boys reporting sexual assault: **Between 3.6% and 20%**[13]
		The most common place where young women experience sexual coercion and harassment: **In school**[14]
		Per cent of all victims of sexual assault recorded in justice and rape crisis databases aged 15 years and below: **Between 33% and 66%** [15, 16]
	Current status (2010 or latest available data)	Number of young people living with HIV: **5 million [4.3 million–5.9 million] in 2009**[10]
		No updated global or multi-country study reports on sexual and physical violence against women
9. Reach out to young people most at risk	**Progress indicator: % of sex workers, injecting drug users and men under 25 who have sex with men reached with HIV prevention programmes** [17]	
	Status [earliest available year]	2008 Sex workers: In 37 countries reporting, the median is 58%[5] 2008 MSM: In 31 countries reporting, the median is 41%[5] 2008 IDU: In 19 countries reporting, the median is 37%[5]
	Current status (2010 or latest available data)	2010 Sex workers: In 48 countries reporting, the median is 42%[3] 2010 MSM: In 37 countries reporting, the median is 61%[3] 2010 IDU: In 27 countries reporting, the median is 19%[3]
	Progress indicator: % of sex workers, injecting drug users and men under 25 who have sex with men who had received an HIV test in the past 12 months and knew their results [18]	
	Status [earliest available year]	No global aggregates available.
	Current status (2010 or latest available data)	2007–2010 Sex workers: In 78 countries reporting, the median is 41%[3] 2005–2010 MSM: In 63 countries reporting, the median is 36%[3] 2005–2010 IDU: In 51 countries reporting, the median is 24%[3]
10. Strengthen partnerships, monitor progress	**Progress indicator: % of countries with a monitoring and evaluation (M&E) plan**	
	Status [earliest available year]	Overall, 39 out of 95 countries reported they had one national M&E plan in their 2006 National Composite Policy Index (NCPI) reports[2]
		Of 85 countries that reported the NCPI consistently between 2006 and 2010, 34 reported they had one national M&E plan in 2006
	Current status (2010 or latest available data)	Overall, 112 out of 172 countries reported they had one national M&E plan in 2010 NCPI reports[3]
		Of 85 countries that reported the NCPI consistently between 2006 and 2010, 64 reported they had one national M&E plan in 2010
	Progress indicator: % of countries who included civil society in the development of multi-sectoral strategies	
	Status [earliest available year]	Overall, 71 out of 95 countries reported that civil society was actively involved in the development of the multi-sectoral strategy in their 2006 NCPI reports[2]
		Of 85 countries that reported the NCPI consistently between 2006 and 2010, 64 reported that civil society was actively involved in the development of the multi-sectoral strategy in their 2006 NCPI reports
	Current status (2010 or latest available data)	Overall, 129 out of 172 countries reported that civil society was actively involved in the development of the multi-sectoral strategy in their 2010 NCPI reports[3]
		Of 85 countries that reported the NCPI consistently between 2006 and 2010, 70 reported that civil society was actively involved in the development of the multi-sectoral strategy in their 2010 NCPI reports

1 Eighty-five countries reported consistently from 2006 to 2010.

2 Source: UNGASS Country Progress Reports 2006.

3 Source: UNGASS Country Progress Reports 2010.

4 Source: UNICEF global databases, 2010.

5 Source: UNGASS Country Progress Reports 2008.

6 Global aggregates for behavioural indicators are challenging to calculate and compare. Figures on this indicator reflect population-adjusted averages from countries with available data from the DHS at the time of publication of *UNAIDS Report on the Global AIDS Epidemic 2010*.

7 There is no global aggregate for this indicator, as data are not methodologically comparable across countries and the indicator definition changed over time. Definition remained the same between 2008 and 2010.

8 Source: UNICEF global databases, 2010.

9 Source: AIDS Indicator Surveys (AIS), Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other nationally representative surveys, 2003–2009.

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17 Data shown here are medians and interquartile ranges. Data are not necessarily comparable as there may be differences in methods used over time and across countries. Aggregates are only descriptive; they do not reflect trend. Indicator definition changed over time, only comparable between 2008 and 2010.

18 Median and interquartile range. Data are not necessarily comparable as there may be differences in methods used over time and across countries. Aggregates are only descriptive; they do not reflect trend.

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TABLE 1: Demographic, epidemiology and education indicators for adolescents and young people

	DEMOGRAPHICS					EPIDEMIOLOGY							
	Population (thousands), 2009			Young people aged 10–24 as a % of total population	Type of epidemic	Estimated number of young people living with HIV, 2009							
	Total	Age 10–19	Age 15–24			Female 10–19	Low-high estimate	Male 10–19	Low-high estimate	Female 15–24	Low-high estimate	Male 15–24	Low-high estimate
Afghanistan	28,150	6,767	5,626	33	L	-	-	-	-	-	-	-	-
Albania	3,155	604	604	28	L	-	-	-	-	-	-	-	-
Algeria	34,895	6,698	7,341	30	L	<500	[<500 - <1,000]	<1,000	[<500 - 1,900]	1,400	[<1,000 - 2,600]	2,200	[<1,000 - 6,500]
Andorra	86	-	-	-	-	-	-	-	-	-	-	-	-
Angola	18,498	4,411	3,787	33	G	11,000	[8,000 - 15,000]	5,400	[3,800 - 7,500]	29,000	[21,000 - 40,000]	12,000	[8,200 - 16,000]
Antigua and Barbuda	88	-	-	-	-	-	-	-	-	-	-	-	-
Argentina	40,276	6,828	6,692	25	C	1,800	[<1,000 - 3,100]	2,500	[<1,000 - 8,000]	5,900	[2,600 - 10,000]	9,000	[3,400 - 29,000]
Armenia	3,083	482	587	26	C	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]
Australia	21,293	2,826	2,904	20	-	<500	[<200 - <500]	<500	[<200 - 1,100]	<1,000	[<500 - 1,400]	1,200	[<1,000 - 4,000]
Austria	8,364	955	1,031	18	-	<500	[<200 - <1,000]	<500	[<200 - 1,300]	<1,000	[<500 - 1,800]	1,600	[<1,000 - 5,000]
Azerbaijan	8,832	1,629	1,811	29	L	<500	[<200 - <500]	<100	[<100 - <200]	<1,000	[<500 - 1,300]	<500	[<200 - <500]
Bahamas	342	61	59	26	-	<500	[<100 - <1,000]	<200	[<100 - <500]	<1,000	[<500 - 1,900]	<500	[<200 - <1,000]
Bahrain	791	139	141	27	-	-	-	-	-	-	-	-	-
Bangladesh	162,221	33,907	33,013	31	L	<500	[<200 - <500]	<500	[<200 - <1,000]	<1,000	[<500 - 1,100]	1,000	[<500 - 2,900]
Barbados	256	34	37	21	-	<100	[<100 - <100]	<100	[<100 - <100]	<500	[<200 - <500]	<200	[<200 - <500]
Belarus	9,634	1,139	1,466	20	C	<200	[<100 - <200]	<100	[<100 - <100]	<1,000	[<1,000 - <1,000]	<500	[<500 - <500]
Belgium	10,647	1,248	1,285	18	-	<100	[<100 - <100]	<100	[<100 - <500]	<200	[<100 - <500]	<500	[<200 - <1,000]
Belize	307	70	64	32	C	<500	[<200 - <500]	<200	[<100 - <200]	<1,000	[<500 - <1,000]	<500	[<200 - <500]
Benin	8,935	2,041	1,747	32	G	2,500	[1,700 - 3,500]	1,300	[<1,000 - 1,900]	6,500	[4,600 - 9,200]	2,700	[1,800 - 4,000]
Bhutan	697	150	155	32	L	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]
Bolivia (Plurinational State of)	9,863	2,188	1,962	31	L	<500	[<200 - <1,000]	<500	[<200 - 1,200]	<1,000	[<500 - 1,200]	1,000	[<500 - 3,100]
Bosnia and Herzegovina	3,767	459	535	20	L	-	-	-	-	-	-	-	-
Botswana	1,950	432	434	33	G	9,200	[7,100 - 12,000]	5,400	[3,800 - 7,600]	26,000	[20,000 - 35,000]	12,000	[8,300 - 16,000]
Brazil	193,734	33,724	34,005	26	C	-	[8,000-23,000]	-	[7,000-19,000]	-	[23,000-62,000]	-	[20,000-54,000]
Brunei Darussalam	400	70	72	27	-	-	-	-	-	-	-	-	-
Bulgaria	7,545	756	938	17	L	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <200]	<200	[<100 - <200]
Burkina Faso	15,757	3,634	3,111	32	G	7,600	[5,300 - 11,000]	6,300	[4,600 - 8,500]	12,000	[8,300 - 17,000]	6,900	[5,100 - 9,400]
Burundi	8,303	1,955	1,912	35	G	10,000	[8,100 - 14,000]	7,300	[5,800 - 9,200]	20,000	[15,000 - 26,000]	9,200	[7,300 - 12,000]
Cambodia	14,805	3,570	3,511	35	C	2,300	[1,000 - 5,500]	2,200	[1,100 - 4,700]	2,200	[<1,000 - 5,200]	1,400	[<1,000 - 2,900]
Cameroon	19,522	4,459	4,075	33	G	29,000	[23,000 - 40,000]	14,000	[11,000 - 19,000]	79,000	[63,000 - 110,000]	32,000	[24,000 - 43,000]
Canada	33,573	4,221	4,503	19	-	<500	[<200 - <1,000]	<1,000	[<500 - 1,300]	2,000	[<1,000 - 3,700]	3,200	[1,000 - 11,000]
Cape Verde	506	123	115	35	G	-	-	-	-	-	-	-	-
Central African Republic	4,422	1,014	897	-	G	5,600	[3,500 - 7,900]	4,200	[2,600 - 5,800]	10,000	[6,200 - 14,000]	4,400	[2,700 - 6,100]
Chad	11,206	2,621	2,213	32	G	9,400	[6,400 - 20,000]	4,700	[3,200 - 9,600]	27,000	[19,000 - 57,000]	11,000	[7,400 - 22,000]
Chile	16,970	2,861	2,941	25	C	<1,000	[<500 - 1,100]	<1,000	[<500 - 2,700]	2,100	[1,000 - 3,700]	3,200	[1,300 - 10,000]
China	1,345,751	206,753	230,945	24	C	-	[1,800-5,000]	-	[1,700-4,200]	-	[9,000-23,000]	-	[14,000-35,000]
Colombia	45,660	8,740	8,409	28	C	2,500	[1,100 - 5,800]	3,200	[1,100 - 11,000]	6,000	[2,600 - 14,000]	9,000	[3,200 - 30,000]
Comoros	676	142	133	31	C	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]
Congo	3,683	846	766	33	G	4,200	[3,300 - 5,700]	2,600	[2,000 - 3,400]	10,000	[8,100 - 14,000]	4,800	[3,700 - 6,300]
Cook Islands	20	-	-	-	-	-	-	-	-	-	-	-	-
Costa Rica	4,579	850	883	28	C	<200	[<100 - <500]	<500	[<200 - <500]	<1,000	[<500 - <1,000]	<1,000	[<1,000 - 1,200]
Côte d'Ivoire	21,075	4,784	4,203	32	G	20,000	[13,000 - 29,000]	15,000	[10,000 - 24,000]	33,000	[23,000 - 49,000]	16,000	[10,000 - 24,000]
Croatia	4,416	507	544	18	L	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <200]
Cuba	11,204	1,500	1,610	21	L	<500	[<200 - <500]	<500	[<200 - <1,000]	<1,000	[<500 - <1,000]	<1,000	[<500 - 2,300]
Cyprus	871	122	133	22	-	-	-	-	-	-	-	-	-
Czech Republic	10,369	1,096	1,332	17	-	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <500]
Democratic People's Republic of Korea	23,906	3,971	3,880	24	L	-	-	-	-	-	-	-	-
Democratic Republic of the Congo	66,020	15,938	13,300	33	G	-	[24,000 - 40,000]	-	[12,000 - 20,000]	-	[60,000 - 99,000]	-	[25,000 - 41,000]
Denmark	5,470	696	655	18	-	<100	[<100 - <100]	<100	[<100 - <200]	<200	[<200 - <500]	<500	[<500 - <500]
Djibouti	864	199	187	33	G	<1,000	[<500 - 1,000]	<500	[<200 - <1,000]	1,800	[<1,000 - 2,700]	<1,000	[<500 - 1,200]
Dominica	67	-	-	-	-	-	-	-	-	-	-	-	-
Dominican Republic	10,090	2,025	1,916	29	C	2,300	[1,300 - 3,300]	1,300	[<1,000 - 1,900]	6,200	[3,600 - 8,900]	2,600	[1,400 - 3,800]
Ecuador	13,625	2,762	2,554	29	C	<1,000	[<500 - 1,400]	1,100	[<500 - 3,700]	2,200	[1,000 - 3,700]	3,400	[1,400 - 11,000]
Egypt	82,999	16,603	17,148	31	L	<500	[<500 - <1,000]	<1,000	[<500 - <1,000]	<1,000	[<1,000 - 1,500]	1,600	[1,000 - 2,400]
El Salvador	6,163	1,431	1,238	32	C	<1,000	[<500 - 1,400]	<1,000	[<500 - 3,000]	2,100	[1,000 - 3,800]	2,600	[1,000 - 8,800]
Equatorial Guinea	676	156	137	32	G	1,100	[<1,000 - 1,800]	<500	[<500 - <1,000]	3,600	[1,900 - 5,700]	1,400	[<1,000 - 2,300]

	EPIDEMIOLOGY							EDUCATION			
	HIV prevalence (%) among young people aged 15–24, 2009				Young people (aged 15–24) living with HIV as a % of adults (15+) living with HIV, 2009	Number of new infections among young people aged 15–24, 2009		Primary school net enrolment ratio 2005–2009*		Secondary school net enrolment ratio 2005–2009*	
	Female 15–24	Low-high estimate	Male 15–24	Low-high estimate		Estimate	Low-high estimate	Female	Male	Female	Male
Afghanistan	-	-	-	-	-	-	-	46	74	15	38
Albania	-	-	-	-	-	-	-	91 x	91 x	73 x	75 x
Algeria	<0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.2]	21	-	-	94	96	68 x	65 x
Andorra	-	-	-	-	-	-	-	79	81	75	69
Angola	1.6	[1.1 - 2.2]	0.6	[0.4 - 0.9]	22	8,000	[5,400 - 11,000]	48 x	55 x	-	-
Antigua and Barbuda	-	-	-	-	-	-	-	86	90	-	-
Argentina	0.2	[0.1 - 0.3]	0.3	[0.1 - 0.8]	14	-	-	-	-	84	75
Armenia	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	-	-	-	86	83	88	83
Australia	0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.3]	11	-	-	97	96	89	87
Austria	0.2	[0.1 - 0.3]	0.3	[0.1 - 0.9]	17	-	-	98 x	97 x	-	-
Azerbaijan	0.1	[0.1 - 0.1]	<0.1	[<0.1 - 0.1]	29	-	-	95	97	97	99
Bahamas	3.1	[0.8 - 6.6]	1.4	[0.5 - 2.8]	21	-	-	92	90	87	83
Bahrain	-	-	-	-	-	-	-	97	98	92	87
Bangladesh	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	26	-	-	86	85	43	40
Barbados	1.1	[0.8 - 1.4]	0.9	[0.7 - 1.1]	-	-	-	-	-	-	-
Belarus	0.1	[0.1 - 0.1]	<0.1	[<0.1 - 0.1]	-	-	-	96	93	-	-
Belgium	<0.1	[<0.1 - 0.1]	<0.1	[<0.1 - 0.1]	-	-	-	99	98	85	89
Belize	1.8	[1.4 - 2.7]	0.7	[0.5 - 1.1]	-	-	-	98	98	66	61
Benin	0.7	[0.5 - 1.1]	0.3	[0.2 - 0.4]	17	1,900	[1,200 - 2,500]	86	99	13 x	26 x
Bhutan	<0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.1]	-	-	-	88	86	49	46
Bolivia (Plurinational State of)	0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.3]	15	-	-	94	93	70	70
Bosnia and Herzegovina	-	-	-	-	-	-	-	-	-	-	-
Botswana	11.8	[9.0 - 15.9]	5.2	[3.7 - 7.3]	13	6,000	[4,300 - 8,800]	88	86	67	62
Brazil	-	[0.1 - 0.4]	-	[0.1 - 0.3]	-	-	-	93	95	85	78
Brunei Darussalam	-	-	-	-	-	-	-	93	93	90	87
Bulgaria	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	-	-	-	96	96	82	85
Burkina Faso	0.8	[0.6 - 1.2]	0.5	[0.3 - 0.6]	20	2,300	[1,300 - 3,600]	59	67	13	18
Burundi	2.1	[1.6 - 2.7]	1.0	[0.8 - 1.2]	19	4,300	[3,200 - 5,100]	99	100	-	-
Cambodia	0.1	[0.1 - 0.3]	0.1	[<0.1 - 0.2]	6	-	-	87	90	32	36
Cameroon	3.9	[3.1 - 5.4]	1.6	[1.2 - 2.1]	20	22,000	[18,000 - 25,000]	82	94	-	-
Canada	0.1	[<0.1 - 0.2]	0.1	[<0.1 - 0.5]	8	-	-	100 x	99 x	94 x	95 x
Cape Verde	-	-	-	-	-	-	-	84	85	60 x	54 x
Central African Republic	2.2	[1.4 - 3.1]	1.0	[0.6 - 1.4]	13	1,600	[<1,000 - 2,400]	57	77	8	13
Chad	2.5	[1.7 - 5.2]	1.0	[0.7 - 2.0]	21	5,900	[3,700 - 21,000]	50 x	72 x	5 x	16 x
Chile	0.1	[0.1 - 0.3]	0.2	[0.1 - 0.7]	14	-	-	94	95	87	84
China	-	[<0.1 - <0.1]	-	[<0.1 - <0.1]	-	-	-	100	100	-	-
Colombia	0.1	[0.1 - 0.3]	0.2	[0.1 - 0.7]	10	-	-	90	90	75	68
Comoros	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - 0.1]	-	<100	[<100 - <100]	67 x	79 x	15	15
Congo	2.6	[2.1 - 3.6]	1.2	[0.9 - 1.6]	22	2,400	[1,900 - 2,900]	56	62	-	-
Cook Islands	-	-	-	-	-	-	-	83 x	87 x	61 x	57 x
Costa Rica	0.1	[0.1 - 0.2]	0.2	[0.1 - 0.3]	15	-	-	93	91	-	-
Côte d'Ivoire	1.5	[1.1 - 2.3]	0.7	[0.5 - 1.1]	13	5,200	[2,600 - 9,100]	50 x	62 x	15 x	27 x
Croatia	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - 0.1]	-	-	-	90	91	89	87
Cuba	0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.3]	21	-	-	99	99	83	82
Cyprus	-	-	-	-	-	-	-	98	99	97	95
Czech Republic	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - 0.1]	-	-	-	91	88	-	-
Democratic People's Republic of Korea	-	-	-	-	-	-	-	-	-	-	-
Democratic Republic of the Congo	-	[0.9 - 1.5]	-	[0.4 - 0.6]	-	-	[18,000 - 24,000]	32 x	33 x	-	-
Denmark	0.1	[<0.1 - 0.1]	0.1	[0.1 - 0.1]	-	-	-	96	95	91	88
Djibouti	1.9	[1.0 - 2.9]	0.8	[0.4 - 1.3]	19	-	-	39	44	18	25
Dominica	-	-	-	-	-	-	-	76	69	74	62
Dominican Republic	0.7	[0.4 - 0.9]	0.3	[0.1 - 0.4]	16	-	-	80	80	63	52
Ecuador	0.2	[0.1 - 0.3]	0.2	[0.1 - 0.8]	16	-	-	97	96	62	61
Egypt	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	23	-	-	92	95	69 x	73 x
El Salvador	0.3	[0.1 - 0.5]	0.4	[0.2 - 1.3]	15	-	-	95	93	56	54
Equatorial Guinea	5.0	[2.7 - 7.9]	1.9	[1.0 - 3.2]	28	1,000	[<500 - 1,800]	63 x	70 x	-	-

TABLE 1: Demographic, epidemiology and education indicators for adolescents and young people

	DEMOGRAPHICS					EPIDEMIOLOGY							
	Population (thousands), 2009			Young people aged 10–24 as a % of total population	Type of epidemic	Estimated number of young people living with HIV, 2009							
	Total	Age 10–19	Age 15–24			Female 10–19	Low-high estimate	Male 10–19	Low-high estimate	Female 15–24	Low-high estimate	Male 15–24	Low-high estimate
Eritrea	5,073	1,113	1,038	32	G	<1,000	[<1,000 - 1,600]	<1,000	[<500 - 1,200]	2,100	[1,200 - 3,600]	<1,000	[<1,000 - 1,500]
Estonia	1,340	146	192	19	-	<100	[<100 - <100]	<100	[<100 - <100]	<500	[<200 - <500]	<500	[<200 - <500]
Ethiopia	82,825	19,998	16,936	33	G	-	-	-	-	-	-	-	-
Fiji	849	176	163	30	L	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <500]
Finland	5,326	641	659	18	-	<100	[<100 - <100]	<100	[<100 - <200]	<200	[<100 - <200]	<200	[<100 - <1,000]
France	62,343	7,456	7,706	18	-	1,400	[<1,000 - 2,500]	2,000	[<1,000 - 6,300]	4,800	[2,200 - 8,500]	7,300	[3,000 - 23,000]
Gabon	1,475	342	310	33	G	1,900	[1,100 - 2,700]	<1,000	[<1,000 - 1,300]	5,400	[3,200 - 8,000]	2,200	[1,300 - 3,200]
Gambia	1,705	386	321	31	C	1,300	[<1,000 - 2,300]	<500	[<500 - <1,000]	3,600	[2,100 - 6,200]	1,500	[<1,000 - 2,500]
Georgia	4,260	602	705	22	L	<100	[<100 - <100]	<100	[<100 - <100]	<200	[<200 - <500]	<100	[<100 - <200]
Germany	82,167	8,378	9,328	16	-	<500	[<500 - <500]	1,200	[<1,000 - 1500]	1,300	[1,000 - 1,700]	4,300	[3,400 - 5,200]
Ghana	23,837	5,347	4,852	32	G	12,000	[9,100 - 17,000]	6,800	[4,900 - 9,600]	30,000	[23,000 - 42,000]	13,000	[8,900 - 18,000]
Greece	11,161	1,092	1,211	16	-	<100	[<100 - <200]	<200	[<100 - <500]	<500	[<200 - <500]	<500	[<500 - 1,600]
Grenada	104	22	24	33	-	-	-	-	-	-	-	-	-
Guatemala	14,027	3,310	2,835	33	C	1,600	[<1,000 - 2,800]	2,000	[<1,000 - 6,400]	4,800	[2,300 - 8,400]	6,700	[2,700 - 21,000]
Guinea	10,069	2,305	1,992	32	G	4,000	[2,600 - 5,600]	2,500	[1,700 - 3,800]	9,400	[6,100 - 13,000]	4,200	[2,700 - 6,200]
Guinea-Bissau	1,611	354	296	30	G	<1,000	[<1,000 - 1,400]	<500	[<500 - <1,000]	3,000	[2,200 - 4,300]	1,200	[<1,000 - 1,700]
Guyana	762	151	129	28	C	<500	[<100 - <1,000]	<500	[<100 - <500]	<1,000	[<200 - <1,000]	<500	[<200 - <1,000]
Haiti	10,033	2,282	2,131	33	G	6,500	[4,800 - 8,900]	4,100	[3,000 - 5,600]	14,000	[11,000 - 20,000]	6,200	[4,600 - 8,300]
Holy See	1	-	-	-	-	-	-	-	-	-	-	-	-
Honduras	7,466	1,751	1,591	33	C	1,000	[<500 - 1,700]	1,200	[<500 - 3,800]	2,100	[<1,000 - 3,500]	3,000	[1,100 - 9,100]
Hungary	9,993	1,123	1,254	18	L	<100	[<100 - <100]	<100	[<100 - <500]	<200	[<100 - <500]	<500	[<100 - <1,000]
Iceland	323	46	47	21	-	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <200]
India	1,198,003	243,387	231,362	30	C	46,000	[41,000 - 53,000]	49,000	[43,000 - 56,000]	140,000	[120,000 - 160,000]	150,000	[130,000 - 180,000]
Indonesia	229,965	40,926	41,076	27	C	1,600	[<1,000 - 2,700]	1,300	[<1,000 - 2,100]	9,800	[5,700 - 17,000]	13,000	[7,800 - 21,000]
Iran (Islamic Republic of)	74,196	13,301	17,048	30	L	<500	[<500 - <1,000]	<500	[<500 - <500]	1,700	[1,200 - 2,500]	2,300	[1,500 - 2,800]
Iraq	30,747	7,199	6,099	33	L	-	-	-	-	-	-	-	-
Ireland	4,515	565	608	20	-	<100	[<100 - <100]	<100	[<100 - <500]	<200	[<100 - <500]	<500	[<200 - <1,000]
Israel	7,170	1,184	1,112	24	-	<100	[<100 - <200]	<100	[<100 - <500]	<500	[<100 - <500]	<500	[<200 - 1,200]
Italy	59,870	5,676	5,903	14	-	<500	[<200 - <500]	<500	[<200 - <500]	<1,000	[<500 - 1,400]	1,000	[<1,000 - 1,600]
Jamaica	2,719	568	516	30	C	<1,000	[<500 - 1,500]	<1,000	[<500 - 2,900]	1,900	[<1,000 - 3,900]	2,700	[1,000 - 8,500]
Japan	127,156	12,020	12,866	15	-	<100	[<100 - <200]	<100	[<100 - <500]	<500	[<200 - <500]	<500	[<200 - <1,000]
Jordan	6,316	1,368	1,305	32	L	-	-	-	-	-	-	-	-
Kazakhstan	15,637	2,561	2,983	26	C	<1,000	[<1,000 - 1,400]	<500	[<200 - <500]	2,800	[1,800 - 4,600]	1,000	[<1,000 - 1,700]
Kenya	39,802	9,058	8,381	33	G	82,000	[61,000 - 110,000]	54,000	[39,000 - 71,000]	160,000	[120,000 - 220,000]	73,000	[54,000 - 97,000]
Kiribati	98	-	-	-	-	-	-	-	-	-	-	-	-
Kuwait	2,985	415	440	22	-	-	-	-	-	-	-	-	-
Kyrgyzstan	5,482	1,134	1,155	31	L	<100	[<100 - <200]	<100	[<100 - <200]	<500	[<500 - <1,000]	<1,000	[<500 - <1,000]
Lao People's Democratic Republic	6,320	1,571	1,388	35	L	<500	[<500 - <1,000]	<500	[<500 - <500]	1,300	[<1,000 - 2,200]	1,000	[<1,000 - 1,600]
Latvia	2,249	246	335	19	C	<100	[<100 - <100]	<100	[<100 - <100]	<200	[<200 - <500]	<500	[<200 - <500]
Lebanon	4,224	788	764	28	L	<100	[<100 - <100]	<100	[<100 - <200]	<200	[<200 - <500]	<500	[<200 - <500]
Lesotho	2,067	515	483	36	G	13,000	[11,000 - 18,000]	6,800	[5,100 - 9,300]	35,000	[28,000 - 48,000]	13,000	[9,800 - 18,000]
Liberia	3,955	912	782	32	G	1,600	[<1,000 - 2,900]	1,200	[<500 - 2,200]	2,700	[<1,000 - 5,000]	1,100	[<500 - 2,100]
Libyan Arab Jamahiriya	6,420	1,122	1,157	27	L	-	-	-	-	-	-	-	-
Liechtenstein	36	-	-	-	-	-	-	-	-	-	-	-	-
Lithuania	3,287	427	503	21	L	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]
Luxembourg	486	61	60	19	-	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <200]
Madagascar	19,625	4,674	3,902	33	C	<1,000	[<500 - 1,100]	<1,000	[<500 - 2,600]	1,800	[<1,000 - 2,800]	2,700	[1,200 - 7,600]
Malawi	15,263	3,748	3,020	33	G	49,000	[38,000 - 66,000]	32,000	[24,000 - 43,000]	100,000	[81,000 - 140,000]	48,000	[36,000 - 64,000]
Malaysia	27,468	5,305	5,170	28	C	<200	[<100 - <500]	<500	[<500 - <500]	<1,000	[<1,000 - 1,200]	3,500	[2,800 - 4,300]
Maldives	309	72	77	35	L	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]
Mali	13,010	3,101	2,728	34	C	3,600	[1,600 - 6,500]	2,600	[1,100 - 4,800]	6,500	[2,800 - 12,000]	2,800	[1,200 - 5,300]
Malta	409	52	57	20	-	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]
Marshall Islands	62	-	-	-	-	-	-	-	-	-	-	-	-
Mauritania	3,291	738	663	32	C	<500	[<200 - <1,000]	<500	[<200 - 1,400]	<1,000	[<500 - 1,500]	1,500	[<1,000 - 4,500]
Mauritius	1,288	214	205	24	C	<100	[<100 - <100]	<100	[<100 - <100]	<500	[<200 - <500]	<500	[<200 - <500]
Mexico	109,610	20,991	19,744	28	C	4,400	[3,300 - 6,300]	4,600	[3,400 - 6,700]	14,000	[10,000 - 20,000]	17,000	[13,000 - 25,000]

	EPIDEMIOLOGY							EDUCATION			
	HIV prevalence (%) among young people aged 15–24, 2009				Young people (aged 15–24) living with HIV as a % of adults (15+) living with HIV, 2009	Number of new infections among young people aged 15–24, 2009		Primary school net enrolment ratio 2005–2009*		Secondary school net enrolment ratio 2005–2009*	
	Female 15–24	Low-high estimate	Male 15–24	Low-high estimate		Estimate	Low-high estimate	Female	Male	Female	Male
Eritrea	0.4	[0.2 - 0.7]	0.2	[0.1 - 0.3]	14	<500	[<200 - <1,000]	36	42	22	30
Estonia	0.2	[0.2 - 0.3]	0.3	[0.2 - 0.4]	-	-	-	94	95	91	88
Ethiopia	-	-	-	-	-	-	-	75	81	20	31
Fiji	0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.3]	-	-	-	89	90	83	76
Finland	<0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.2]	-	-	-	96	96	97	96
France	0.1	[0.1 - 0.2]	0.2	[0.1 - 0.6]	8	-	-	99	98	99	98
Gabon	3.5	[2.1 - 5.2]	1.4	[0.8 - 2.0]	18	1,400	[<500 - 2,000]	80 x	81 x	-	-
Gambia	2.4	[1.4 - 4]	0.9	[0.5 - 1.6]	30	1,500	[<1,000 - 2,800]	71	67	41	42
Georgia	<0.1	[<0.1 - 0.1]	<0.1	[<0.1 - <0.1]	-	-	-	98	100	79	82
Germany	<0.1	[<0.1 - <0.1]	0.1	[0.1 - 0.1]	8	-	-	98	98	-	-
Ghana	1.3	[0.9 - 1.8]	0.5	[0.4 - 0.7]	18	8,300	[6,300 - 10,000]	77	76	45	49
Greece	0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.2]	-	-	-	100	99	91	91
Grenada	-	-	-	-	-	-	-	93	94	85	93
Guatemala	0.3	[0.2 - 0.6]	0.5	[0.2 - 1.4]	18	-	-	94	97	39	41
Guinea	0.9	[0.6 - 1.3]	0.4	[0.3 - 0.6]	20	2,200	[1,200 - 3,000]	66	76	21	34
Guinea-Bissau	2.0	[1.5 - 2.9]	0.8	[0.5 - 1.1]	21	<1,000	[<500 - 1,100]	43 x	61 x	7 x	12 x
Guyana	0.8	[0.2 - 1.5]	0.6	[0.2 - 1]	-	-	-	95	95	-	-
Haiti	1.3	[1 - 1.8]	0.6	[0.4 - 0.8]	19	-	-	-	-	-	-
Holy See	-	-	-	-	-	-	-	-	-	-	-
Honduras	0.2	[0.1 - 0.4]	0.3	[0.1 - 1.1]	14	-	-	98	96	-	-
Hungary	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - 0.1]	-	-	-	89	90	91	91
Iceland	0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.4]	-	-	-	98	97	91	89
India	0.1	[0.1 - 0.2]	0.1	[0.1 - 0.2]	13	-	-	88	91	-	-
Indonesia	<0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.1]	8	-	-	94	97	68	69
Iran (Islamic Republic of)	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	4	-	-	-	-	75	75
Iraq	-	-	-	-	-	-	-	81	93	33	46
Ireland	0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.3]	-	-	-	98	96	90	86
Israel	<0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.2]	-	-	-	98	97	88	85
Italy	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - 0.1]	1	-	-	98	99	93	92
Jamaica	0.7	[0.3 - 1.4]	1.0	[0.4 - 3.1]	15	-	-	79	82	79	75
Japan	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	-	-	-	-	-	98	98
Jordan	-	-	-	-	-	-	-	90	89	84	80
Kazakhstan	0.2	[0.1 - 0.3]	0.1	[<0.1 - 0.1]	29	-	-	90	88	89	88
Kenya	4.1	[3.0 - 5.4]	1.8	[1.3 - 2.4]	18	42,000	[27,000 - 56,000]	82	81	48	50
Kiribati	-	-	-	-	-	-	-	-	-	72	65
Kuwait	-	-	-	-	-	-	-	87	89	80	80
Kyrgyzstan	0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.2]	-	-	-	83	84	81	80
Lao People's Democratic Republic	0.2	[0.1 - 0.3]	0.1	[0.1 - 0.2]	28	-	-	81	84	33	39
Latvia	0.1	[0.1 - 0.2]	0.2	[0.1 - 0.2]	-	-	-	96 x	98 x	-	-
Lebanon	<0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.1]	-	-	-	89	91	79	71
Lesotho	14.2	[11.2 - 19.2]	5.4	[4.1 - 7.4]	18	9,400	[7,900 - 11,000]	74	71	31	20
Liberia	0.7	[0.2 - 1.2]	0.3	[0.1 - 0.5]	12	<1,000	[<100 - 1,500]	66 x	85 x	14 x	25 x
Libyan Arab Jamahiriya	-	-	-	-	-	-	-	-	-	-	-
Liechtenstein	-	-	-	-	-	-	-	92	87	81	85
Lithuania	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	-	-	-	91	93	92	91
Luxembourg	0.1	[<0.1 - 0.2]	0.1	[<0.1 - 0.4]	-	-	-	97	95	85	82
Madagascar	0.1	[<0.1 - 0.1]	0.1	[0.1 - 0.4]	19	<1,000	[<1,000 - 1,200]	99	98	24	23
Malawi	6.8	[5.3 - 9.2]	3.1	[2.3 - 4.2]	19	26,000	[18,000 - 33,000]	93	88	24	26
Malaysia	<0.1	[<0.1 - <0.1]	0.1	[0.1 - 0.2]	4	-	-	96	96	70	66
Maldives	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	-	-	-	95	97	71	68
Mali	0.5	[0.2 - 0.9]	0.2	[0.1 - 0.4]	14	1,600	[<200 - 3,200]	66	79	22	35
Malta	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - 0.1]	-	-	-	92	91	85	79
Marshall Islands	-	-	-	-	-	-	-	66	67	47	43
Mauritania	0.3	[0.1 - 0.5]	0.4	[0.2 - 1.4]	18	<500	[<500 - <1,000]	79	74	15	17
Mauritius	0.2	[0.1 - 0.3]	0.3	[0.2 - 0.4]	-	<200	[<100 - <500]	95	93	81	79
Mexico	0.1	[0.1 - 0.2]	0.2	[0.1 - 0.2]	14	-	-	98	98	74	71

TABLE 1: Demographic, epidemiology and education indicators for adolescents and young people

	DEMOGRAPHICS					EPIDEMIOLOGY							
	Population (thousands), 2009			Young people aged 10–24 as a % of total population	Type of epidemic	Estimated number of young people living with HIV, 2009							
	Total	Age 10–19	Age 15–24			Female 10–19	Low-high estimate	Male 10–19	Low-high estimate	Female 15–24	Low-high estimate	Male 15–24	Low-high estimate
Micronesia (Federated States of)	111	27	25	35	-	-	-	-	-	-	-	-	-
Monaco	33	-	-	-	-	-	-	-	-	-	-	-	-
Mongolia	2,671	530	596	31	L	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <500]
Montenegro	624	86	93	22	L	-	-	-	-	-	-	-	-
Morocco	31,993	6,277	6,414	30	L	<1,000	[<500 - 1,200]	<1,000	[<500 - 3,000]	2,000	[<1,000 - 3,500]	2,900	[1,100 - 9,900]
Mozambique	22,894	5,237	4,487	32	G	63,000	[51,000 - 88,000]	26,000	[20,000 - 36,000]	200,000	[160,000 - 280,000]	71,000	[55,000 - 100,000]
Myanmar	50,020	8,911	9,229	27	C	4,900	[4,100 - 5,700]	5,200	[4,400 - 6,100]	15,000	[13,000 - 18,000]	18,000	[15,000 - 21,000]
Namibia	2,171	507	470	33	G	3,800	[2,400 - 5,600]	2,300	[1,300 - 3,700]	14,000	[8,700 - 20,000]	5,300	[3,100 - 8,600]
Nauru	10	-	-	-	-	-	-	-	-	-	-	-	-
Nepal	29,331	6,821	6,059	33	C	1,600	[<1,000 - 2,600]	2,000	[<1,000 - 5,800]	3,900	[1,900 - 6,400]	5,500	[2,400 - 16,000]
Netherlands	16,592	2,019	2,022	18	-	<200	[<100 - <500]	<200	[<100 - <1,000]	<500	[<500 - 1,000]	<1,000	[<500 - 2,900]
New Zealand	4,266	616	626	22	-	<100	[<100 - <100]	<100	[<100 - <200]	<100	[<100 - <200]	<200	[<100 - <500]
Nicaragua	5,743	1,338	1,235	33	C	<200	[<200 - <500]	<500	[<200 - <500]	<1,000	[<500 - <1,000]	<1,000	[<1,000 - 1,100]
Niger	15,290	3,512	2,744	31	C	2,800	[2,100 - 3,700]	1,600	[1,200 - 2,100]	6,700	[6,500 - 6,800]	3,000	[3,000 - 3,100]
Nigeria	154,729	35,386	31,068	32	G	180,000	[150,000 - 250,000]	100,000	[76,000 - 130,000]	440,000	[360,000 - 600,000]	190,000	[140,000 - 250,000]
Niue	1	-	-	-	-	-	-	-	-	-	-	-	-
Norway	4,812	642	624	20	-	<100	[<100 - <100]	<100	[<100 - <200]	<100	[<100 - <200]	<200	[<100 - <1,000]
Occupied Palestinian Territory	4,277	1,023	847	33	-	-	-	-	-	-	-	-	-
Oman	2,845	592	587	31	L	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <200]	<200	[<200 - <200]
Pakistan	180,808	40,478	38,093	32	L	2,100	[<1,000 - 3,400]	3,200	[1,300 - 9,600]	7,200	[3,300 - 12,000]	12,000	[4,800 - 36,000]
Palau	20	-	-	-	-	-	-	-	-	-	-	-	-
Panama	3,454	631	602	27	C	<500	[<200 - <1,000]	<1,000	[<200 - 1,600]	<1,000	[<500 - 1,600]	1,300	[<1,000 - 4,200]
Papua New Guinea	6,732	1,522	1,307	32	G	1,300	[<1,000 - 1,900]	<1,000	[<500 - <1,000]	5,000	[3,600 - 7,200]	2,000	[1,300 - 2,900]
Paraguay	6,349	1,368	1,296	31	C	<500	[<200 - <500]	<500	[<200 - 1,200]	<1,000	[<500 - 1,300]	1,300	[<1,000 - 4,000]
Peru	29,165	5,822	5,596	29	C	1,100	[<1,000 - 1,700]	1,700	[1,100 - 2,500]	3,400	[2,200 - 5,100]	6,100	[3,900 - 9,000]
Philippines	91,983	19,735	18,433	31	L	<500	[<200 - <1,000]	<500	[<200 - 1,400]	<1,000	[<500 - 1,700]	1,400	[<500 - 4,100]
Poland	38,074	4,622	5,535	20	C	<200	[<100 - <500]	<500	[<100 - <1,000]	<1,000	[<500 - 1,300]	1,100	[<500 - 3,700]
Portugal	10,707	1,114	1,193	16	-	<500	[<200 - <1,000]	<500	[<200 - 1,500]	1,100	[<500 - 2,200]	1,900	[<1,000 - 6,300]
Qatar	1,409	155	262	23	-	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]
Republic of Korea	48,333	6,682	6,596	20	-	<200	[<100 - <500]	<500	[<100 - <1,000]	<1,000	[<500 - 1,100]	<1,000	[<500 - 3,400]
Republic of Moldova	3,604	535	667	25	C	<100	[<100 - <100]	<100	[<100 - <100]	<500	[<500 - <500]	<200	[<200 - <500]
Romania	21,275	2,392	2,966	19	L	<200	[<100 - <500]	<500	[<100 - <1,000]	<1,000	[<500 - 1,000]	<1,000	[<500 - 2,700]
Russian Federation	140,874	15,491	21,401	20	C	5,200	[4,200 - 6,200]	1,900	[1,500 - 2,300]	33,000	[27,000 - 40,000]	17,000	[14,000 - 21,000]
Rwanda	9,998	2,227	2,216	34	G	6,900	[4,800 - 8,500]	5,700	[3,900 - 7,000]	17,000	[12,000 - 21,000]	11,000	[7,400 - 13,000]
Saint Kitts and Nevis	52	-	-	-	-	-	-	-	-	-	-	-	-
Saint Lucia	172	33	34	29	-	-	-	-	-	-	-	-	-
Saint Vincent and the Grenadines	109	21	21	28	-	-	-	-	-	-	-	-	-
Samoa	179	47	39	36	-	-	-	-	-	-	-	-	-
San Marino	31	-	-	-	-	-	-	-	-	-	-	-	-
Sao Tome and Principe	163	39	35	34	-	-	-	-	-	-	-	-	-
Saudi Arabia	25,721	5,191	4,842	29	-	-	-	-	-	-	-	-	-
Senegal	12,534	3,008	2,620	34	C	2,900	[2,200 - 4,100]	1,300	[<1,000 - 1,800]	8,700	[6,500 - 12,000]	3,400	[2,400 - 4,800]
Serbia	9,850	1,246	1,383	20	L	<100	[<100 - <200]	<200	[<100 - <500]	<500	[<200 - <500]	<1,000	[<500 - 1,000]
Seychelles	84	-	-	-	-	-	-	-	-	-	-	-	-
Sierra Leone	5,696	1,258	1,100	31	G	2,100	[1,300 - 3,600]	<1,000	[<500 - 1,300]	7,600	[4,700 - 13,000]	2,800	[1,700 - 4,900]
Singapore	4,737	688	664	21	-	<100	[<100 - <100]	<100	[<100 - <500]	<200	[<100 - <500]	<200	[<100 - <1,000]
Slovakia	5,406	674	796	20	L	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <200]
Slovenia	2,020	203	240	17	-	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <100]	<100	[<100 - <200]
Solomon Islands	523	119	105	32	-	-	-	-	-	-	-	-	-
Somalia	9,133	2,027	1,689	31	C	2,000	[1,400 - 3,300]	1,100	[<1,000 - 1,800]	5,500	[3,800 - 9,200]	3,600	[2,400 - 6,000]
South Africa	50,110	9,985	10,074	30	G	210,000	[190,000 - 230,000]	82,000	[74,000 - 92,000]	700,000	[630,000 - 770,000]	230,000	[210,000 - 260,000]
Spain	44,904	4,259	4,803	15	-	<1,000	[<500 - <1,000]	1,300	[1,000 - 1,600]	1,800	[1,400 - 2,200]	4,400	[3,500 - 5,500]
Sri Lanka	20,238	3,063	3,378	24	L	<100	[<100 - <200]	<100	[<100 - <200]	<200	[<200 - <500]	<500	[<500 - <1,000]
Sudan	42,272	9,738	8,557	32	G	19,000	[14,000 - 28,000]	6,700	[4,900 - 9,900]	54,000	[39,000 - 78,000]	22,000	[16,000 - 32,000]
Suriname	520	94	90	27	C	<100	[<100 - <200]	<100	[<100 - <500]	<200	[<100 - <500]	<500	[<100 - <1,000]
Swaziland	1,185	309	295	38	G	7,400	[5,900 - 10,000]	3,600	[2,700 - 4,900]	23,000	[18,000 - 31,000]	9,500	[7,100 - 13,000]

	EPIDEMIOLOGY							EDUCATION			
	HIV prevalence (%) among young people aged 15–24, 2009				Young people (aged 15–24) living with HIV as a % of adults (15+) living with HIV, 2009	Number of new infections among young people aged 15–24, 2009		Primary school net enrolment ratio 2005–2009*		Secondary school net enrolment ratio 2005–2009*	
	Female 15–24	Low-high estimate	Male 15–24	Low-high estimate		Estimate	Low-high estimate	Female	Male	Female	Male
Micronesia (Federated States of)	-	-	-	-	-	-	-	-	-	-	-
Monaco	-	-	-	-	-	-	-	-	-	-	-
Mongolia	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - 0.1]	-	-	-	88	89	85	79
Montenegro	-	-	-	-	-	-	-	-	-	-	-
Morocco	0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.3]	20	-	-	87	92	32 x	37 x
Mozambique	8.6	[7.0 - 12.1]	3.1	[2.4 - 4.4]	23	49,000	[41,000 - 56,000]	77	82	6	6
Myanmar	0.3	[0.2 - 0.3]	0.3	[0.3 - 0.4]	14	-	-	-	-	50	49
Namibia	5.8	[3.7 - 8.6]	2.3	[1.3 - 3.6]	12	2,000	[<500 - 4,400]	91	87	60	49
Nauru	-	-	-	-	-	-	-	73	72	-	-
Nepal	0.1	[0.1 - 0.2]	0.2	[0.1 - 0.6]	16	-	-	64 x	78 x	-	-
Netherlands	<0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.3]	5	-	-	98	99	89	88
New Zealand	<0.1	[<0.1 - 0.1]	<0.1	[<0.1 - 0.1]	-	-	-	100	99	92 x	90 x
Nicaragua	0.1	[0.1 - 0.1]	0.1	[0.1 - 0.2]	19	-	-	92	92	48	42
Niger	0.5	[0.5 - 0.5]	0.2	[0.2 - 0.2]	18	2,100	[1,400 - 2,800]	48	60	7	11
Nigeria	2.9	[2.3 - 3.9]	1.2	[0.9 - 1.6]	22	120,000	[110,000 - 140,000]	58	64	22	29
Niue	-	-	-	-	-	-	-	98 x	99 x	96 x	91 x
Norway	<0.1	[<0.1 - 0.1]	<0.1	[<0.1 - 0.2]	-	-	-	99	99	96	96
Occupied Palestinian Territory	-	-	-	-	-	-	-	75	75	90	85
Oman	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	-	-	-	69	67	78	79
Pakistan	<0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.2]	20	-	-	60	72	28	37
Palau	-	-	-	-	-	-	-	94 x	98 x	-	-
Panama	0.3	[0.1 - 0.5]	0.4	[0.2 - 1.3]	11	-	-	98	99	69	63
Papua New Guinea	0.8	[0.6 - 1.2]	0.3	[0.2 - 0.5]	23	-	-	-	-	-	-
Paraguay	0.1	[0.1 - 0.2]	0.2	[0.1 - 0.6]	18	-	-	90	90	60	57
Peru	0.1	[0.1 - 0.2]	0.2	[0.1 - 0.3]	13	-	-	95	94	75	75
Philippines	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	26	-	-	93	91	66	55
Poland	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - 0.1]	7	-	-	96	95	95	93
Portugal	0.2	[0.1 - 0.4]	0.3	[0.1 - 0.9]	7	-	-	98	99	92	84
Qatar	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	-	-	-	94 x	95 x	98	67
Republic of Korea	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - 0.1]	17	-	-	98	100	94	97
Republic of Moldova	0.1	[0.1 - 0.1]	0.1	[<0.1 - 0.1]	-	-	-	87	88	85	82
Romania	<0.1	[<0.1 - 0.1]	0.1	[<0.1 - 0.2]	9	-	-	90	91	72	74
Russian Federation	0.3	[0.3 - 0.4]	0.2	[0.1 - 0.2]	-	-	-	-	-	-	-
Rwanda	1.9	[1.3 - 2.3]	1.3	[0.9 - 1.6]	20	3,700	[1,400 - 6,600]	97	95	-	-
Saint Kitts and Nevis	-	-	-	-	-	-	-	96	91	85	87
Saint Lucia	-	-	-	-	-	-	-	91	92	82	77
Saint Vincent and the Grenadines	-	-	-	-	-	-	-	92	97	95	85
Samoa	-	-	-	-	-	-	-	93	93	75	66
San Marino	-	-	-	-	-	-	-	-	-	-	-
Sao Tome and Principe	-	-	-	-	-	-	-	97	95	40	36
Saudi Arabia	-	-	-	-	-	-	-	84	85	76	70
Senegal	0.7	[0.5 - 1]	0.3	[0.2 - 0.4]	22	2,200	[1,400 - 2,900]	74	72	22	28
Serbia	0.1	[<0.1 - 0.1]	0.1	[0.1 - 0.2]	-	-	-	95	95	89	87
Seychelles	-	-	-	-	-	-	-	100 x	99 x	-	-
Sierra Leone	1.5	[0.9 - 2.5]	0.6	[0.3 - 1]	22	1,800	[1,000 - 4,300]	-	-	20	30
Singapore	<0.1	[<0.1 - 0.1]	<0.1	[<0.1 - 0.2]	-	-	-	-	-	-	-
Slovakia	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	-	-	-	-	-	-	-
Slovenia	<0.1	[<0.1 - 0.1]	<0.1	[<0.1 - 0.1]	-	-	-	97	97	92	91
Solomon Islands	-	-	-	-	-	-	-	67	67	29	32
Somalia	0.6	[0.4 - 1.1]	0.4	[0.3 - 0.7]	28	-	-	-	-	-	-
South Africa	13.6	[12.3 - 15.0]	4.5	[4.1 - 5]	18	160,000	[140,000 - 190,000]	88	87	74	70
Spain	0.1	[0.1 - 0.1]	0.2	[0.1 - 0.2]	5	-	-	100	100	97	93
Sri Lanka	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	-	-	-	100	99	-	-
Sudan	1.3	[0.9 - 1.8]	0.5	[0.4 - 0.7]	30	-	-	36 x	43 x	-	-
Suriname	0.4	[0.2 - 0.7]	0.6	[0.2 - 2.0]	-	-	-	90	91	74	55
Swaziland	15.6	[12.6 - 21.3]	6.5	[4.8 - 8.8]	19	5,600	[4,600 - 6,600]	84	82	26	31

TABLE 1: Demographic, epidemiology and education indicators for adolescents and young people

	DEMOGRAPHICS					EPIDEMIOLOGY							
	Population (thousands), 2009			Young people aged 10–24 as a % of total population	Type of epidemic	Estimated number of young people living with HIV, 2009							
	Total	Age 10–19	Age 15–24			Female 10–19	Low-high estimate	Male 10–19	Low-high estimate	Female 15–24	Low-high estimate	Male 15–24	Low-high estimate
Sweden	9,249	1,138	1,228	19	-	<100	[<100 - <200]	<100	[<100 - <500]	<200	[<100 - <500]	<500	[<100 - <1,000]
Switzerland	7,568	873	913	18	-	<200	[<100 - <500]	<500	[<100 - <1,000]	<1,000	[<500 - <1,000]	<1,000	[<500 - 2,700]
Syrian Arab Republic	21,906	4,501	4,616	31	L	-	-	-	-	-	-	-	-
Tajikistan	6,952	1,699	1,619	36	L	<100	[<100 - <100]	<100	[<100 - <100]	<500	[<200 - <500]	<500	[<500 - <1,000]
Thailand	67,764	10,375	10,741	23	C	11,000	[8,500 - 14,000]	9,000	[7,200 - 11,000]	30,000	[22,000 - 38,000]	24,000	[19,000 - 29,000]
The former Yugoslav Republic of Macedonia	2,042	292	314	22	L	-	-	-	-	-	-	-	-
Timor-Leste	1,134	282	232	34	L	-	-	-	-	-	-	-	-
Togo	6,619	1,521	1,364	33	G	5,600	[4,000 - 7,900]	2,800	[1,900 - 3,900]	15,000	[11,000 - 21,000]	6,100	[4,200 - 8,500]
Tonga	104	23	19	30	-	-	-	-	-	-	-	-	-
Trinidad and Tobago	1,339	204	249	26	-	<500	[<200 - <1,000]	<500	[<200 - 1,200]	<1,000	[<500 - 1600]	1,300	[<1,000 - 4,300]
Tunisia	10,272	1,815	2,030	28	L	<100	[<100 - <200]	<100	[<100 - <500]	<500	[<100 - <500]	<500	[<200 - <1,000]
Turkey	74,816	13,663	13,282	27	L	<200	[<100 - <200]	<200	[<100 - <500]	<500	[<200 - <1,000]	<1,000	[<500 - 1,600]
Turkmenistan	5,110	1,065	1,115	31	L	-	-	-	-	-	-	-	-
Tuvalu	10	-	-	-	-	-	-	-	-	-	-	-	-
Uganda	32,710	8,077	6,686	34	G	78,000	[63,000 - 100,000]	49,000	[38,000 - 61,000]	170,000	[140,000 - 220,000]	79,000	[61,000 - 98,000]
Ukraine	45,708	5,163	6,641	19	C	1,800	[1,400 - 2,200]	<1,000	[<1,000 - <1,000]	10,000	[8,100 - 13,000]	5,300	[4,100 - 6,800]
United Arab Emirates	4,599	501	570	18	-	-	-	-	-	-	-	-	-
United Kingdom	61,565	7,627	8,128	19	-	<1,000	[<500 - 1,700]	1,400	[<1,000 - 5,200]	4,100	[1,800 - 7,000]	6,400	[2,400 - 23,000]
United Republic of Tanzania	43,739	10,009	8,695	32	G	76,000	[61,000 - 100,000]	47,000	[36,000 - 61,000]	170,000	[140,000 - 230,000]	76,000	[58,000 - 99,000]
United States	314,659	43,532	44,620	21	-	11,000	[6,500 - 21,000]	17,000	[9,700 - 31,000]	40,000	[23,000 - 73,000]	66,000	[37,000 - 120,000]
Uruguay	3,361	529	512	23	C	<200	[<100 - <500]	<500	[<100 - <1,000]	<1,000	[<500 - <1,000]	<1,000	[<500 - 2,600]
Uzbekistan	27,488	6,092	6,189	33	C	<200	[<200 - <500]	<200	[<100 - <500]	1,000	[<1,000 - 1,900]	1,400	[<1,000 - 2,500]
Vanuatu	240	54	49	32	-	-	-	-	-	-	-	-	-
Venezuela (Bolivarian Republic of)	28,583	5,487	5,387	29	C	-	-	-	-	-	-	-	-
Viet Nam	88,069	17,182	17,256	29	C	1,100	[<1,000 - 1,700]	<1,000	[<1,000 - 1,400]	5,900	[3,900 - 8,800]	7,500	[5,300 - 11,000]
Yemen	23,580	5,964	5,208	35	L	-	-	-	-	-	-	-	-
Zambia	12,935	3,088	2,612	33	G	49,000	[40,000 - 66,000]	31,000	[24,000 - 41,000]	120,000	[94,000 - 160,000]	55,000	[42,000 - 72,000]
Zimbabwe	12,523	3,314	3,167	38	G	60,000	[47,000 - 82,000]	44,000	[34,000 - 60,000]	110,000	[86,000 - 150,000]	52,000	[40,000 - 71,000]
SUMMARY INDICATORS													
Africa	1,008,354	227,318	204,896	32		1,100,000	[970,000 - 1,400,000]	620,000	[520,000 - 760,000]	2,800,000	[2,400,000 - 3,500,000]	1,200,000	[960,000 - 1,400,000]
Sub-Saharan Africa	841,775	194,803	170,807	33		1,100,000	[970,000 - 1,400,000]	620,000	[520,000 - 760,000]	2,800,000	[2,400,000 - 3,400,000]	1,100,000	[960,000 - 1,400,000]
Eastern and Southern Africa	392,853	91,042	80,622	33		760,000	[670,000 - 910,000]	430,000	[370,000 - 510,000]	1,900,000	[1,700,000 - 2,300,000]	780,000	[670,000 - 930,000]
West and Central Africa	405,786	93,824	81,440	32		330,000	[270,000 - 440,000]	190,000	[140,000 - 240,000]	800,000	[640,000 - 1,100,000]	340,000	[260,000 - 450,000]
Middle East and North Africa	413,313	83,589	85,564	31		22,000	[17,000 - 30,000]	9,700	[7,800 - 12,000]	62,000	[48,000 - 84,000]	32,000	[26,000 - 41,000]
Asia	3,632,042	663,166	669,258	27		77,000	[60,000 - 75,000]	78,000	[62,000 - 83,000]	210,000	[190,000 - 230,000]	240,000	[210,000 - 290,000]
South Asia	1,619,757	334,645	317,763	30		50,000	[44,000 - 57,000]	54,000	[47,000 - 66,000]	150,000	[130,000 - 170,000]	170,000	[150,000 - 210,000]
East Asia and the Pacific	2,012,285	328,521	351,494	25		27,000	[15,000 - 30,000]	23,000	[14,000 - 34,000]	83,000	[49,000 - 107,000]	100,000	[56,000 - 128,000]
Latin America and the Caribbean	576,790	107,678	104,362	28		44,000	[34,000 - 55,000]	44,000	[31,000 - 82,000]	120,000	[94,000 - 150,000]	130,000	[91,000 - 240,000]
CEE/CIS	404,153	57,595	66,998	23		9,000	[7,700 - 10,000]	3,900	[3,400 - 4,500]	52,000	[44,000 - 59,000]	29,000	[25,000 - 33,000]
Industrialized countries	988,390	117,594	124,411	18		18,000	[12,000 - 26,000]	27,000	[19,000 - 42,000]	62,000	[43,000 - 92,000]	100,000	[72,000 - 160,000]
Developing countries	5,580,485	1,069,532	1,051,938	28		1,200,000	[1,100,000 - 1,500,000]	750,000	[640,000 - 860,000]	3,100,000	[2,800,000 - 3,800,000]	1,500,000	[1,300,000 - 1,800,000]
Least developed countries	835,486	190,214	169,214	32		500,000	[410,000 - 650,000]	300,000	[250,000 - 380,000]	1,200,000	[980,000 - 1,600,000]	540,000	[440,000 - 680,000]
World	6,813,327	1,214,488	1,212,656	27		1,300,000	[1,100,000 - 1,500,000]	780,000	[670,000 - 900,000]	3,200,000	[2,900,000 - 3,900,000]	1,700,000	[1,400,000 - 1,900,000]

DEFINITIONS OF THE INDICATORS

Type of epidemic: HIV epidemics are categorized as low level (L), concentrated (C) and generalized (G). For further information, see page 60.

Estimated number of young people living with HIV: Estimated number of young people (aged 10–19 and 15–24) living with HIV as of 2009.

HIV prevalence among young people: Percentage of young men and women (aged 15–24) living with HIV as of 2009.

Number of new infections among young people: Estimated number of new HIV infections among young people (aged 15–24) as of 2009.

Primary school net enrolment ratio: Number of children enrolled in primary school who are of official primary school age, expressed as a percentage of the total number of children of official primary school age.

Secondary school net enrolment ratio: Number of children enrolled in secondary school who are of official secondary school age, expressed as a percentage of the total number of children of official secondary school age.

	EPIDEMIOLOGY							EDUCATION			
	HIV prevalence (%) among young people aged 15–24, 2009				Young people (aged 15–24) living with HIV as a % of adults (15+) living with HIV, 2009	Number of new infections among young people aged 15–24, 2009		Primary school net enrolment ratio 2005–2009*		Secondary school net enrolment ratio 2005–2009*	
	Female 15–24	Low-high estimate	Male 15–24	Low-high estimate		Estimate	Low-high estimate	Female	Male	Female	Male
Sweden	<0.1	[<0.1 - 0.1]	<0.1	[<0.1 - 0.2]	-	-	-	94	95	99	99
Switzerland	0.1	[0.1 - 0.2]	0.2	[0.1 - 0.6]	8	-	-	94	94	83	87
Syrian Arab Republic	-	-	-	-	-	-	-	92 x	97 x	67	68
Tajikistan	<0.1	[<0.1 - 0.1]	<0.1	[<0.1 - 0.1]	-	-	-	95	99	77	88
Thailand	-	[0.4 - 0.7]	-	[0.4 - 0.5]	10	-	-	89	91	77	68
The former Yugoslav Republic of Macedonia	-	-	-	-	-	-	-	87	86	81	82
Timor-Leste	-	-	-	-	-	-	-	74	77	33	30
Togo	2.2	[1.5 - 3.1]	0.9	[0.6 - 1.2]	19	4,000	[2,300 - 5,800]	89	98	15 x	30 x
Tonga	-	-	-	-	-	-	-	-	-	74	60
Trinidad and Tobago	0.7	[0.3 - 1.2]	1.0	[0.4 - 3.3]	16	-	-	91	92	76	71
Tunisia	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - 0.1]	-	-	-	98	97	76	67
Turkey	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - <0.1]	-	-	-	94	96	70	77
Turkmenistan	-	-	-	-	-	-	-	-	-	-	-
Tuvalu	-	-	-	-	-	-	-	-	-	-	-
Uganda	4.8	[4 - 6.4]	2.3	[1.8 - 2.8]	24	46,000	[38,000 - 53,000]	98	96	21	22
Ukraine	0.3	[0.2 - 0.4]	0.2	[0.1 - 0.2]	5	-	-	89	89	85	84
United Arab Emirates	-	-	-	-	-	-	-	91	92	85	83
United Kingdom	0.1	[<0.1 - 0.2]	0.2	[0.1 - 0.6]	12	-	-	100	99	95	92
United Republic of Tanzania	3.9	[3.1 - 5.3]	1.7	[1.3 - 2.3]	21	40,000	[31,000 - 52,000]	99	100	5 x	5 x
United States	0.2	[0.1 - 0.3]	0.3	[0.2 - 0.5]	9	-	-	93	91	89	88
Uruguay	0.2	[0.1 - 0.3]	0.3	[0.1 - 1]	14	-	-	98	97	71	64
Uzbekistan	<0.1	[<0.1 - 0.1]	<0.1	[<0.1 - 0.1]	9	-	-	87	89	90	92
Vanuatu	-	-	-	-	-	-	-	96	98	35 x	41 x
Venezuela (Bolivarian Republic of)	-	-	-	-	-	-	-	90	90	74	66
Viet Nam	0.1	[<0.1 - 0.1]	0.1	[0.1 - 0.1]	5	-	-	91 x	96 x	-	-
Yemen	-	-	-	-	-	-	-	66	79	26	49
Zambia	8.9	[7.3 - 12.0]	4.2	[3.2 - 5.5]	20	27,000	[22,000 - 32,000]	96	95	39	47
Zimbabwe	6.9	[5.3 - 9.3]	3.3	[2.5 - 4.4]	16	22,000	[14,000 - 31,000]	91	89	37	39
SUMMARY INDICATORS											
Africa	2.7	[2.4 - 3.4]	1.1	[0.9 - 1.4]	19	700,000	[630,000 - 780,000]	79	83	29	33
Sub-Saharan Africa	3.3	[2.8 - 4.0]	1.3	[1.1 - 1.6]	19	700,000	[620,000 - 780,000]	77	81	28	32
Eastern and Southern Africa	4.8	[4.2 - 5.7]	1.9	[1.7 - 2.3]	18	460,000	[400,000 - 520,000]	87	88	33	35
West and Central Africa	2.0	[1.6 - 2.6]	0.8	[0.6 - 1.1]	20	210,000	[190,000 - 250,000]	64	71	22	29
Middle East and North Africa	0.2	[0.2 - 0.3]	0.1	[0.1 - 0.1]	23	26,000	[20,000 - 32,000]	86	91	62	66
Asia	0.1	[0.1 - 0.1]	0.1	[0.1 - 0.1]	11	90,000	[73,000 - 110,000]	89	92	-	-
South Asia	0.1	[0.1 - 0.1]	0.1	[0.1 - 0.1]	13	51,000	[43,000 - 61,000]	83	88	-	-
East Asia and the Pacific	<0.1	[<0.1 - <0.1]	<0.1	[<0.1 - 0.1]	8	39,000	[28,000 - 50,000]	97	98	67 **	65 **
Latin America and the Caribbean	0.2	[0.2 - 0.3]	0.2	[0.2 - 0.5]	14	44,000	[36,000 - 57,000]	94	95	77	72
CEE/CIS	0.2	[0.1 - 0.2]	0.1	[0.1 - 0.1]	6	22,000	[17,000 - 26,000]	92	93	81	82
Industrialized countries	0.1	[0.1 - 0.2]	0.2	[0.1 - 0.3]	8	31,000	[21,000 - 48,000]	95	95	92	91
Developing countries	0.6	[0.6 - 0.8]	0.3	[0.3 - 0.3]	17	840,000	[770,000 - 920,000]	87	90	53 **	54 **
Least developed countries	1.5	[1.2 - 2.0]	0.7	[0.5 - 0.8]	20	300,000	[260,000 - 370,000]	81	85	29	33
World	0.6	[0.5 - 0.7]	0.3	[0.2 - 0.3]	16	890,000	[810,000 - 970,000]	88	91	60 **	61 **

MAIN DATA SOURCES

Type of epidemic: WHO, UNAIDS and UNICEF, *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector – Progress Report 2010.*

Estimated number of young people living with HIV: UNAIDS, *UNAIDS Report on the Global AIDS Epidemic 2010*.

HIV prevalence among young people: UNAIDS, *UNAIDS Report on the Global AIDS Epidemic 2010.*

Estimated number of new HIV infections among young people: UNAIDS estimates, 2010.

Total population: United Nations Population Division.

Primary and secondary school net enrolment: UNESCO Institute for Statistics.

NOTES

– Data not available.

* Data refer to the most recent year available during the period specified in the column heading.

** Excludes China.

x Data refer to years or periods other than those specified in the column heading, differ from the standard definition or refer to only part of a country. Such data are not included in the calculation of regional and global averages.

y Data differ from the standard definition or refer to only part of a country. Such data are included in the calculation of regional and global averages.

TABLE 2: Knowledge, sexual behaviour, access and testing indicators for young people

	KNOWLEDGE		SEXUAL BEHAVIOUR					
	% young people (15–24) who have comprehensive knowledge of HIV, 2005–2010*		% of young people (15–24) who had sex with more than one partner in the last 12 months (2005–2010)*		% of young people (15–24) with multiple partners who used a condom at last sex (2005–2010)*		Median age at first sex among young people aged 20–24 (2005–2010)*	
	Female	Male	Female	Male	Female	Male	Female	Male
Afghanistan	-	-	-	-	-	-	-	-
Albania	36	22	<1	6	-	55	-	20
Algeria	13	-	-	-	-	-	-	-
Andorra	-	-	-	-	-	-	-	-
Angola	-	-	-	-	-	-	-	-
Antigua and Barbuda	-	-	-	-	-	-	-	-
Argentina	-	-	-	-	-	-	-	-
Armenia	23	15	0	13	-	79	-	19
Australia	-	-	-	-	-	-	-	-
Austria	-	-	-	-	-	-	-	-
Azerbaijan	5	5	0	9	-	29	-	-
Bahamas	-	-	-	-	-	-	-	-
Bahrain	-	-	-	-	-	-	-	-
Bangladesh	15	-	-	-	-	-	-	-
Barbados	-	-	-	-	-	-	-	-
Belarus	34	-	-	-	-	-	-	-
Belgium	-	-	-	-	-	-	-	-
Belize	40	-	1	-	-	-	-	-
Benin	16	35	1	10	27	45	18	18
Bhutan	-	-	-	-	-	-	-	-
Bolivia (Plurinational State of)	24	28	-	14	-	41	19	17
Bosnia and Herzegovina	44	-	-	-	-	-	-	-
Botswana	-	-	-	-	-	-	-	-
Brazil	-	-	-	-	-	-	16	-
Brunei Darussalam	-	-	-	-	-	-	-	-
Bulgaria	17	15	-	-	-	-	-	-
Burkina Faso	19	-	1	-	71 x	-	-	-
Burundi	30	-	1	-	-	-	-	-
Cambodia	50	45	<1	1	-	75	-	-
Cameroon	32	-	5	-	68	-	-	-
Canada	-	-	-	-	-	-	-	-
Cape Verde	36	36	4	33	64	80	17	17
Central African Republic	17	26	6	21	59	73	-	-
Chad	-	-	-	-	-	-	-	-
Chile	-	-	-	-	-	-	-	-
China	-	-	-	-	-	-	-	-
Colombia	24	-	6	-	39	-	17	-
Comoros	-	-	-	-	-	-	-	-
Congo	8	22	9	21	26	40	17	16
Cook Islands	-	-	-	-	-	-	-	-
Costa Rica	-	-	-	-	-	-	-	-
Côte d'Ivoire	18	28	5	20	45	62	17	18
Croatia	-	-	-	-	-	-	-	-
Cuba	52	-	-	-	-	-	-	-
Cyprus	-	-	-	-	-	-	-	-
Czech Republic	-	-	-	-	-	-	-	-
Democratic People's Republic of Korea	-	-	-	-	-	-	-	-
Democratic Republic of the Congo	15	21	3	14	9	22	17	18
Denmark	-	-	-	-	-	-	-	-
Djibouti	18	-	-	-	-	-	-	-
Dominica	-	-	-	-	-	-	-	-
Dominican Republic	41	34	5	23	34	62	18	16
Ecuador	-	-	-	-	-	-	-	-
Egypt	5	18	-	-	-	-	-	-
El Salvador	27	-	-	-	-	-	-	-
Equatorial Guinea	-	-	-	-	-	-	-	-

	% of young people who had sex before age 15 (2005–2010)*				ACCESS			TESTING			
					Antenatal care coverage among young women aged <20 (%), 2005–2009*	% of young people (15–24) who know a source of condoms (2005–2010)*		% of young people (15–24) who know a place to get tested (2005–2010)*		% of young people (15–24) who were tested and received results (2005–2010)*	
	Female 15–19	Male 15–19	Female 20–24	Male 20–24		Female	Male	Female	Male	Female	Male
Afghanistan	-	-	-	-	-	-	-	-	-	-	-
Albania	1	1	<1	1	97	79	88	26	37	1	2
Algeria	-	-	-	-	82 x	-	-	18	-	<1	-
Andorra	-	-	-	-	-	-	-	-	-	-	-
Angola	-	-	-	-	83	-	-	-	-	-	-
Antigua and Barbuda	-	-	-	-	-	-	-	-	-	-	-
Argentina	-	-	-	-	-	-	-	-	-	-	-
Armenia	<1	3	<1	3	90	69	62	-	-	-	-
Australia	-	-	-	-	-	-	-	-	-	-	-
Austria	-	-	-	-	-	-	-	-	-	-	-
Azerbaijan	<1	1	1	1	69	33	60	28	22	-	-
Bahamas	-	-	-	-	-	-	-	-	-	-	-
Bahrain	-	-	-	-	-	-	-	-	-	-	-
Bangladesh	-	-	-	1	55	-	-	-	-	-	-
Barbados	-	-	-	-	-	-	-	-	-	-	-
Belarus	-	-	-	-	-	-	-	95	-	41	-
Belgium	-	-	-	-	-	-	-	-	-	-	-
Belize	-	-	-	-	93 x	-	-	80	-	34	-
Benin	13	13	12	13	81	38	77	39	45	13	8
Bhutan	-	-	-	-	90	-	-	-	-	-	-
Bolivia (Plurinational State of)	7	10	7	15	87	70	84	-	40	-	5
Bosnia and Herzegovina	1	-	-	-	-	-	-	65	-	2	-
Botswana	-	-	-	-	90	-	-	-	-	-	-
Brazil	33	-	28	-	-	-	-	-	-	-	-
Brunei Darussalam	-	-	-	-	-	-	-	-	-	-	-
Bulgaria	-	-	-	-	-	-	-	-	-	-	-
Burkina Faso	6	-	-	-	89	-	-	41	-	12	-
Burundi	3	-	-	-	88	-	-	58	-	8	-
Cambodia	1	<1	1	<1	69	53	47	46	42	9	8
Cameroon	13	-	-	-	80	-	-	71	-	25	-
Canada	-	-	-	-	-	-	-	-	-	-	-
Cape Verde	11	32	13	23	98	-	-	-	-	-	-
Central African Republic	29	12	-	-	78	-	-	48	52	17	9
Chad	-	-	-	-	-	-	-	-	-	-	-
Chile	-	-	-	-	-	-	-	-	-	-	-
China	-	-	-	-	-	-	-	-	-	-	-
Colombia	14	-	14	-	93	95	-	74	-	33	-
Comoros	-	-	-	-	-	-	-	-	-	-	-
Congo	23	24	18	25	87	63	83	55	55	18	8
Cook Islands	-	-	-	-	-	-	-	-	-	-	-
Costa Rica	-	-	-	-	-	-	-	-	-	-	-
Côte d'Ivoire	20	17	18	14	87	60	87	-	-	7	4
Croatia	-	-	-	-	-	-	-	-	-	-	-
Cuba	-	-	-	-	-	-	-	89	-	43	-
Cyprus	-	-	-	-	-	-	-	-	-	-	-
Czech Republic	-	-	-	-	-	-	-	-	-	-	-
Democratic People's Republic of Korea	-	-	-	-	-	-	-	-	-	-	-
Democratic Republic of the Congo	18	18	19	17	85	37	61	34	40	6	5
Denmark	-	-	-	-	-	-	-	-	-	-	-
Djibouti	-	-	-	-	-	-	-	-	-	-	-
Dominica	-	-	-	-	-	-	-	-	-	-	-
Dominican Republic	14	21	16	27	99	90	-	91	75	40	17
Ecuador	-	-	-	-	-	-	-	-	-	-	-
Egypt	-	-	-	-	73	-	-	-	-	-	-
El Salvador	-	-	-	-	95	-	-	-	-	-	-
Equatorial Guinea	-	-	-	-	-	-	-	-	-	-	-

TABLE 2: Knowledge, sexual behaviour, access and testing indicators for young people (cont'd)

	KNOWLEDGE		SEXUAL BEHAVIOUR					
	% young people (15–24) who have comprehensive knowledge of HIV, 2005–2010*		% of young people (15–24) who had sex with more than one partner in the last 12 months (2005–2010)*		% of young people (15–24) with multiple partners who used a condom at last sex (2005–2010)*		Median age at first sex among young people aged 20–24 (2005–2010)*	
	Female	Male	Female	Male	Female	Male	Female	Male
Eritrea	-	-	-	-	-	-	-	-
Estonia	-	-	-	-	-	-	-	-
Ethiopia	20	33	<1	1	-	-	18	-
Fiji	-	-	-	-	-	-	-	-
Finland	-	-	-	-	-	-	-	-
France	-	-	-	-	-	-	-	-
Gabon	-	-	-	-	-	-	-	-
Gambia	39	-	1	-	64 x	-	-	-
Georgia	15	-	-	-	-	-	-	-
Germany	-	-	-	-	-	-	-	-
Ghana	28	34	2	6	43 x	61 x	19	20
Greece	-	-	-	-	-	-	-	-
Grenada	-	-	-	-	-	-	-	-
Guatemala	-	-	-	-	27 x	-	-	-
Guinea	17	23	2	19	28	39	16	18
Guinea-Bissau	18	-	6	-	58	-	-	-
Guyana	50	-	2	9	-	62	18	18
Haiti	34	40	2	20	23	51	18	15
Holy See	-	-	-	-	-	-	-	-
Honduras	30	-	1	-	27	-	18	-
Hungary	-	-	-	-	-	-	-	-
Iceland	-	-	-	-	-	-	-	-
India	20	36	<1	2	17 x	32	19	-
Indonesia	10 y	15 y	-	-	-	-	-	-
Iran (Islamic Republic of)	-	-	-	-	-	-	-	-
Iraq	3	-	-	-	-	-	-	-
Ireland	-	-	-	-	-	-	-	-
Israel	-	-	-	-	-	-	-	-
Italy	-	-	-	-	-	-	-	-
Jamaica	60	-	-	-	-	-	-	-
Japan	-	-	-	-	-	-	-	-
Jordan	13 y	-	-	-	-	-	-	-
Kazakhstan	22	-	-	-	-	-	-	-
Kenya	48	55	2	8	37	67	18	17
Kiribati	-	-	-	-	-	-	-	-
Kuwait	-	-	-	-	-	-	-	-
Kyrgyzstan	20	-	1	-	-	-	-	-
Lao People's Democratic Republic	-	-	-	-	-	-	-	-
Latvia	-	-	-	-	-	-	-	-
Lebanon	-	-	-	-	-	-	-	-
Lesotho	39	29	4	21	48	60	18	17
Liberia	21	27	7	15	16	28	16	18
Libyan Arab Jamahiriya	-	-	-	-	-	-	-	-
Liechtenstein	-	-	-	-	-	-	-	-
Lithuania	-	-	-	-	-	-	-	-
Luxembourg	-	-	-	-	-	-	-	-
Madagascar	23	26	3	18	3	4	17	18
Malawi	42	42	1	6	48	46	-	-
Malaysia	-	-	-	-	-	-	-	-
Maldives	35 y	-	-	-	-	-	-	-
Mali	18	22	2	6	8	28	16	-
Malta	-	-	-	-	-	-	-	-
Marshall Islands	27	39	5	10	9 x	23 x	18	17
Mauritania	5	14	-	-	-	-	-	-
Mauritius	-	-	-	-	-	-	-	-
Mexico	-	-	-	-	-	-	-	-

	% of young people who had sex before age 15 (2005–2010)*				ACCESS			TESTING			
					Antenatal care coverage among young women aged <20 (%), 2005–2009*	% of young people (15–24) who know a source of condoms (2005–2010)*		% of young people (15–24) who know a place to get tested (2005–2010)*		% of young people (15–24) who were tested and received results (2005–2010)*	
	Female 15–19	Male 15–19	Female 20–24	Male 20–24		Female	Male	Female	Male	Female	Male
Eritrea	-	-	-	-	-	-	-	-	-	-	-
Estonia	-	-	-	-	-	-	-	-	-	-	-
Ethiopia	11	2	22	2	27	34	56	-	-	5	5
Fiji	-	-	-	-	-	-	-	-	-	-	-
Finland	-	-	-	-	-	-	-	-	-	-	-
France	-	-	-	-	-	-	-	-	-	-	-
Gabon	-	-	-	-	-	-	-	-	-	-	-
Gambia	4	-	-	-	96	-	-	54	-	9	-
Georgia	-	-	-	-	99	-	-	22	-	7	-
Germany	-	-	-	-	-	-	-	-	-	-	-
Ghana	8	4	7	5	90	74	87	68	71	10	7
Greece	-	-	-	-	-	-	-	-	-	-	-
Grenada	-	-	-	-	-	-	-	-	-	-	-
Guatemala	29	29	28	32	93	-	-	-	-	-	-
Guinea	20	18	25	16	-	43	69	-	-	2	5
Guinea-Bissau	22	-	-	-	75	-	-	17	-	3	-
Guyana	8	11	10	16	92	80	91	81	-	25	-
Haiti	15	42	14	44	86	79	85	-	-	12	6
Holy See	-	-	-	-	-	-	-	-	-	-	-
Honduras	10	-	12	-	92	76	-	-	-	-	-
Hungary	-	-	-	-	-	-	-	-	-	-	-
Iceland	-	-	-	-	-	-	-	-	-	-	-
India	8	3	13	2	78	46	85	-	-	3	1
Indonesia	-	-	-	-	91	39 y	-	6 y	5 y	-	-
Iran (Islamic Republic of)	-	-	-	-	-	-	-	-	-	-	-
Iraq	-	-	-	-	87	-	-	5	-	1	-
Ireland	-	-	-	-	-	-	-	-	-	-	-
Israel	-	-	-	-	-	-	-	-	-	-	-
Italy	-	-	-	-	-	-	-	-	-	-	-
Jamaica	-	-	-	-	89	-	-	85	-	35	-
Japan	-	-	-	-	-	-	-	-	-	-	-
Jordan	-	-	-	-	98	69 y	-	-	-	-	-
Kazakhstan	-	-	-	-	100	-	-	74	-	38	-
Kenya	12	22	10	22	89	65	84	90	89	48	31
Kiribati	-	-	-	-	-	-	-	-	-	-	-
Kuwait	-	-	-	-	-	-	-	-	-	-	-
Kyrgyzstan	<1	-	-	-	100 x	-	-	52	-	18	-
Lao People's Democratic Republic	9	-	14	-	38	-	-	-	-	-	-
Latvia	-	-	-	-	-	-	-	-	-	-	-
Lebanon	-	-	-	-	-	-	-	-	-	-	-
Lesotho	9	26	7	18	92	72	77	89	74	58	26
Liberia	19	9	16	8	80	49	52	24	27	4	3
Libyan Arab Jamahiriya	-	-	-	-	-	-	-	-	-	-	-
Liechtenstein	-	-	-	-	-	-	-	-	-	-	-
Lithuania	-	-	-	-	-	-	-	-	-	-	-
Luxembourg	-	-	-	-	-	-	-	-	-	-	-
Madagascar	17	8	18	10	83	60	66	46	39	11	7
Malawi	14	16	-	-	92	-	-	87	89	22	18
Malaysia	-	-	-	-	-	-	-	-	-	-	-
Maldives	<1	-	<1	-	-	89 y	-	83 y	83 y	-	-
Mali	24	6	26	4	71	25	41	22	30	7	5
Malta	-	-	-	-	-	-	-	-	-	-	-
Marshall Islands	15	25	12	29	81	82	91	84	84	-	-
Mauritania	-	-	-	-	77	-	-	17	26	4	3
Mauritius	-	-	-	-	-	-	-	-	-	-	-
Mexico	17	11	4	4	-	-	-	-	-	-	-

TABLE 2: Knowledge, sexual behaviour, access and testing indicators for young people (cont'd)

	KNOWLEDGE		SEXUAL BEHAVIOUR					
	% young people (15–24) who have comprehensive knowledge of HIV, 2005–2010*		% of young people (15–24) who had sex with more than one partner in the last 12 months (2005–2010)*		% of young people (15–24) with multiple partners who used a condom at last sex (2005–2010)*		Median age at first sex among young people aged 20–24 (2005–2010)*	
	Female	Male	Female	Male	Female	Male	Female	Male
Micronesia (Federated States of)	-	-	-	-	-	-	-	-
Monaco	-	-	-	-	-	-	-	-
Mongolia	31	-	-	-	-	-	19	-
Montenegro	30	-	<1	-	-	-	-	-
Morocco	-	-	-	-	-	-	-	-
Mozambique	36	34	4	16	33	37	16	17
Myanmar	-	-	-	-	-	-	-	-
Namibia	65	62	2	11	74	82	18	17
Nauru	13	10	-	-	8 x	17 x	17	16
Nepal	28	44	<1	2	-	59 x	18	-
Netherlands	-	-	-	-	-	-	-	-
New Zealand	-	-	-	-	-	-	-	-
Nicaragua	-	-	-	-	-	-	18	-
Niger	13	16	<1	2	-	42 x	16	-
Nigeria	22	33	1	6	29	56	18	-
Niue	-	-	-	-	-	-	-	-
Norway	-	-	-	-	-	-	-	-
Occupied Palestinian Territory	-	-	-	-	-	-	-	-
Oman	-	-	-	-	-	-	-	-
Pakistan	3	-	-	-	-	-	-	-
Palau	-	-	-	-	-	-	-	-
Panama	-	-	-	-	-	-	-	-
Papua New Guinea	-	-	-	-	-	-	19	19
Paraguay	-	-	7	-	51	-	-	-
Peru	19	-	1	-	38 x	-	19	-
Philippines	21	-	-	-	-	-	-	-
Poland	-	-	-	-	-	-	-	-
Portugal	-	-	-	-	-	-	-	-
Qatar	-	-	-	-	-	-	-	-
Republic of Korea	-	-	-	-	-	-	-	-
Republic of Moldova	42 y	39 y	2	17	30	60	20	18
Romania	-	-	-	-	-	-	-	-
Russian Federation	-	-	-	-	-	-	-	-
Rwanda	51	54	<1	1	-	-	-	-
Saint Kitts and Nevis	-	-	-	-	-	-	-	-
Saint Lucia	-	-	-	-	-	-	-	-
Saint Vincent and the Grenadines	-	-	-	-	-	-	-	-
Samoa	3	6	-	-	-	-	-	-
San Marino	-	-	-	-	-	-	-	-
Sao Tome and Principe	43	43	2	12	-	59	18	18
Saudi Arabia	-	-	-	-	-	-	-	-
Senegal	19	24	1	6	33	64	20	19
Serbia	42	-	2	-	80 x	-	-	-
Seychelles	-	-	-	-	-	-	-	-
Sierra Leone	17	28	4	10	12	29	16	18
Singapore	-	-	-	-	-	-	-	-
Slovakia	-	-	-	-	-	-	-	-
Slovenia	-	-	-	-	-	-	-	-
Solomon Islands	29	35	-	-	18	39	18	18
Somalia	4	-	-	-	-	-	-	-
South Africa	-	-	-	-	-	-	-	-
Spain	-	-	-	-	-	-	-	-
Sri Lanka	-	-	-	-	-	-	-	-
Sudan	-	-	-	-	-	-	-	-
Suriname	41	-	3	-	80	-	-	-
Swaziland	52	52	2	10	51 x	67	18	19

	% of young people who had sex before age 15 (2005–2010)*				ACCESS			TESTING			
					Antenatal care coverage among young women aged <20 (%), 2005–2009*	% of young people (15–24) who know a source of condoms (2005–2010)*		% of young people (15–24) who know a place to get tested (2005–2010)*		% of young people (15–24) who were tested and received results (2005–2010)*	
	Female 15–19	Male 15–19	Female 20–24	Male 20–24		Female	Male	Female	Male	Female	Male
Micronesia (Federated States of)	-	-	-	-	-	-	-	-	-	-	-
Monaco	-	-	-	-	-	-	-	-	-	-	-
Mongolia	<1	-	1	-	99	-	-	50	-	10	-
Montenegro	<1	-	-	-	-	-	-	70	-	-	-
Morocco	-	-	-	-	-	-	-	-	-	-	-
Mozambique	23	27	27	22	94	62	74	76	71	36	15
Myanmar	-	-	-	-	71	-	-	-	-	-	-
Namibia	7	19	7	17	95	89	91	90	83	37	17
Nauru	15	35	15	28	-	59	70	35	45	8	5
Nepal	6	3	10	5	51	87	97	42	73	-	-
Netherlands	-	-	-	-	-	-	-	-	-	-	-
New Zealand	-	-	-	-	-	-	-	-	-	-	-
Nicaragua	13	-	15	-	90	-	-	-	-	-	-
Niger	26	5	34	5	46	9	28	-	-	2	2
Nigeria	15	6	16	5	43	37	68	45	59	9	7
Niue	-	-	-	-	-	-	-	-	-	-	-
Norway	-	-	-	-	-	-	-	-	-	-	-
Occupied Palestinian Territory	-	-	-	-	-	-	-	-	-	-	-
Oman	-	-	-	-	-	-	-	-	-	-	-
Pakistan	-	-	-	-	59	-	-	-	-	-	-
Palau	-	-	-	-	-	-	-	-	-	-	-
Panama	-	-	-	-	-	-	-	-	-	-	-
Papua New Guinea	4	4	5	4	79	-	-	-	-	-	-
Paraguay	7	-	8	-	-	-	-	-	-	-	-
Peru	6	-	7	-	92	-	-	-	-	-	-
Philippines	2	-	2	-	91	65	-	47	-	1	-
Poland	-	-	-	-	-	-	-	-	-	-	-
Portugal	-	-	-	-	-	-	-	-	-	-	-
Qatar	-	-	-	-	-	-	-	-	-	-	-
Republic of Korea	-	-	-	-	-	-	-	-	-	-	-
Republic of Moldova	1	9	1	8	99	90	97	-	-	23	21
Romania	-	-	-	-	-	-	-	-	-	-	-
Russian Federation	-	-	-	-	-	-	-	-	-	-	-
Rwanda	5	15	3	11	94	37	73	-	-	17	12
Saint Kitts and Nevis	-	-	-	-	-	-	-	-	-	-	-
Saint Lucia	-	-	-	-	-	-	-	-	-	-	-
Saint Vincent and the Grenadines	-	-	-	-	-	-	-	-	-	-	-
Samoa	-	-	-	-	-	-	46	31	42	2	1
San Marino	-	-	-	-	-	-	-	-	-	-	-
Sao Tome and Principe	10	12	8	13	99	83	92	84	80	49	21
Saudi Arabia	-	-	-	-	-	-	-	-	-	-	-
Senegal	9	13	10	12	86	46	69	-	-	2	2
Serbia	1	-	-	-	-	-	-	70	-	-	-
Seychelles	-	-	-	-	-	-	-	-	-	-	-
Sierra Leone	22	11	27	11	88	27	43	30	31	9	3
Singapore	-	-	-	-	-	-	-	-	-	-	-
Slovakia	-	-	-	-	-	-	-	-	-	-	-
Slovenia	-	-	-	-	-	-	-	-	-	-	-
Solomon Islands	15	16	10	8	69	46	81	-	-	-	-
Somalia	-	-	-	-	24	-	-	17	-	3	-
South Africa	-	-	-	-	-	-	-	-	-	-	-
Spain	-	-	-	-	-	-	-	-	-	-	-
Sri Lanka	-	-	-	-	99	-	-	-	-	-	-
Sudan	-	-	-	-	67	-	-	-	-	-	-
Suriname	9	-	-	-	88	-	-	81	-	27	-
Swaziland	7	5	6	5	86	85	88	87	70	28	7

TABLE 2: Knowledge, sexual behaviour, access and testing indicators for young people (cont'd)

	KNOWLEDGE		SEXUAL BEHAVIOUR					
	% young people (15–24) who have comprehensive knowledge of HIV, 2005–2010*		% of young people (15–24) who had sex with more than one partner in the last 12 months (2005–2010)*		% of young people (15–24) with multiple partners who used a condom at last sex (2005–2010)*		Median age at first sex among young people aged 20–24 (2005–2010)*	
	Female	Male	Female	Male	Female	Male	Female	Male
Sweden	-	-	-	-	-	-	-	-
Switzerland	-	-	-	-	-	-	-	-
Syrian Arab Republic	7	-	-	-	-	-	-	-
Tajikistan	2	-	-	-	-	-	-	-
Thailand	46	-	-	-	-	-	-	-
The former Yugoslav Republic of Macedonia	27	-	1	-	36 x	-	-	-
Timor-Leste	12	20	-	1	-	-	-	-
Togo	15	-	3	-	50	-	-	-
Tonga	-	-	-	-	-	-	-	-
Trinidad and Tobago	54	-	3	-	67	-	-	-
Tunisia	-	-	-	-	-	-	-	-
Turkey	-	-	-	-	-	-	-	-
Turkmenistan	5	-	-	-	-	-	-	-
Tuvalu	39	61	-	-	-	-	-	18
Uganda	32	38	2	9	39	45	17	18
Ukraine	45	43	3	16	63	64	19	18
United Arab Emirates	-	-	-	-	-	-	-	-
United Kingdom	-	-	-	-	-	-	-	-
United Republic of Tanzania	39	42	3	12	32	36	18	19
United States	-	-	-	-	-	-	-	-
Uruguay	-	-	-	-	-	-	-	-
Uzbekistan	31	-	<1	-	-	-	-	-
Vanuatu	15	-	-	-	-	-	-	-
Venezuela (Bolivarian Republic of)	-	-	-	-	-	-	-	-
Viet Nam	44	-	0	<1	-	-	-	-
Yemen	2 y	-	-	-	-	-	-	-
Zambia	38	41	1	5	42 x	43	17	18
Zimbabwe	53	-	1	7	38 x	59	19	20
SUMMARY INDICATORS								
Africa	24	31	2	8	32	47	18	-
Sub-Saharan Africa	26	33	2	8	32	47	18	-
Eastern and Southern Africa	34	40	2	8	34	45	18	-
West and Central Africa	20	28	2	9	31	48	18	-
Middle East and North Africa	-	-	-	-	-	-	-	-
Asia	19 **	33 **	<1 **	2 **	17 **	34 **	19 **	-
South Asia	17	36	<1	2	17	33	19	-
East Asia and the Pacific	24 **	-	-	-	-	-	-	-
Latin America and the Caribbean	-	-	-	-	-	-	17	-
CEE/CIS	-	-	-	-	-	-	-	-
Industrialized countries	-	-	-	-	-	-	-	-
Developing countries	20 **	33 **	1 **	-	-	-	18 **	-
Least developed countries	22	33	2	9	-	-	-	-
World	21 **	-	-	-	-	-	-	-

DEFINITIONS OF THE INDICATORS

Comprehensive knowledge of HIV: Percentage of young men and women (15–24) who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission and who know that a healthy-looking person can be HIV-positive

Sex with more than one partner in the last 12 months: Percentage of young men and women (15–24) who had sexual intercourse with more than one partner in the last 12 months.

Condom use with multiple partners: Percentage of young men and women (15–24) who had more than one partner in the past 12 months and who reported the use of a condom during their last sexual intercourse.

Median age at first sex: Median age at first sex among young people (20–24).

Sex before age 15: Percentage of young people (15–19 and 20–24) who say they had sex before age 15.

Antenatal care coverage: Percentage of women (<20 years old) attended at least once during pregnancy by skilled health personnel (doctors, nurses or midwives).

Know a source of condoms: Percentage of young people (15–24) who know a source of condoms.

Know a place to get tested: Percentage of young people (15–24) who know where to get an HIV test.

Have been tested and received results: Percentage of young people (15–24) who were tested and received results.

	% of young people who had sex before age 15 (2005–2010)*				ACCESS			TESTING			
					Antenatal care coverage among young women aged <20 (%), 2005–2009*	% of young people (15–24) who know a source of condoms (2005–2010)*		% of young people (15–24) who know a place to get tested (2005–2010)*		% of young people (15–24) who were tested and received results (2005–2010)*	
	Female 15–19	Male 15–19	Female 20–24	Male 20–24		Female	Male	Female	Male	Female	Male
Sweden	-	-	-	-	-	-	-	-	-	-	-
Switzerland	-	-	-	-	-	-	-	-	-	-	-
Syrian Arab Republic	-	-	-	-	91	-	-	-	-	-	-
Tajikistan	-	-	-	-	95	-	-	8	-	-	-
Thailand	-	-	-	-	97	-	-	-	-	-	-
The former Yugoslav Republic of Macedonia	1	-	-	-	-	-	-	53	-	-	-
Timor-Leste	1	1	3	<1	-	13	32	20	33	-	-
Togo	12	-	-	-	83	-	-	47	-	8	-
Tonga	-	-	-	-	-	-	-	-	-	-	-
Trinidad and Tobago	5	-	-	-	95 x	-	-	83	-	24	-
Tunisia	-	-	-	-	-	-	-	-	-	-	-
Turkey	-	-	-	-	92	-	-	-	-	-	-
Turkmenistan	-	-	-	-	100 x	-	-	-	-	-	-
Tuvalu	2	19	1	10	-	91	93	90	87	7	11
Uganda	12	14	20	10	95	70	90	81	85	21	12
Ukraine	1	3	1	1	97	96	98	73	77	32	18
United Arab Emirates	-	-	-	-	-	-	-	-	-	-	-
United Kingdom	-	-	-	-	-	-	-	-	-	-	-
United Republic of Tanzania	11	11	12	8	78	59	77	76	80	33	19
United States	-	-	-	-	-	-	-	-	-	-	-
Uruguay	-	-	-	-	-	-	-	-	-	-	-
Uzbekistan	-	-	-	-	99 x	-	-	46	-	23	-
Vanuatu	-	-	-	-	85	-	-	49	-	-	-
Venezuela (Bolivarian Republic of)	-	-	-	-	-	-	-	-	-	-	-
Viet Nam	1	<1	1	<1	77 x	56	57	71	-	4	-
Yemen	-	-	-	-	49	-	-	12 y	-	-	-
Zambia	7	9	6	7	94	76	81	91	89	30	14
Zimbabwe	5	5	6	4	93	70	73	73	69	21	12
SUMMARY INDICATORS											
Africa	14	11	17	9	69	47	69	55	-	14	10
Sub-Saharan Africa	14	11	17	9	69	47	69	57	63	15	10
Eastern and Southern Africa	12	11	16	10	71	55	72	75	78	22	14
West and Central Africa	16	10	17	9	66	40	66	44	53	9	6
Middle East and North Africa	-	-	-	-	74	-	-	-	-	-	-
Asia	7 **	3 **	11 **	2 **	76	48 **	83 **	-	-	3 **	1 **
South Asia	8	3	12	2	73	47	85	-	-	3	1
East Asia and the Pacific	-	-	-	-	86 **	49 **	-	31 **	-	-	-
Latin America and the Caribbean	22	-	17	-	-	-	-	-	-	-	-
CEE/CIS	-	-	-	-	94	-	-	-	-	-	-
Industrialized countries	-	-	-	-	-	-	-	-	-	-	-
Developing countries	11 **	6 **	13 **	4 **	76	49 **	-	-	-	8 **	-
Least developed countries	13	11	17	7	66	49	67	-	-	13	-
World	11 **	-	-	-	76	-	-	-	-	-	-

MAIN DATA SOURCES

All data in Table 2: UNICEF global databases, 2010.

NOTES

– Data not available.

x Based on small denominators (typically 25–49 unweighted cases).

y Data differ from the standard definition or refer to only part of a country. Such data are included in the calculation of regional and global averages.

* Data refer to the most recent year available during the period specified in the column heading.

** Excludes China.

TABLE 3: HIV and AIDS indicators for higher-risk young people

	EPIDEMIOLOGY			KNOWLEDGE		
	HIV prevalence (%) among higher-risk populations in capital city (<25 years), 2005–2009*			% of higher-risk populations (<25 years) with comprehensive knowledge of HIV, 2005–2009*		
	Injecting drug users	Sex workers	Men who have sex with men	Injecting drug users	Sex workers	Men who have sex with men
Afghanistan	7.6	0	-	30	1	-
Albania	-	-	0	0	-	-
Algeria	-	1.2	-	-	-	-
Andorra	-	-	-	-	-	-
Angola	-	18.2	-	-	64	-
Antigua and Barbuda	-	-	-	-	-	-
Argentina	-	-	-	-	-	-
Armenia	0	0	0	62	54	36
Australia	0	-	-	-	-	-
Austria	-	-	-	-	-	-
Azerbaijan	3.7	0	0	34	34	59
Bahamas	-	-	24	-	-	29
Bahrain	-	-	-	-	-	-
Bangladesh	0.2	0.2	0	30	29	23
Barbados	-	-	-	-	33	-
Belarus	3.9	2.9	0	52	72	74
Belgium	-	0.6	1.8	-	-	-
Belize	-	-	-	-	-	-
Benin	4.8	9.4	-	26	62	0
Bhutan	-	-	-	-	-	-
Bolivia (Plurinational State of)	-	-	-	-	41	53
Bosnia and Herzegovina	-	0	-	-	-	-
Botswana	-	-	-	-	-	-
Brazil	-	-	-	-	-	-
Brunei Darussalam	-	-	-	-	-	-
Bulgaria	8.1	0.7	4	31	37	34
Burkina Faso	-	9.8	-	-	-	-
Burundi	-	45.6	-	-	55	-
Cambodia	-	-	2.3	-	-	-
Cameroon	-	-	-	-	-	-
Canada	2.9	-	2.2	-	-	-
Cape Verde	0	-	-	-	-	-
Central African Republic	-	-	-	-	-	-
Chad	-	19.4	-	-	5	-
Chile	-	-	7.3	-	-	64
China	8.3	0.4	4.1	49	52	51
Colombia	-	0.5	9.5	-	25	-
Comoros	-	0	-	-	-	-
Congo	-	-	0	-	-	0
Cook Islands	-	-	-	-	-	-
Costa Rica	-	-	-	-	-	-
Côte d'Ivoire	-	-	-	-	29	-
Croatia	-	-	-	-	-	-
Cuba	-	-	0.9	-	61	65
Cyprus	-	-	-	-	-	-
Czech Republic	-	-	-	-	-	68
Democratic People's Republic of Korea	-	-	-	-	-	-
Democratic Republic of the Congo	-	-	-	-	29	-
Denmark	-	-	-	-	-	-
Djibouti	-	7.9	-	-	-	-
Dominica	-	-	-	-	-	-
Dominican Republic	-	-	-	-	-	-
Ecuador	-	-	-	-	47	61
Egypt	-	-	-	-	-	-
El Salvador	-	-	-	-	5	-
Equatorial Guinea	-	-	-	-	-	-
Eritrea	-	3	-	-	-	-

	SEXUAL BEHAVIOUR			ACCESS	TESTING		
	% of higher-risk populations (<25 years) using a condom at last sex, 2005–2009*			% of IDUs (<25 years) reporting the use of sterile injecting equipment the last time they injected, 2007–2009*	% of higher-risk populations (<25 years) who received an HIV test and knew the result, 2005–2009*		
	Injecting drug users	Sex workers	Men who have sex with men		Injecting drug users	Sex workers	Men who have sex with men
Afghanistan	43	60	-	95	25	4	-
Albania	-	-	-	-	-	-	-
Algeria	-	-	-	-	0	-	-
Andorra	-	-	-	-	-	-	-
Angola	-	77	-	-	-	33	-
Antigua and Barbuda	-	-	-	-	-	-	-
Argentina	65	-	91	-	45	-	-
Armenia	70	88	86	100	0	18	7
Australia	32	-	-	-	-	-	67
Austria	-	-	-	-	-	-	-
Azerbaijan	19	79	48	71	5	4	14
Bahamas	-	-	72	-	-	-	48
Bahrain	-	-	-	-	-	-	-
Bangladesh	40	62	18	30	5	4	2
Barbados	-	73	-	-	-	80	-
Belarus	51	67	70	83	52	81	78
Belgium	-	-	-	-	24	-	89
Belize	-	-	-	-	-	-	-
Benin	60	9	-	26	26	86	-
Bhutan	-	-	-	-	-	-	-
Bolivia (Plurinational State of)	-	88	67	-	-	41	36
Bosnia and Herzegovina	-	79	-	-	12	75	-
Botswana	-	-	-	-	-	-	-
Brazil	-	-	-	-	-	-	-
Brunei Darussalam	-	-	-	-	-	-	-
Bulgaria	43	92	66	84	40	53	42
Burkina Faso	-	98	-	-	-	100	-
Burundi	-	86	-	-	-	62	-
Cambodia	-	99	89	-	36	66	57
Cameroon	-	-	-	-	-	32	-
Canada	35	-	65	-	49	-	36
Cape Verde	-	-	-	-	-	-	-
Central African Republic	-	-	-	-	-	-	-
Chad	-	43	-	-	-	38	-
Chile	-	74	50	-	-	91	26
China	38	86	77	62	28	34	43
Colombia	-	99	-	-	-	41	-
Comoros	-	68	-	-	-	100	-
Congo	-	-	24	-	-	-	0
Cook Islands	-	-	-	-	-	-	-
Costa Rica	-	-	-	-	-	-	-
Côte d'Ivoire	-	-	-	-	-	44	63
Croatia	-	-	-	-	-	-	-
Cuba	-	56	30	-	-	27	23
Cyprus	-	-	-	-	-	-	-
Czech Republic	-	-	27	-	-	-	41
Democratic People's Republic of Korea	-	-	-	-	-	-	-
Democratic Republic of the Congo	-	64	-	-	-	33	-
Denmark	-	-	-	-	-	-	-
Djibouti	-	95	-	-	-	92	-
Dominica	-	-	-	-	-	-	-
Dominican Republic	-	-	-	-	-	-	-
Ecuador	-	96	63	-	-	87	42
Egypt	-	-	-	-	-	-	-
El Salvador	-	-	-	-	-	95	-
Equatorial Guinea	-	-	-	-	-	-	-
Eritrea	-	46	-	-	-	93	-

TABLE 3: HIV and AIDS indicators for higher-risk young people (cont'd)

	EPIDEMIOLOGY			KNOWLEDGE		
	HIV prevalence (%) among higher-risk populations in capital city (<25 years), 2005–2009*			% of higher-risk populations (<25 years) with comprehensive knowledge of HIV, 2005–2009*		
	Injecting drug users	Sex workers	Men who have sex with men	Injecting drug users	Sex workers	Men who have sex with men
Estonia	59.6	11.7	0	69	82	59
Ethiopia	-	-	-	-	36	-
Fiji	-	-	-	-	-	-
Finland	-	-	0	-	-	-
France	-	-	-	-	-	-
Gabon	-	12	-	-	27	-
Gambia	-	-	-	-	-	-
Georgia	0	0	3.5	30	0	21
Germany	-	-	1.6	-	-	-
Ghana	-	-	-	-	-	-
Greece	-	-	-	-	4	21
Grenada	-	-	-	-	-	-
Guatemala	-	-	-	-	4	31
Guinea	-	25.9	-	-	5	-
Guinea-Bissau	-	23.8	-	-	33	-
Guyana	-	6.6	-	-	30	43
Haiti	-	-	-	-	5	38
Holy See	-	-	-	-	-	-
Honduras	-	1	4	-	25	9
Hungary	0	-	1.1	-	-	-
Iceland	-	-	-	-	-	-
India	-	-	-	27	23	35
Indonesia	41.5	10.4	4.2	52	25	40
Iran (Islamic Republic of)	9.4	-	0	16	10	11
Iraq	-	-	-	-	-	-
Ireland	-	-	-	-	-	-
Israel	-	-	-	-	-	-
Italy	-	-	-	-	-	-
Jamaica	-	3.7	28.1	-	-	-
Japan	-	-	-	-	-	-
Jordan	-	-	-	-	-	-
Kazakhstan	3.6	0.5	0	74	66	66
Kenya	-	-	-	-	57	-
Kiribati	-	-	-	-	-	-
Kuwait	-	-	-	-	-	-
Kyrgyzstan	4.8	2	2.2	45	86	82
Lao People's Democratic Republic	-	0.6	5.2	-	44	30
Latvia	24.8	-	4.8	39	-	42
Lebanon	-	-	-	-	-	-
Lesotho	-	-	-	-	-	-
Liberia	-	-	-	-	-	-
Libyan Arab Jamahiriya	-	-	-	-	-	-
Liechtenstein	-	-	-	-	-	-
Lithuania	-	0	0	-	33	14
Luxembourg	0	-	-	-	-	-
Madagascar	-	0.5	-	-	-	-
Malawi	-	-	-	-	-	-
Malaysia	-	-	-	-	-	-
Maldives	0	0	0	-	-	-
Mali	-	25.7	-	-	-	-
Malta	-	-	-	-	-	-
Marshall Islands	-	-	-	-	-	-
Mauritania	-	-	-	-	-	-
Mauritius	-	-	-	-	2	-
Mexico	2.4	1.7	7.9	-	53	63
Micronesia (Federated States of)	-	-	-	-	-	-
Monaco	-	-	-	-	-	-

	SEXUAL BEHAVIOUR			ACCESS	TESTING		
	% of higher-risk populations (<25 years) using a condom at last sex, 2005–2009*			% of IDUs (<25 years) reporting the use of sterile injecting equipment the last time they injected, 2007–2009*	% of higher-risk populations (<25 years) who received an HIV test and knew the result, 2005–2009*		
	Injecting drug users	Sex workers	Men who have sex with men		Injecting drug users	Sex workers	Men who have sex with men
Estonia	71	91	55	-	51	60	26
Ethiopia	-	98	-	-	-	-	-
Fiji	-	-	-	-	-	-	-
Finland	-	-	-	-	-	-	-
France	-	-	-	-	-	-	-
Gabon	-	77	-	-	-	59	-
Gambia	-	-	-	-	-	-	-
Georgia	85	100	60	43	5	0	11
Germany	-	65	56	-	-	-	21
Ghana	-	-	-	-	-	-	-
Greece	-	0	13	-	-	57	84
Grenada	-	-	-	-	-	-	-
Guatemala	-	95	81	-	-	92	63
Guinea	-	84	-	-	-	50	-
Guinea-Bissau	-	91	-	-	-	30	-
Guyana	-	57	100	-	-	91	97
Haiti	-	-	-	-	-	71	71
Holy See	-	-	-	-	-	-	-
Honduras	-	79	-	-	-	81	25
Hungary	-	-	25	-	100	-	100
Iceland	-	-	-	-	-	-	-
India	13	88	44	85	21	38	7
Indonesia	35	64	56	87	37	27	31
Iran (Islamic Republic of)	34	59	45	77	16	23	11
Iraq	-	-	-	-	-	-	-
Ireland	-	-	-	-	-	-	-
Israel	-	-	-	-	-	-	-
Italy	-	-	-	-	-	-	-
Jamaica	-	97	73	-	-	72	47
Japan	-	-	-	-	-	-	-
Jordan	-	-	-	-	-	-	-
Kazakhstan	61	97	75	63	51	78	57
Kenya	-	87	-	-	-	95	-
Kiribati	-	-	-	-	-	-	-
Kuwait	-	-	-	-	-	-	-
Kyrgyzstan	57	94	93	78	29	37	69
Lao People's Democratic Republic	-	94	24	-	-	12	12
Latvia	42	-	46	85	59	-	28
Lebanon	-	-	-	-	-	-	-
Lesotho	-	-	-	-	-	-	-
Liberia	-	-	-	-	-	-	-
Libyan Arab Jamahiriya	-	-	-	-	-	-	-
Liechtenstein	-	-	-	-	-	-	-
Lithuania	-	89	54	97	72	40	29
Luxembourg	-	-	-	-	-	-	-
Madagascar	-	85	-	-	-	46	-
Malawi	-	-	-	-	-	-	-
Malaysia	-	-	-	-	-	-	-
Maldives	-	-	-	71	15	21	12
Mali	-	97	-	-	-	-	-
Malta	-	-	-	-	-	-	-
Marshall Islands	-	-	-	-	-	-	-
Mauritania	-	-	-	-	-	59	-
Mauritius	-	100	62	-	-	29	4
Mexico	31	66	61	40	12	61	49
Micronesia (Federated States of)	-	-	-	-	-	-	-
Monaco	-	-	-	-	-	-	-

TABLE 3: HIV and AIDS indicators for higher-risk young people (cont'd)

	EPIDEMIOLOGY			KNOWLEDGE		
	HIV prevalence (%) among higher-risk populations in capital city (<25 years), 2005–2009*			% of higher-risk populations (<25 years) with comprehensive knowledge of HIV, 2005–2009*		
	Injecting drug users	Sex workers	Men who have sex with men	Injecting drug users	Sex workers	Men who have sex with men
Mongolia	-	-	-	-	50	55
Montenegro	-	0	-	-	-	-
Morocco	0	1.4	-	-	-	-
Mozambique	-	-	-	-	-	-
Myanmar	27.8	13.6	12.6	78	65	68
Namibia	-	-	-	-	-	-
Nauru	-	-	-	-	-	-
Nepal	7	-	1.3	64	-	59
Netherlands	-	-	-	-	-	-
New Zealand	-	-	0	-	-	-
Nicaragua	-	-	-	-	-	-
Niger	-	23.2	-	-	8	-
Nigeria	2.9	26.8	9.6	42	34	44
Niue	-	-	-	-	-	-
Norway	-	-	-	-	-	-
Occupied Palestinian Territory	-	-	-	-	-	-
Oman	-	-	-	-	-	-
Pakistan	22.5	2.4	-	20	14	-
Palau	-	-	-	-	-	-
Panama	-	-	0	-	-	-
Papua New Guinea	-	7.2	1.9	-	39	72
Paraguay	4	-	-	-	-	30
Peru	-	0.2	-	-	-	-
Philippines	0.2	0.1	0.6	37	29	32
Poland	-	-	-	-	-	-
Portugal	4.9	-	-	-	-	-
Qatar	-	-	-	-	-	-
Republic of Korea	-	-	-	-	-	-
Republic of Moldova	10	1.7	-	66	28	46
Romania	1.2	-	-	7	11	42
Russian Federation	12	4.1	10.8	34	44	76
Rwanda	-	-	-	-	-	-
Saint Kitts and Nevis	-	-	-	-	-	-
Saint Lucia	12.5	-	-	0	-	-
Saint Vincent and the Grenadines	-	-	-	-	-	-
Samoa	-	-	-	-	-	-
San Marino	-	-	-	-	-	-
Sao Tome and Principe	-	-	-	-	84	-
Saudi Arabia	-	-	-	-	-	-
Senegal	-	9.5	12.7	-	20	-
Serbia	0	1.7	1.9	40	17	65
Seychelles	-	-	-	-	-	-
Sierra Leone	-	-	-	-	-	-
Singapore	-	-	-	-	-	-
Slovakia	-	-	-	-	-	-
Slovenia	0	-	-	-	-	-
Solomon Islands	-	-	-	-	-	-
Somalia	-	-	-	-	-	-
South Africa	-	-	-	-	-	-
Spain	20	3.2	8	-	-	-
Sri Lanka	-	0	0.8	-	10	17
Sudan	-	0	-	-	29	-
Suriname	-	-	-	-	-	-
Swaziland	-	-	-	-	34	-
Sweden	0	0	-	71	86	-
Switzerland	0	-	1.2	-	-	-
Syrian Arab Republic	-	-	-	-	-	-

	SEXUAL BEHAVIOUR			ACCESS	TESTING		
	% of higher-risk populations (<25 years) using a condom at last sex, 2005–2009*			% of IDUs (<25 years) reporting the use of sterile injecting equipment the last time they injected, 2007–2009*	% of higher-risk populations (<25 years) who received an HIV test and knew the result, 2005–2009*		
	Injecting drug users	Sex workers	Men who have sex with men		Injecting drug users	Sex workers	Men who have sex with men
Mongolia	-	89	80	-	-	46	70
Montenegro	-	-	-	-	-	-	-
Morocco	15	49	-	10	11	44	-
Mozambique	-	-	-	-	-	-	-
Myanmar	79	96	84	83	26	68	45
Namibia	-	-	-	-	-	-	-
Nauru	-	-	-	-	-	-	-
Nepal	49	-	75	98	19	-	36
Netherlands	-	-	-	-	-	-	-
New Zealand	-	-	-	-	-	-	-
Nicaragua	-	-	-	-	-	-	-
Niger	-	79	-	-	-	40	-
Nigeria	70	98	52	85	20	36	27
Niue	-	-	-	-	-	-	-
Norway	-	-	-	-	-	-	-
Occupied Palestinian Territory	-	-	-	-	-	-	-
Oman	-	-	-	-	-	-	-
Pakistan	29	39	24	79	12	13	-
Palau	-	-	-	-	-	-	-
Panama	-	-	-	-	-	-	-
Papua New Guinea	-	53	41	-	-	52	63
Paraguay	-	53	53	-	100	-	-
Peru	-	-	42	-	-	4	0
Philippines	26	65	30	83	1	16	4
Poland	-	-	-	-	-	-	-
Portugal	36	-	41	59	41	-	39
Qatar	-	-	-	-	-	-	-
Republic of Korea	-	-	-	-	-	-	-
Republic of Moldova	35	96	34	99	48	19	35
Romania	22	99	-	87	14	25	-
Russian Federation	54	68	58	86	34	36	-
Rwanda	-	-	-	-	-	-	-
Saint Kitts and Nevis	-	-	-	-	-	-	-
Saint Lucia	-	-	95	-	22	-	100
Saint Vincent and the Grenadines	-	-	-	-	-	-	-
Samoa	-	-	-	-	-	-	-
San Marino	-	-	-	-	-	-	-
Sao Tome and Principe	-	63	-	-	-	-	-
Saudi Arabia	-	-	-	-	-	-	-
Senegal	-	91	72	-	-	36	31
Serbia	37	83	62	90	17	32	31
Seychelles	-	-	-	-	-	-	-
Sierra Leone	-	-	-	-	-	-	-
Singapore	-	-	-	-	-	-	-
Slovakia	-	-	-	-	-	-	-
Slovenia	-	-	25	-	-	-	-
Solomon Islands	-	-	-	-	-	-	-
Somalia	-	-	-	-	-	-	-
South Africa	-	-	-	-	-	-	-
Spain	-	-	-	-	-	-	-
Sri Lanka	-	88	62	-	-	25	7
Sudan	-	46	-	-	-	6	-
Suriname	-	-	-	-	-	-	-
Swaziland	-	87	-	-	-	92	-
Sweden	10	0	47	54	84	56	37
Switzerland	36	-	79	95	70	-	33
Syrian Arab Republic	-	-	-	-	-	-	-

TABLE 3: HIV and AIDS indicators for higher-risk young people (cont'd)

	EPIDEMIOLOGY			KNOWLEDGE		
	HIV prevalence (%) among higher-risk populations in capital city (<25 years), 2005–2009*			% of higher-risk populations (<25 years) with comprehensive knowledge of HIV, 2005–2009*		
	Injecting drug users	Sex workers	Men who have sex with men	Injecting drug users	Sex workers	Men who have sex with men
Tajikistan	12.3	1.5	0	60	37	0
Thailand	-	-	-	-	29	19
The former Yugoslav Republic of Macedonia	-	-	-	40	49	34
Timor-Leste	-	-	-	-	-	-
Togo	-	19.5	-	-	55	57
Tonga	-	-	-	-	-	-
Trinidad and Tobago	-	-	5.8	-	-	-
Tunisia	-	0.3	-	19	11	23
Turkey	0	-	1.7	-	-	0
Turkmenistan	-	-	-	-	-	-
Tuvalu	-	-	-	-	-	-
Uganda	-	-	-	-	-	-
Ukraine	10.2	8.7	7.9	54	46	72
United Arab Emirates	-	-	-	-	-	-
United Kingdom	1	-	-	-	-	-
United Republic of Tanzania	-	-	-	-	-	-
United States	-	-	-	-	-	-
Uruguay	0	-	6.9	-	-	-
Uzbekistan	7.2	2.1	6.4	41	34	30
Vanuatu	-	-	-	-	-	-
Venezuela (Bolivarian Republic of)	-	-	-	-	-	-
Viet Nam	-	-	3	53	51	48
Yemen	-	-	-	-	-	-
Zambia	-	-	-	-	40	-
Zimbabwe	-	-	-	-	-	-

	SEXUAL BEHAVIOUR			ACCESS	TESTING		
	% of higher-risk populations (<25 years) using a condom at last sex, 2005–2009*			% of IDUs (<25 years) reporting the use of sterile injecting equipment the last time they injected, 2007–2009*	% of higher-risk populations (<25 years) who received an HIV test and knew the result, 2005–2009*		
	Injecting drug users	Sex workers	Men who have sex with men		Injecting drug users	Sex workers	Men who have sex with men
Tajikistan	49	96	80	80	28	45	-
Thailand	40	-	89	61	57	29	17
The former Yugoslav Republic of Macedonia	49	76	49	67	36	28	51
Timor-Leste	-	-	-	-	-	-	-
Togo	-	87	67	-	-	56	47
Tonga	-	-	27	-	-	-	-
Trinidad and Tobago	-	-	-	-	-	-	-
Tunisia	-	-	-	-	9	13	16
Turkey	17	34	27	17	22	-	38
Turkmenistan	-	-	-	-	-	-	-
Tuvalu	-	-	-	-	-	-	-
Uganda	-	-	-	-	-	-	-
Ukraine	53	88	63	89	21	56	43
United Arab Emirates	-	-	-	-	-	-	-
United Kingdom	42	-	-	78	-	-	20
United Republic of Tanzania	-	-	-	-	-	-	-
United States	-	-	59	-	0	-	-
Uruguay	-	-	44	-	0	-	-
Uzbekistan	30	80	91	79	23	31	28
Vanuatu	-	-	63	-	-	-	-
Venezuela (Bolivarian Republic of)	-	-	-	-	-	-	-
Viet Nam	54	79	70	94	18	32	16
Yemen	-	-	-	-	-	-	-
Zambia	-	-	-	-	-	18	-
Zimbabwe	-	-	-	-	-	-	-

DEFINITIONS OF THE INDICATORS

HIV prevalence among higher-risk populations: Percentage of higher-risk populations (injecting drug users, sex workers and men who have sex with men <25 years) living with HIV.

Comprehensive knowledge of HIV: Percentage of higher-risk populations (injecting drug users, sex workers and men who have sex with men <25 years) who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission and who know that a healthy-looking person can be HIV-positive.

Condom use at last sex: Percentage of higher-risk populations (injecting drug users, sex workers and men who have sex with men <25 years) using a condom at last sex.

Sterile injecting equipment: Percentage of injecting drug users (<25 years) reporting the use of sterile injecting equipment the last time they injected.

HIV testing: Percentage of higher-risk populations who received an HIV test in the past 12 months and knew the result.

MAIN DATA SOURCES

All data in Table 3: UNAIDS, *UNAIDS Report on the Global AIDS Epidemic 2010*, and UNAIDS online database, <www.aidsinfoonline.org>.

NOTES

– Data not available.

* Data refer to the most recent year available during the period specified in the column heading.

CLASSIFICATIONS

CLASSIFICATION BY HIV EPIDEMIC LEVEL

HIV epidemics are categorized as low level, concentrated or generalized based on the following principles and numerical proxies.

Low level
Principle. Although HIV infection may have existed for many years, it has never spread to significant levels in any subpopulation. Recorded infection is largely confined to individuals with high-risk behaviours, such as sex workers, people who inject drugs and men who have sex with men. This epidemic state suggests that networks of risk are rather diffuse (with low levels of partner exchange or sharing of drug-injecting equipment) or that the virus has been introduced only very recently.

Concentrated
Principle. HIV has spread rapidly in a defined subpopulation but is not well established in the general population. This epidemic state suggests active networks of risk within the subpopulation. The future course of the epidemic is determined by the frequency and nature of links between highly infected subpopulations and the general population.

Generalized
Principle. In generalized epidemics, HIV is firmly established in the general population. Although subpopulations at high risk may continue to contribute disproportionately to the transmission of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of subpopulations at higher risk of infection.

UNICEF REGIONAL CLASSIFICATION

The countries and territories included in each of UNICEF's regional groupings are listed below. Averages presented in the Summary Indicators section at the end of the statistical tables are calculated using data from the countries and territories in accordance with this classification.

Note, however: **Industrialized countries/territories** are defined as those *not* included in the UNICEF Regional Classification. **Developing countries/territories** are classified as such for purposes of statistical analysis only. There is no established convention for the designation of 'developed' and 'developing' countries or areas in the United Nations system. **Least developed countries/territories** are those classified as such by the United Nations.

Africa
Sub-Saharan Africa; North Africa (Algeria, Egypt, Libyan Arab Jamahiriya, Morocco, Tunisia)

Sub-Saharan Africa
Eastern and Southern Africa; West and Central Africa; Djibouti and the Sudan

Eastern and Southern Africa
Angola; Botswana; Burundi; Comoros; Eritrea; Ethiopia; Kenya; Lesotho; Madagascar; Malawi; Mauritius; Mozambique; Namibia; Rwanda; Seychelles; Somalia; South Africa; Swaziland; Uganda; United Republic of Tanzania; Zambia; Zimbabwe

West and Central Africa
Benin; Burkina Faso; Cameroon; Cape Verde; Central African Republic; Chad; Congo; Côte d'Ivoire; Democratic Republic of the Congo; Equatorial Guinea; Gabon; Gambia; Ghana; Guinea; Guinea-Bissau; Liberia; Mali; Mauritania; Niger; Nigeria; Sao Tome and Principe; Senegal; Sierra Leone; Togo

Middle East and North Africa
Algeria; Bahrain; Djibouti; Egypt; Iran (Islamic Republic of); Iraq; Jordan; Kuwait; Lebanon; Libyan Arab Jamahiriya; Morocco; Occupied Palestinian Territory; Oman; Qatar; Saudi Arabia; Sudan; Syrian Arab Republic; Tunisia; United Arab Emirates; Yemen

Asia
South Asia; East Asia and the Pacific

South Asia
Afghanistan; Bangladesh; Bhutan; Federal Democratic Republic of Nepal; India; Maldives; Pakistan; Sri Lanka

East Asia and the Pacific
Brunei Darussalam; Cambodia; China; Cook Islands; Democratic People's Republic of Korea; Indonesia; Kiribati; Lao People's Democratic Republic; Malaysia; Marshall Islands; Micronesia (Federated States of); Mongolia; Myanmar; Nauru; Niue; Palau; Papua New Guinea; Philippines; Republic of Fiji; Republic of Korea; Samoa; Singapore; Solomon Islands; Thailand; Timor-Leste; Tonga; Tuvalu; Vanuatu; Viet Nam

Latin America and the Caribbean
Antigua and Barbuda; Argentina; Bahamas; Barbados; Belize; Bolivia (Plurinational State of); Brazil; Chile; Colombia; Costa Rica; Cuba; Dominica; Dominican Republic; Ecuador; El Salvador; Grenada; Guatemala; Guyana; Haiti; Honduras; Jamaica; Mexico; Nicaragua; Panama; Paraguay; Peru; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Suriname; Trinidad and Tobago; Uruguay; Venezuela (Bolivarian Republic of)

CEE/CIS
Albania; Armenia; Azerbaijan; Belarus; Bosnia and Herzegovina; Bulgaria; Croatia; Georgia; Kazakhstan; Kyrgyzstan; Montenegro; Republic of Moldova; Romania; Russian Federation; Serbia; Tajikistan; The former Yugoslav Republic of Macedonia; Turkey; Turkmenistan; Ukraine; Uzbekistan

Industrialized countries/territories
Andorra; Australia; Austria; Belgium; Canada; Cyprus; Czech Republic; Denmark; Estonia; Finland; France; Germany; Greece; Holy See; Hungary; Iceland; Ireland; Israel; Italy; Japan; Latvia; Liechtenstein; Lithuania; Luxembourg; Malta; Monaco; Netherlands; New Zealand; Norway; Poland; Portugal; San Marino; Slovakia; Slovenia; Spain; Sweden; Switzerland; United Kingdom; United States

Developing countries/territories
Afghanistan; Algeria; Angola; Antigua and Barbuda; Argentina; Armenia; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belize; Benin; Bhutan; Bolivia (Plurinational State of); Botswana; Brazil; Brunei Darussalam; Burkina Faso; Burundi; Cambodia; Cameroon; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Cuba; Cyprus; Democratic Republic of the Congo; Democratic People's Republic of Korea; Djibouti; Dominica; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Ethiopia; Federal Democratic Republic of Nepal; Gabon; Gambia; Georgia; Ghana; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; India; Indonesia; Iran (Islamic Republic of); Iraq; Israel; Jamaica; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Lebanon; Lesotho; Liberia; Libyan Arab Jamahiriya; Madagascar; Malawi; Malaysia; Maldives; Mali; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Mongolia; Morocco; Mozambique; Myanmar; Namibia; Nauru; Nicaragua; Niger; Nigeria; Niue; Occupied Palestinian Territory; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Qatar; Republic of Fiji; Republic of Korea; Rwanda; Saint Kitts and Nevis; Saint Lucia; Saint Vincent and the Grenadines; Samoa; Sao Tome and Principe; Saudi Arabia; Senegal; Seychelles; Sierra Leone; Singapore; Solomon Islands; Somalia; South Africa; Sri Lanka; Sudan; Suriname; Swaziland; Syrian Arab Republic; Tajikistan; Thailand; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; United Arab Emirates; United Republic of Tanzania; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe

Least developed countries/territories
Afghanistan; Angola; Bangladesh; Benin; Bhutan; Burkina Faso; Burundi; Cambodia; Central African Republic; Chad; Comoros; Democratic Republic of the Congo; Djibouti; Equatorial Guinea; Eritrea; Ethiopia; Federal Democratic Republic of Nepal; Gambia; Guinea; Guinea-Bissau; Haiti; Kiribati; Lao People's Democratic Republic; Lesotho; Liberia; Madagascar; Malawi; Maldives; Mali; Mauritania; Mozambique; Myanmar; Niger; Rwanda; Samoa; Sao Tome and Principe; Senegal; Sierra Leone; Solomon Islands; Somalia; Sudan; Timor-Leste; Togo; Tuvalu; Uganda; United Republic of Tanzania; Vanuatu; Yemen; Zambia

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