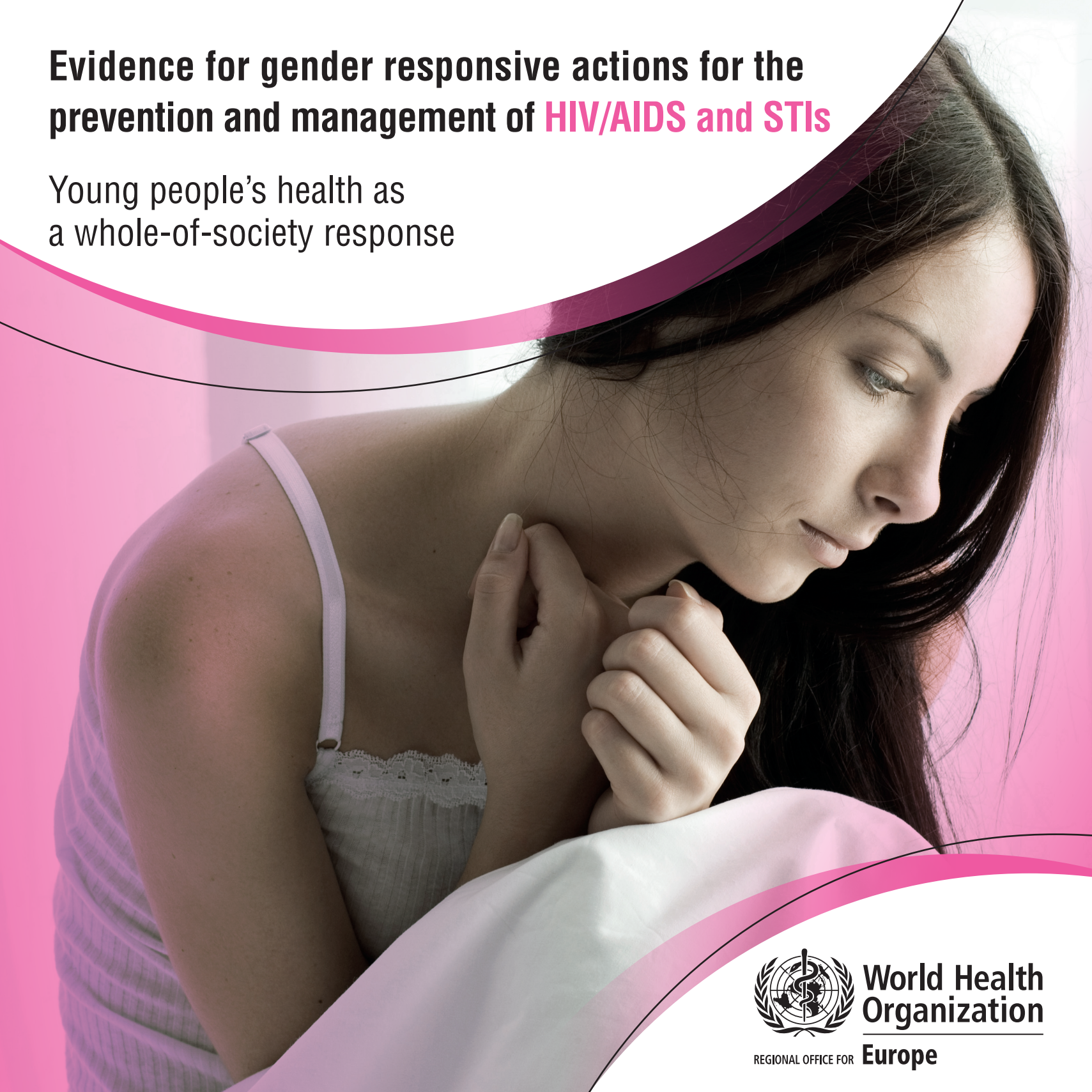
Evidence for gender responsive actions for the prevention and management of HIV/AIDS and STIs

Young people's health as a whole-of-society response



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Keywords

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Abstract

The WHO Regional Office for Europe supports Member States in improving adolescent health by recommending comprehensive, multisectoral and evidence-informed adolescent health approaches; by delineating the critical contribution of the health sector; by fostering actions towards reducing inequalities; and by addressing gender as a key determinant of adolescent health. This publication aims to support this work in the framework of the *European strategy for child and adolescent health and development*, and is part of the WHO Regional Office for Europe contribution to the development of a new policy framework for Europe, Health 2020, for which the WHO Regional Office for Europe has been mandated by the 53 Member States.

The publication summarizes current knowledge on what works in preventing and managing HIV/STIs. It is part of a series that includes social and emotional well-being, chronic conditions and disabilities, adolescent pregnancy, HIV/STIs, overweight and obesity, violence, injuries and substance abuse.

The publication assumes the position that young people's health is the responsibility of the whole society, and that interventions need to be gender responsive in order to be successful. It therefore looks at actions at various levels, such as cross-sector policies, families and communities actions, and interventions by health systems and health services. The publication does not prescribe nor recommend any particular course of action, which needs to be informed by the country specific context. It rather provides a basis to stimulate countries to further refine national policies so that they contribute effectively to the health and well-being of young people.

Acknowledgment

This publication was developed under the guidance of Valentina Baltag (Adolescents' health) and Isabel Yordi Aguirre (Gender and health) from the WHO Regional Office for Europe.

Many international experts and WHO staff members have contributed to the series **Young people's health as a whole-of-society response**, and we are very grateful for their valuable inputs, support and guidance. The conceptual foundation for this publication was based on the Action Tool of the European strategy for child and adolescent health and development http://www.euro.who.int/__data/assets/pdf_file/0011/81848/Action_Tool.pdf.

For the HIV/STIs part of the serie, we are particularly grateful to Lourdes Cantarero who conducted the the literature review on gender, adolescents and HIV/STIs, and Jane Ferguson, Lali Khotenashvili and Petra Kolip for their valuable comments during the peer review process.

Foreword

In May 2011, the World Health Assembly adopted a resolution urging Member States to accelerate the development of policies and plans to address the main determinants of young people's health.

This series of publications, advocating a whole-of-society response to young people's health, and looking at the evidence for gender responsive actions, will be a timely resource for Member States as they implement both the resolution and the European strategy for child and adolescent health and development. The publications clearly show that not only are the health, education, social protection and employment sectors jointly responsible for the health of adolescents, but that effective interventions do exist. Ensuring that adolescents who are pregnant or have children can stay in or return to school, or enacting regulations to limit unhealthy snacks and soft drinks in school cafeterias are examples of policies that are beyond the mandate of health systems and yet generate health. By bringing evidence to the attention of policy-makers, these publications take a practical step toward achieving one of the core aims of the new European policy for health, Health 2020: to promote and strengthen innovative ways of working across sector and agency boundaries for health and well-being.

A common shortcoming of adolescent health programmes across the WHO European Region is that they often look at adolescents as a homogeneous cohort. Far too often programmes are blind to the fact that boys and girls differ in their exposure and vulnerability to health risks and conditions, such as depressive disorders, injuries, substance abuse, eating disorders, sexually transmitted infections, violence and self-inflicted injuries, including suicide. They are affected differently not only by the socioeconomic circumstances of their community and their ethnicity but also by gender norms and values. Research shows this, yet there is insufficient progress in transforming knowledge into policy action. I hope this publication will be a useful tool to facilitate this transformation.

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Introduction

The WHO Regional Office for Europe supports Member States in improving adolescent health in four main ways: by recommending comprehensive, multisectoral and evidence-informed adolescent health approaches; by delineating and supporting the critical contribution of the health sector, including the leadership role of ministries of health to influence other sectors, such as education, employment and social protection policies; by fostering actions towards reducing inequities in health both within and between countries; and by addressing gender as a key determinant of adolescent health.

By bringing together and coherently interconnecting knowledge and evidence on effective interventions and good practices for the better health, equity and well-being of young people, this publication aims to support this work using the framework of the European strategy for child and adolescent health and development. It is also part of the WHO Regional Office for Europe's contribution to the development of a new policy framework for Europe, Health 2020, for which the WHO Regional Office for Europe has been mandated by the 53 Member States (resolution EUR/RC60/R5).

The publication summarizes current knowledge on what is effective in preventing and managing HIV/AIDS and STIs. It is part of a series that includes social and emotional well-being, chronic conditions and disabilities, adolescent pregnancy, HIV/STIs, mental health, overweight and obesity, violence, and injuries and substance abuse. The publication includes two parts. The first part is a summary table of effective interventions and good practices for preventing and managing HIV/AIDS and STIs. The table emphasizes intersectoral governance and accountability for young people's health and development, and takes a whole-of society approach to young people's health. It therefore looks at actions at various levels such as cross-sector policies, families and communities actions, and interventions by health systems and health services. It demonstrates that health systems in general, and health ministries in particular, can work proactively with other sectors to identify practical policy options that maximize the positive health effects of other policies on young people's well-being, and minimize any negative effects. Interventions need to be gender responsive in order to be successful; the publication therefore looks at presented practices through a distinct gender perspective.

The second part explains the impact of gender norms, values and discrimination on the health of adolescents relevant to prevention and management of HIV/AIDS and STIs. Through a review of the existing evidence, it looks at why is it important to look at gender as a determinant of adolescence health, what are the main differences between girls and boys in exposure to risk, norms and values and access to services, and what are the different responses from the health sector and the community. It complements the Gender Tool of the European strategy for child and adolescent health and development http://www.euro.who.int/__data/assets/pdf_file/0020/76511/EuroStrat_Gender_tool.pdf. It gives the readers a deeper understanding of the gender dimension of actions listed in Part I.

The evidence base of this publication includes a review of existing literature, such as scientific and research articles and books, policy reviews, evaluations, and 'grey' literature. It needs to be emphasized that this is not a comprehensive and systematic review of the evidence in the area of prevention and management of HIV/AIDS and STIs, nor of approaches to support policies and their implementation. The publication does not rank presented interventions and good practices in any priority order, and does not assess them against the strengths of the evidences behind them. The publication does not prescribe nor recommend any particular course of action, which needs to be informed by country specific context. It rather provides a basis to stimulate countries to further refine national policies and strategies so that they contribute effectively to the health and well-being of young people.

PRIORITY	CROSS SECTOR ACTIONS		FAMILY & COMMUNITY	HEALTH SYSTEM	HEALTH SERVICES
	HEALTH IN ALL POLICIES	SCHOOL SETTING			
Prevent and manage HIV/AIDS and STIs among adolescents boys and girls	Ensure that legal, policy and regulatory framework supports the rights of adolescents to age appropriate information, confidentiality and privacy, and reinforce the principle of evolving capacities of the child in the existing policies and procedures for autonomous decision and informed consent [14, 8, 20, 21] Enforce laws and policies that directly address gender inequality and protect most-at-risk adolescents[1] (MARA), decriminalize the behaviours that place them most at risk, and ensure that MARA have access to the services they need [15, 18, 21] Implement interventions for HIV prevention, treatment and care that reach migrant populations [28] Put in place policies to protect YPLHIV from stigma, discrimination, and to support them in making decisions about disclosure of their HIV status [8, 13] Enforce laws and policies that protect women and girls against sexual violence, disinheritance and gender discrimination of all kinds, including harmful traditional practices and sexual violence in and outside of marriage [18] Design and implement sex and STIs/HIV education programmes that incorporate characteristics of effective programmes and take into account the social and cultural influences on young people sexual behaviours[2] [5, 11, 29] Expand social marketing projects to prevent HIV that are tailored to the needs of the young people, and designed with their involvement [4, 7] Ensure that social mobilization campaigns against gender inequality and HIV related stigma and discrimination involve YPLHIV [18] Put in workplace HIV policies and interventions with emphasis on prevention and non-discrimination [23] Ensure girls protection from foregoing education because of care giving to HIV infected parents or siblings [23] Develop livelihood and vocational skills programmes to increase employment opportunities [23, 26]	Implement comprehensive[3] sex and STIs/HIV education programmes that incorporate characteristics of effective programmes and take into account the social and cultural influences on young people sexual behaviours [1,4, 5, 11, 17, 29] Complement SRH education with selected social and health services either directly or through linkages to the community [7, 9, 26] Keep girls in schools and make schools free of sexual violence [18] Provide access to alternative education approaches for YPLHIV, including flexible instruction hours, acceleration and catch-up programmes, home-based care and education [26]	Implement dedicated (community-based or centre for young people) services for MARA, including demand and harm reduction initiatives [7, 17] Implement culturally appropriate interventions for young migrants, related training for health and community workers, and greater involvement of migrant communities in service delivery [28] Implement social support programmes for YPLHIV, care-givers and orphans, which engage men and transform care-giving roles [18] Implement interventions targeting youth and community as a whole to increase use of existing services [2, 4, 25], mitigate the impact of HIV-related stigma and discrimination, and change gender norms that affect the risk of HIV infection [25] Implement sex and STIs/HIV education programmes with multiple components[4] that are based on local needs, send clear, consistent messages about appropriate sexual behaviour, and take into account the social and cultural influences on young people sexual behaviours [2, 3, 5, 11] Implement parenting programmes with certain characteristics[5] to improve adolescents' SRH [3, 10] Implement community-based (on-site) STI case management, i.e. by integration of STI case management into existing community-based projects directed at young people [4, 7] Promote campaigns and community dialogue to change harmful gender norms, engage men and boys and eliminate violence against women and girls [18]	Ensure that strategic information on the STIs/HIV epidemic among young people and its social drivers is available and informs programmatic and policy decision-making [6, 21, 22] Implement interventions to control HIV that are adapted to the country epidemiological situation: interventions to control HIV among injecting drug users, including harm reduction programmes; measures to prevent heterosexual transmission targeted at those with high-risk partners; interventions to control HIV among men who have sex with men [27] Implement interventions for HIV prevention, treatment and care that reach migrant populations [27, 28] Implement gender sensitive and appropriately-adapted to young people needs STIs/HIV prevention and control interventions, including information and counselling, condom use, harm reduction, HIV testing and counselling, treatment, care and support services, and adolescent specific comprehensive approach to STIs case management[6] [6, 7, 16, 17, 24, 29] Strengthen referral within and outside the health system, coordination and partnerships between health, social and child protection services, to provide effective support to MARA and YPLHIV, including facilities to establish support groups for YPLHIV [8, 20, 24] Improve accessibility of health care facilities and train staff to be able to deal with young people on the basis of their specific situations and needs, including the needs of young migrants [4, 24] Promote linkages and convergence of STIs/HIV prevention interventions, including HIV counselling and testing, with sexual and reproductive health services, tuberculosis services, and PMTCT [8, 7, 24, 29] Consider the benefits, acceptability and feasibility of introducing HPV vaccination programmes [6, 19] Ensure that financial considerations are not a limiting factor for YP in accessing services, appropriate medicines and technology [6, 8]	Provide services that reflect characteristics of youth friendly health services and are linked to activities to increase the use of services [4, 7, 12, 24] Ensure that local procedures protect and support young people in their decisions about disclosure of their HIV status [8, 13] Implement standardized approaches to the assessment and management of sexually abused children and adolescents, performed by a trained clinician following locally defined procedures and guidelines [6] Make available syphilis screening of high-risk adolescent girls and young women, e.g. in antenatal and post-abortion clinics [7] Ensure that facilities have procedures to involve YPLHIV in service provision[7] and that they provide age, developmentally and educationally appropriate information on care, treatment, support and prevention for YPLHIV [8, 24] Use culturally appropriate materials for young migrants population and increase efforts to inform migrant communities about available services [28]

[1] e.g. boys who have sex with men or other boys, young sex workers, young people who inject drugs and street children

[2] see Annex for characteristics of effective curriculum-based programmes for sex and HIV education, and for social and cultural factors that influence young people sexual behaviors

[3] comprehensive programs encourage abstinence as the safest choice but also encourage young people who are having sex to always use condoms or other measures of contraception

[4] multicomponent community based programmes are based on broad-based collaborations with various agencies and stakeholders, and combine a range of strategies such as sex education in the classroom, individual counselling and community events

[6] a comprehensive approach to case management encompasses: (1) identification of the sexually transmitted infections syndrome; (2) appropriate antimicrobial treatment for the syndrome; (3) education and counselling on ways to avoid or reduce risk of infection with sexually transmitted pathogens, including HIV; (4) promotion of the correct and consistent use of condoms; (5) partner notification, where applicable, using notification approaches appropriate to the circumstances of an individual patient

[5] see Annex for recommended characteristics

[7] i.e. as counselors (pre and post-HIV test), as outreach workers, and by contributing to policy and programme design and oversight

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Gender impacts on adolescent health with focus on prevention and management of HIV/AIDS and STIs

"In order to ensure that women and men of all ages have equal access to opportunities for achieving their full health potential and health equity, the health sector needs to recognize that they differ in terms of both sex and gender. Because of social (gender) and biological (sex) differences, women and men face different health risks, experience different responses from health systems, and their health-seeking behaviour, and health outcomes differ."

Source: Strategy for integrating gender analysis and actions into the work of WHO. Geneva, World Health Organization, 2009.

HIV/AIDS and STIs among adolescent girls and boys – what do we know?

Negative outcomes of early pregnancy and sexually transmitted infections (STIs), including HIV/AIDS, threaten the health of people in the second decade of life more than any other age group (Bearinger et al., 2007). Since the 1990s, the prevalence of STIs has continued to rise in most countries, including developed countries (WHO, 2006b). Worldwide, the largest proportion of STIs is believed to occur in people younger than 25 years, with more than a fifth to greater than half of some STIs occurring in young people (Dehne and Riedner, 2005). About two thirds of all Chlamydia infections in Europe are diagnosed in the 15-24-year-old age group. Data from epidemiological surveys show that within countries and also between countries in the same region, the prevalence and incidence of STIs can vary widely, between urban and rural populations and even between similar population groups, reflecting differences in social, cultural, religious, and economic factors (WHO 2001; WHO 2006a).

The HIV epidemic has begun to stabilize in some countries with generalized epidemics in which transmission is largely through heterosexual relationships. Countries that have successfully decreased national HIV prevalence have achieved these gains mostly by encouraging safer sexual behaviours in adolescents (UNAIDS, 2010). However, the HIV epidemic continues to grow in the eastern Europecentral and eastern Europe and Commonwealth of Independent States (CEE/CIS) region, where transmission is primarily via unsafe needles although heterosexual transmission is increasing. eastern Europe and central Asia is the only region where HIV prevalence clearly remains on the rise. The number of people living with HIV has almost tripled since 2000 and reached an estimated total of 1.4 million in 2009. A rapid rise in HIV infections among people who inject drugs at the turn of the century caused the epidemic in this region to surge (UNAIDS, 2010). In central Asia and eastern Europe, an estimated 430,000 young people are living with HIV/AIDS; twelve per cent of HIV infections diagnosed in 2009 were in the 15–24-year-old age group and 35% were female (ECDC/WHO, 2010). The predominant transmission mode of HIV in Europe varies by area (East, Centre, West), illustrating the wide diversity in the epidemiology of HIV in Europe (ECDC/WHO, 2010). In western Europe rates remain low, except among intravenous drug

users, men having sex with men, sex workers (especially young females), and marginalized populations. In eastern Europe and central Asia, infection rates are rising rapidly, and epidemics are concentrated mainly among people who inject drugs, sex workers, their sexual partners and, to a much lesser extent, men who have sex with men (UNAIDS, 2010). Similarly, adolescents in Europe become infected with HIV because of male homosexual sex, sex work and illegal drug use – behaviours that are heavily stigmatized. At the same time, CEE/CIS region is home to nearly 1 in 4 of the world's injecting drug users (UNICEF, 2010).

In the WHO-Euro region, the incidence of syphilis, gonorrhoea and Chlamydia varies greatly among countries. Rates for all three diseases have risen in various countries over the past 10 years (Van der Heyden et al., 2000). The Russian Federation and Romania have significantly higher rates of both syphilis and gonorrhoea than other countries (Denmark, Belgium, France, Finland, Sweden, the United Kingdom, Romania, Germany and Switzerland) (Panchaud et al., 2000). Incidence of all three STIs is generally higher for adolescent girls than for boys, partly because girls are more likely to be screened (Panchaud et al., 2000). Almost half of the confirmed gonorrhoea cases are in the age group 15 to 24; men are more likely to be infected than women, accounting for 73% of the confirmed cases (ECDC/WHO, 2009). The incidence of Chlamydia varies from 12.2 in Belgium to 569.6 in Sweden and 650.8 in Finland. Young people and adolescents are disproportionally affected by Chlamydia: the age group 15-24 has the highest prevalence rate, at 367 per 100 000 of the corresponding population group. Girls and young women are again more affected (or more frequently diagnosed) than boys and young men (ECDC/WHO, 2009; Panchaud et al. 2000). Condom usage among young adolescents in Europe has increased to very high levels (77% of school age children have had used condom at last sexual intercourse) but wide variations exists between countries with no clear geographical patterns. Condom use was reported more frequently by boys (with an average of 81% compared with 72% by girls). The highest rates of condom use are reported by boys from Greece (91%) and Switzerland (89%); the lowest rates are reported by boys from Slovakia (65%) and Sweden (69%) (WHO, 2008). Although data suggests that the use of condoms by adolescents is increasing worldwide the proportion of sexually active young people who report condom use is clearly too small to contain the spread of STIs (Dehne and Riedner, 2005).

A study conducted in 18 European countries with the aim of examining which individual and national factors affect condom use among adolescents showed that among the 15-year-olds studied, 7.0% of the total variance in condom use was explained by school-related factors (intra-school level correlation) and 5.8% by national/subnational factors. Condom use was significantly associated with gender, alcohol consumption, predominant national religion and national prevalence of human immunodeficiency virus (HIV). There was also a significant association with the Human Development Index ranking, gross domestic product, Gini coefficient and the Gender-related Development Index. This study suggests that while alcohol, gender, human development level, income, religion and HIV prevalence affect condom use in young Europeans, these factors do not explain all or even most of the variation. Nonetheless, since some of these factors are not traditionally associated with young people sexual and reproductive health, these findings should enable more nuanced health policy programming. Knowing that girls in Sweden, for example, often use oral contraception helps to explain the lower condom use there, but the country's recent increase in reported Chlamydia infections indicates that targeted public health interventions are needed to promote dual contraception, e.g. oral contraception and a condom (Lazarus et al. 2009).

What are the explanations behind the differences in STIs and HIV/AIDS among adolescent girls and boys?

Many factors contribute to the risk of STIs, HIV, or negative health outcomes of early pregnancy, with even greater vulnerability for some subgroups. Biologically, the immature reproductive and immune systems of adolescent girls translate to increased susceptibility to STIs and HIV transmission; pregnancy and delivery for those with incomplete body growth exposes them to problems that are less common in adult women (Dehne and Riedner, 2005).

Many societal issues also contribute to risks for adolescents. Aspects of development that characterize adolescence, sexual behaviour, and risk can vary by gender, race, ethnicity, geography, and socioeconomic status, as well as in relation to the traditions, mores, and values defined by the community (Marston and King, 2006). A study from 2000 with data from 14 countries showed that the context of early sexual experience often differs between men and young women. Gender comprises widely held beliefs, expectations, customs and practices within a society that define 'masculine' and 'feminine' attributes, behaviours and roles and responsibilities. Gender is an integral factor in determining an individual's vulnerability to HIV infection, his or her ability to access care, support or treatment, and the ability to cope when infected or affected by HIV (UNAIDS, 2010).

A systematic review that analysed 268 qualitative studies of young people's sexual behaviour revealed how social and cultural forces shape young people's sexual behaviour and can help explain why information campaigns and condom distribution programmes alone are often not effective. The findings suggest that, among other factors, gender stereotypes are crucial in determining social expectations and, in turn, behaviour. All the societies studied had strikingly similar expectations of men's and women's behaviour. Men are expected to be highly heterosexually active, and women chaste. Vaginal penetration is perceived to be important in determining masculinity, and marks the transition from boyhood to manhood. Men are expected to seek physical pleasure, but women desiring sex can be branded "loose" or "cheap". Where romantic love is expected to precede marriage, sex for young women must be linked to romance, and they are expected to be "swept off their feet" into sexual intercourse, in a way that is not logical, planned, or rational. Men, on the other hand, may scheme and plot to obtain sex, for example, by deceiving women into thinking the relationship is a serious one when it is not. Paradoxically, despite the stigmatizing effect for women in carrying condoms or using other contraception, women, not men, are generally considered responsible for pregnancy prevention. These stereotypes lead to refraining from disclosing planned, or rational behaviours in sex practice (i.e. producing a condom), and give limited space for young girls to adopt a pro-active attitude in negotiating sex practices within the societal paradigm of femininity and masculinity (Marston and King, 2006). They also work against prevention messages that support fidelity and other protection measures from HIV infection. Some notions of masculinity also condone violence against women, which has a direct link to HIV vulnerability, and homophobia, which results in stigmatization of men who have sex with men, making these men more likely to hide their sexual behaviour and less likely to access HIV services.

Women often experience the impact of HIV more severely than men. The effects of gender inequality leave women and girls more at risk of exposure to HIV. Less access to education and economic opportunity results in women being more dependent on men in their relationships, and

many who have no means of support must resort to bartering or selling sex to support themselves and their children. When women can't own property and lack legal protections, their dependence within their families is even greater.

Girls are at even greater risk of exposure to HIV. Their age leaves them less able to reject sexual advances than adults. Girls are more likely to be taken out of school than boys, either to care for the family or because there is not enough money to support all the children's education. Addressing women's and girls' needs for HIV prevention, treatment and care is vital for curbing the epidemic (UNAIDS, 2010).

Vulnerability to HIV infection is increased where sex between men is criminalized, as men are either excluded from, or exclude themselves from, sexual health and welfare agencies out of fear. The essential HIV prevention measures for men who have sex with men include consistent and proper use of condoms, including access to condoms and water-based lubricants, must be promoted. High quality HIV-related services like voluntary counselling and testing and specialized clinics must be made available as well as specific and targeted information on prevention and risk reduction strategies designed to appeal to and meet the needs of men who have sex with men. Further quality treatment for sexually transmitted infections with referral for HIV services must be made available.

Gender inequality both fuels and intensifies the impact of the HIV epidemic and is most effectively addressed on the national and community level. In the context of HIV prevention, treatment, care and mitigation, this reinforces the need for interventions that are directed at individual people. Reducing gender inequality requires changing social norms, attitudes and behaviours through a comprehensive set of policies and strategies.

It is well known that mobile populations (migrants and ethnic minorities) are considered more vulnerable and more susceptible to HIV infection, and the HIV/AIDS epidemic in Europe progressively affects them (del Amo et al., 2004; Suligoi et al., 2006). Especially among adolescent migrants, the spread of HIV is a major health topic requiring effective preventive policies (Pajno et al., 2009). The enlargement of the European Union will have an impact on mobility patterns and the AIDS epidemic in Europe. A study conducted with the aim of describing the service use of migrants from eight central and eastern European (CEE) countries at two central London genitourinary medicine (GUM) clinics before and after accession to the European Union on 1 May 2004, showed the following results: between May 2006 and 30 April 2007 individuals born in the eight CEE countries accounted for 7.9% of attendances among women and 2.5% of attendances made by men; the proportion increased significantly over the 6-year study period. Syphilis was more common in CEE men and family planning services were more likely to be required for CEE women than for those born elsewhere. A larger proportion of men from CEE countries were recorded as homosexual or bisexual than men from other countries. Although the majority of CEE migrants are men, proportionately fewer CEE men accessed GUM services than women. Sexual and reproductive health services need to adapt quickly to meet the needs of this growing population (Burns et al., 2009). These highlight the importance of design interventions that are culturally sensitive and gender-specific (Smith, 2003).

Perceptions of a societal double standard with regards to sex still exist in teenage culture and may influence behaviour. Sexuality and its expression take place in a larger context of structural gender inequality that characterizes most societies. The social controls of sexuality and gender relations are complex phenomena that require sophisticated and varied methods of study. Employing group discussions has been shown to be a very effective method for understanding young people's perspectives on many issues (Dias, Matos and Goncalves, 2005).

Are policies and programmes that address risk for STIs and HIV/AIDS gender sensitive?

A systematic review conducted with the aim of examining the effectiveness of interventions seeking to prevent the spread of STIs, including HIV, among young people in Europe between 1995 and 2005, showed that the young people studied were more accepting of peer-led than teacher-led interventions. Peer-led interventions were also more successful in improving sexual knowledge, although there was no clear difference in their effectiveness in changing behaviour. The improvement in sexual health knowledge does not necessarily lead to behavioural change. While knowledge may help improve health-seeking behaviours, additional interventions are needed to reduce STIs among young people (Lazarus et al., 2010).

Gender is a critical factor in STI vulnerability. The high prevalence of HIV among MSM and IDUs (who are mostly male) means that men run a higher risk of HIV than women. On the other hand, young women are biologically more vulnerable to STIs, and socially they are often less able to negotiate condom use. Interestingly, we did not find any studies of STI interventions in Europe that targeted young prisoners, sex workers, or IDUs. To reach "at risk" groups, which often have the highest STI rates, interventions should occur outside school (Lazarus et al. 2010).

At the 2006 High Level Meeting on AIDS, all Member States of the United Nations have pledged "to eliminate gender inequalities, gender-based abuse and violence" and to "increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, and the provision of full access to comprehensive information and education."

Furthermore, as part of the same resolution, all Member States of the United Nations have also pledged to "ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health… and to take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence; and in this context, reiterate the importance of the role of men and boys in achieving gender equality" (UNAIDS, 2010).

Specific policy measures are crucial for making prevention, care and support available to men who have sex with men. First and foremost, they must be included in national HIV programming and funding priorities. Gay, lesbian, bisexual and transgender communities must be empowered to participate equally in the social and political life of their communities and countries.

UNAIDS identifies actions that must be taken to change the structural and socio-cultural underpinnings of stigma and discrimination, and these are also essential to addressing gender inequality:

Priority actions to address gender inequalities

- Top leadership at every level of society must speak out against stigma, discrimination, gender inequality and women's empowerment
- Laws and policies that protect women and girls against sexual violence, disinheritance and gender discrimination of all kinds, including harmful traditional practices and sexual violence in and outside of marriage must be enacted, publicized and enforced.
- Women must be adequately represented in policy-and decision-making on AIDS.

- Laws and policies that directly address gender inequality and bias against people perceived to be at heightened risk for HIV, including sex workers and men who have sex with men, must be enacted and enforced.
- Changes in laws and policies must be accompanied by adequately funded "know your rights and social mobilization campaigns against gender inequality and HIV related stigma and discrimination; the campaigns should involve organizations of people living with HIV along with all other elements of civil society in their planning and implementation.

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Characteristics of effective curriculum-based programmes for sex and HIV education

Developing the curriculum	Content	Implementation
1. Involve multiple people with different backgrounds in theory, research and sex/HIV education.	**Curriculum goals and objectives** 1. Focus on clear health goals, such as the prevention of STIs and HIV and/or pregnancy.	1. Secure at least minimal support from appropriate authorities, such as ministries of health, school districts or community organizations.
2. Assess relevant needs and assets of target group.	2. Focus narrowly on specific behaviours leading to these health goals (such as abstaining from sex or using condoms or other contraceptives); give clear messages about these behaviours; and address situations that might lead to them and how to avoid them.	2. Select educators with desired characteristics, train them and provide monitoring, supervision and support.
3. Use a logic model approach to develop the curriculum that specifies the health goals, the behaviours affecting those health goals, the risk and protective factors affecting those behaviours, and the activities addressing those risk and protective factors.	3. Address multiple sexual–psychosocial risk and protective factors affecting sexual behaviours (such as knowledge, perceived risks, values, attitudes, perceived norms and self efficacy).	3. If needed, implement activities to recruit and retain youths and overcome barriers to their involvement (for example, publicize the programme, offer food or obtain consent from youths or parents).
4. Design activities consistent with community values and available resources (such as staff time, staff skills, facility space and supplies).	**Activities and teaching methods** 4. Create a safe social environment in which youths can participate.	4. Implement virtually all activities as designed.
5. Pilot-test the program.	5. Include multiple activities to change each of the targeted risk and protective factors.	
	6. Use instructionally sound teaching methods that actively involve participants, that help participants personalize the information and that are designed to change each group of risk and protective factors. 7. Use activities, instructional methods and behavioural messages that are appropriate to the culture, developmental age and sexual experience of the participants.	
	8. Cover topics in a logical sequence.	

Source: Kirby D, Laris BA, Rolleri L. *The impact of sex and HIV education programs in schools and communities on sexual behaviors among young adults*. Washington, DC, Family Health International, 2006.

Seven themes on social and cultural factors shaping young people's sexual behaviour to be taken into account when designing HIV programmes[8]

Theme	Elements	Consequence for the behaviour
1. Young people subjectively assess the risks from sexual partners on the basis of whether they are "clean" or "unclean"	Studies repeatedly showed that young people assess the disease risk of a potential partner by how well they know their partner socially, their partner's appearance, or other unreliable indicators. They readily use condoms to protect against disease with "risky" partners. A partner might be judged likely to be 'clean' (disease free) or 'dirty' based on their behaviour and social position".	Young people who use condoms in short term, unstable relationships might not use them in longer term relationships. Such young people may however use condoms with "clean" or long-term partners to avoid pregnancy—which could be more of a concern than disease prevention.
2. Sexual partners have an important influence on behaviour in general	The nature of the partner and the partnership influences not just whether a young person uses a condom but sexual behaviour in general. Individuals might see sex as something that could strengthen a relationship, or as a way to please a partner. If being feminine is thought to require a stable partnership with a man, failed partnerships can damage women's social position. Violence against women within relationships can be seen as normal, or as being the victim's fault.	Pregnancy can be sought as a way to keep hold of a boyfriend. Acceptance of partner' rules in sex practices, difficulties to apply refusal skills Some young people may be reluctant to refuse sex because of fear of physical violence or retribution if they do so. Non-disclosure of violence
3. Condoms can be stigmatizing and associated with lack of trust	Carrying or buying condoms can imply sexual experience undesirable for women, although sometimes desirable for men. Similarly, asking for condoms can imply inappropriate experience for women. Young people also worry that asking for their partner to use a condom implies that they think their partner is diseased; thus, condom-free intercourse can be seen as a sign of trust.	Condom-free intercourse

[8] adapted from Marston C and King E (2006). Factors that shape young people's sexual behaviour: a systematic review. *The Lancet,* 368: 1581-6.

4. Gender stereotypes are crucial in determining social expectations and behaviour	Societies have similar expectations of men's and women's behaviour. Men are expected to be highly heterosexually active, and women chaste. Vaginal penetration is perceived to be important in determining masculinity, and marks the transition from boyhood to manhood. Men are expected to seek physical pleasure, but women desiring sex can be branded "loose" or "cheap". Where romantic love is expected to precede marriage, sex for young women must be linked to romance, and they are expected to be "swept off their feet" into sexual intercourse, in a way that is not logical, planned, or rational. Men, on the other hand, may scheme and plot to obtain sex, for example, by deceiving women into thinking the relationship is a serious one when it is not. Paradoxically, despite the stigmatizing effect for women in carrying condoms or using other contraception, women, not men, are generally considered responsible for pregnancy prevention.	Refraining from disclosing planned, or rational behaviours in sex practice (i.e. producing a condom) Limited space for young girls to adopt a pro-active attitude in negotiating sex practices within societal paradigm of femininity and masculinity
5. There are penalties and rewards for sex from wider society	Social rewards and penalties influence behaviour. Complying with gender expectations can raise social status: for men, by having many partners, for women, by chastity or securing a stable, exclusive relationship with a man. While pregnancy outside marriage can be stigmatizing, for some women pregnancy can be an escape route from the parental home. Young people may behave in particular ways through fear of being caught in the act. Sex can also be a way to obtain money and gifts from boyfriends.	Having many partners to raise social status (for men) Pregnancy as escape route from parental home Behaviours considered risky or taboo can become desirable due to the fact that the relation between individual motivations and social expectations is complex

6. Reputations and social displays of sexual activity or inactivity are important	Reputations are crucial for social control of sexual behaviour. Reputations are linked to displays of chastity for women, or heterosexual activity for men. Women's reputations are damaged by "too many" partners. Even mentioning sex can risk implying sexual experience and damage reputations. Young men's reputations can suffer if they are not seen to push for sexual access and numerous female partners. Young men not having sex with their girlfriends may be accused of being "gay". Some worry they will be unable to achieve penetration, and may even avoid condom use for fear of loss of erection.	Young girls may pretend ignorance of contraceptive methods to preserve reputations. Family members may prevent young people socialising with members of the opposite sex, to protect family and individual reputations. Display of heterosexual activity to maintain young men' reputation, and seek (condom-free) penetrative intercourse
7. Social expectations hamper communication about sex	Social pressures mean that women might not wish to mention sex or acknowledge sexual desires, particularly early in a relationship. For instance, women may avoid saying "yes" directly to sexual activity in case they seem inappropriately willing. This makes "no" difficult to interpret. Young people may avoid discussing sex for fear that raising the possibility may lead to loss of face or hurting others' feelings (through rejection), or damage to reputation (through seeming inappropriately forward). This makes safer sex difficult to plan: if the possibility of sexual intercourse is not acknowledged, contraception is unlikely to be discussed. Young people could also be reluctant to discuss condom use in case it is seen as equivalent to proposing or agreeing to sex.	Young people often avoid speaking openly to partners about sex, instead using deliberate miscommunication and ambiguity. Genuine refusal under these circumstances may be hard to communicate as a result. Difficult to plan safer sex if the possibility of sexual intercourse is not acknowledged

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