

Young people, HIV and AIDS



KEY POINTS:

- AIDS is the leading cause of death among young people (aged 10-24) in Africa, and second leading cause globally
- Young women are twice as likely to acquire HIV as young men
- A youth bulge in Africa threatens to increase new HIV infections further
- Unprotected sex is the most common route of HIV infection among young people
- Low HIV and sexual health knowledge is a key barrier to reducing HIV infections among young people
- A 'life-cycle' approach to HIV prevention can help respond to the changing challenges people face at different ages

Explore this page to find out more about [young people's vulnerability to HIV](#), [young people and key populations](#), [barriers to effective prevention programmes](#), [treatment and support for young people](#), and what [the future](#) might hold.

Young people (10 to 24 years) and adolescents (10 to 19 years), especially young women and young key populations, continue to be disproportionately affected by HIV. In 2016, 2.1 million people aged between 10 and 19 years were living with HIV and 260,000 became newly infected with the virus.¹ The number of adolescents living with HIV has risen by 30% between 2005 and 2016. ²

**3.9 million
young people
(15-24) were
living with HIV
in 2014**

AVERT.org Source: UNAIDS 2015

**62,000
new HIV
infections
among young
people**

The number of adolescents dying due to AIDS-related illnesses tripled between 2000 and 2015, the only age group to have experienced a rise.³ In 2016, 55,000 adolescents between the ages of 10-19 had died through AIDS-related causes.⁴ AIDS is now the leading cause of death among young people in Africa and the second leading cause of death among young people worldwide.⁵

The majority of young people living with HIV are in low- and middle-income countries, with 84% in sub-Saharan Africa.⁶ In fact, half of the 15 to 19-year-olds who are living with HIV in the world live in just six countries: South Africa, Nigeria, Kenya, India, Mozambique and Tanzania.⁷

In 2016, 73% of new HIV infections among adolescents occurred in Africa.⁸ Many African countries already have youthful populations - for example, 51% of the population of South Sudan are under the age of 18.⁹ It is estimated that the number of 10 to 24-year-old Africans is set to rise to more than 750 million by 2060. This means that, even if current progress is maintained, new HIV infections among young people are expected to increase. If progress stalls, the results could be devastating. Estimates suggest that as many as 740,000 additional adolescents could become infected between 2016 and 2030.¹⁰

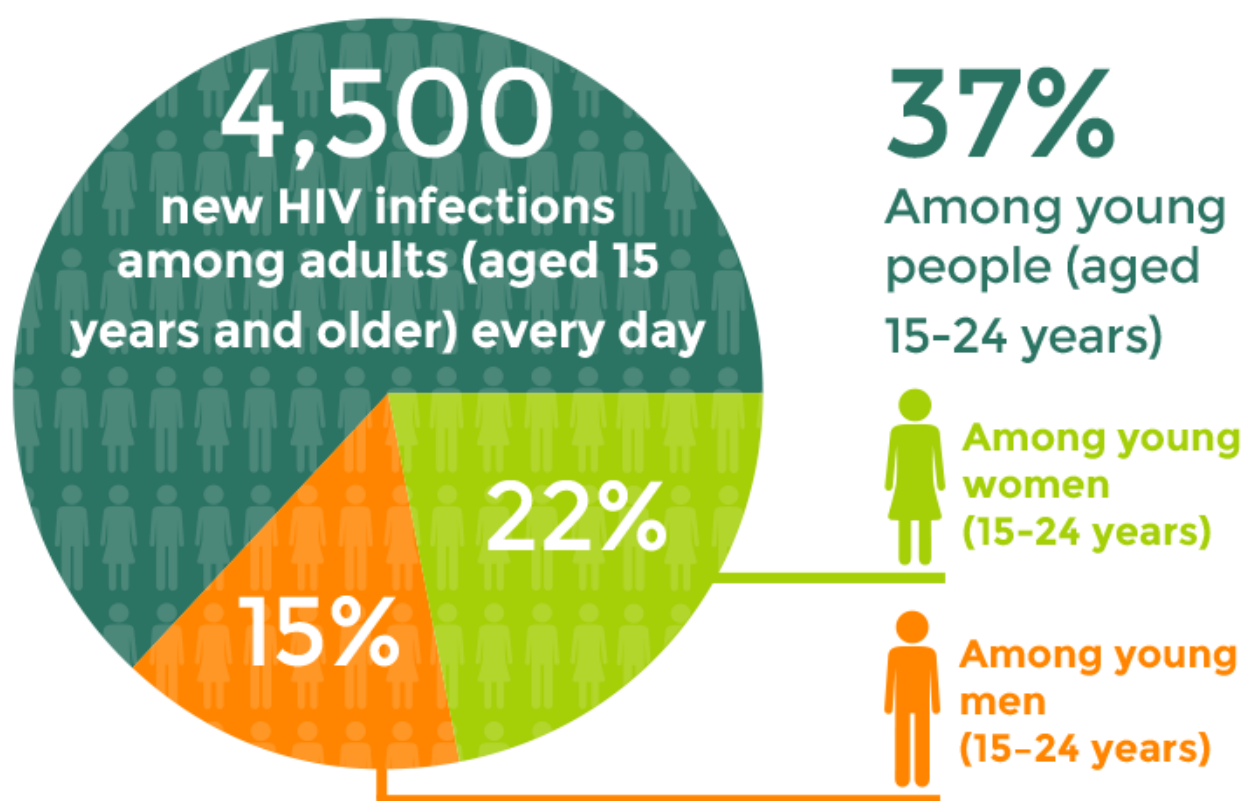
The medical advances that have transformed HIV treatment have yet to alter the stark reality for young people, particularly in low to middle-income countries, such as those in sub-Saharan Africa, and young people within key populations. While AIDS related deaths have halved in children since 2010, they have only fallen by 5% in adolescents.¹¹ AIDS, in other words, is far from over - especially for young people.

- Linda-Gail Bekker, International AIDS Society President¹²

Multiple and intersecting forms of discrimination and structural inequality affect the lives of young people and increase their vulnerability to HIV.

Every week, 7,500 young women across the world acquire HIV.¹³ Young women are more than twice as likely to acquire HIV as young men, every year since 2010 they have made up 67% of new infections among adolescents.^{14 15} and in some regions the difference between genders is particularly stark. For example, in some parts of sub-Saharan Africa, young women are up to eight times more vulnerable to HIV than young men.¹⁶

HIV also disproportionately affects young men who have sex with men, young people who use drugs, young transgender people and young sex workers. In Asia, 95% of young people diagnosed with HIV fall into at least one of these groups.¹⁷



AVERT.org Source: UNAIDS 2017

Why are young people vulnerable to HIV?

Young people are vulnerable to HIV at two stages of their lives; early in the first decade of life when HIV can be transmitted from mother-to-child, sometimes known as vertical transmission (see [children and HIV](#)), and the second decade of life when adolescence brings new vulnerability to HIV.

Around 70% of adolescents living with HIV will have acquired it through vertical transmission and so will have been living with the virus since birth.¹⁸ Whilst programmes to [prevent mother-to-child transmission \(PMTCT\)](#) have been hugely successful in recent years, reducing new infections among adolescents is more difficult.¹⁹

There are many factors that put young people at an elevated risk of HIV. Adolescence and early adulthood is a critical period of development when significant physical and emotional changes occur. Adolescents and young people have growing personal autonomy and responsibility for their individual

health. The transition from childhood to adulthood is also a time for exploring and navigating peer relationships, gender norms, sexuality and economic responsibility.²⁰

Considerable data gaps exist in our knowledge of HIV among adolescents and young people. This is particularly the case for younger adolescents because of the challenges in getting parental approval for their involvement in surveys and a lack of age-appropriate questions. Where data exist, limited sample sizes and lack of disaggregation limits the available evidence to inform programming. In part because of these gaps, adolescents and young people are often missing from national HIV strategic plans, particularly interventions beyond PMTCT.²¹

Vulnerability to HIV transmission via unprotected sex

Excluding vertical transmission, unprotected sex is the most common route of HIV infection for young people, with sharing infected needles the second.²² For some, this is a result of not having the correct knowledge about HIV and how to prevent it, highlighting the need for HIV and sexual and reproductive health and rights (SRHR) education. For others, it is the result of being forced to have unprotected sex, or to inject drugs.²³

Early sexual debut

The age of sexual debut is rising, showing a positive change in attitudes among young people with regards to sexual behaviour.²⁴ However, it is still relatively low in many countries, particularly in Africa, and lower among adolescent girls than boys in low- and middle-income countries.^{25 26}

It is common for young people to become sexually active by late adolescence. UNICEF estimates that between 30-50% of girls will give birth to their first child before 19.²⁷

While only a small percentage of adolescents will become sexually active before the age of 15 (roughly 11% for girls), evidence suggests that some children as young as five are exposed to sexual activities directly or indirectly. Child marriage is a key driver of early sexual debut, and in some settings up to 45% of adolescent girls reported that their first sexual experience was forced.²⁸

Not using condoms

Condom use among young people and adolescents remains relatively low. Demographic and Health Surveys conducted in sub-Saharan Africa between 2010 and 2015 report less than 60% of young women (aged 15 to 24) with multiple partners used a condom during their last sexual intercourse in 19 of 23 countries. In 15 out of 23 countries there were similar results for young men.²⁹

The number of sexual partners young people have is falling, although it remains high in countries most affected by the HIV epidemic.³⁰ For example, more than a quarter of young men in Lesotho, Madagascar and Eswatini are thought to be in multiple relationships.³¹

Older partners

Intergenerational sex (when young people have sexual relationships with older people) is thought to be an important driver of the HIV epidemic in sub-Saharan Africa.

Older partners are more likely to be living with HIV, therefore risking exposure to young people, and are more likely to expose a young person to unsafe sexual behaviours such as low condom use.³² In

many instances, age-disparate sexual relationships take place between older men and young or adolescent women and are transactional in nature, in that they are motivated by the implicit assumption that sex will be exchanged for material support or other benefits.³³

Girls at university or colleges always want nice things and this tempts them to get older men who can afford such a lifestyle especially if their parents can not.

- Allen Kyendikuwa, Uganda, aged 25³⁴

Young people who are part of key populations

Young people may also belong to other key affected populations such as [sex workers](#), [men who have sex with men](#), [people who inject drugs](#) or [transgender people](#). Not only do young people from key populations face widespread discrimination, stigma and violence they also face specific vulnerabilities associated with youth, including power imbalances in relationships and, sometimes, the impact of alienation from family.³⁵ Young people within key populations often have lower knowledge of HIV risks, or lower ability to mitigate those risks, compared with their older, more experienced counterparts.³⁶



Young sex workers

There is little agreement on how to meet the needs of the significant numbers of young people involved in selling sex.³⁷

There is varying data on the age of entry of children into sexual exploitation and young people into sex work. It is estimated that 40% of female sex workers in [North America](#), East and South Asia begin selling sex before the age of 18.³⁸ In Bangladesh, many start before they reach 12-years-old,³⁹ and in India, studies suggest that 17% of female sex workers began selling sex before the age of 15.⁴⁰ A 2011 study from Ukraine found that 20% of female sex workers were aged 10-19.⁴¹

Research shows that adolescents under 18 who sell sex are highly vulnerable to HIV and other

sexually transmitted infections (STIs), have higher levels of HIV and STIs than older sex workers, and have limited access to services such as HIV testing, prevention, and treatment.⁴² Young sex workers face many of the same barriers to HIV prevention as their older counterparts including the inability to negotiate condom use and legal barriers to HIV and sexual health services, which are amplified by their age.⁴³

A study of female sex workers in three main urban areas of Mozambique (Maputo, Beira and Nampula) found that young women who sell sex (aged 15 to 17 years) were less likely to access available HIV testing and treatment services.⁴⁴

Despite their vulnerabilities, young people who sell sex are severely under-represented in research on HIV and sex work. Although secondary analysis from biological and behavioural surveys between 2011–2015 found HIV prevalence among young sex workers to be 28% in Cameroon, 42% in Rwanda, 15% Senegal, and 33% in Zimbabwe.⁴⁵

Most studies of sex workers do not disaggregate programme outcomes by age, and no accurate global estimates exist of the number of young people engaged in selling sex. Data on the prevalence of 10 to 17 year-olds who are sexually exploited is particularly weak. In general, even fewer data are available on young men and young transgender people who sell sex than on young women who do so.⁴⁶

Young transgender people

Young transgender people's immediate HIV risk is related primarily to sexual behaviour, especially unprotected anal sex. Some young transgender people also sell sex or inject street drugs, silicon and hormones, putting them at even higher risk of acquiring HIV. Experiences of stigma, discrimination, abuse, exploitation and violence, including sexual violence, are common.⁴⁷

There is little global data on the HIV among young transgender people but individual studies suggest high HIV prevalence. For example, in Indonesia, HIV prevalence among transgender people was found to be 5.4% among 15 to 19-year-olds and 14.2% among 20 to 24-year-olds.⁴⁸

A US-based study of transgender women who reported being HIV negative or unaware of their status found 8% of those aged 13–19 years were living with HIV.⁴⁹

A study of ethnic-minority transgender women aged 16 to 25 years in Chicago, United States of America (USA), found 22% reported being HIV positive. The majority of respondents (59%) reported exchanging sex for money or other resources.⁵⁰ A comparable proportion (19%) of transgender women aged 15–24 years reported being HIV positive in Chicago and Los Angeles, USA. Again, the majority (67%) reported selling sex. HIV prevalence among those who sold sex (23%) was almost four times as high as among transgender women in the same age group with no history of selling sex.⁵¹

You have triple stigma if you are young, a sex worker and a transgender.

- *Young transgender person, Asia*⁵²

Young men who have sex with men

Available data suggest that young men who have sex with men have greater HIV risk than both heterosexual young people and older men who have sex with men.[53](#)

Men who have sex with men are becoming HIV-positive at a younger age. An estimated 4.2% of men who have sex with men aged 25 and under are living with HIV, compared to 3.7% among all men who have sex with men.[54](#)

Young men who have sex with men are often more vulnerable to the effects of homophobia (manifested in discrimination, bullying, harassment, family disapproval, social isolation and violence), as well as criminalisation and self-stigmatisation. This can have serious repercussions for their physical and mental health and their ability to access HIV testing, counselling and treatment.[55](#)

Use of drugs or alcohol and selling sex contribute to HIV risk and represent overlapping vulnerabilities that some young men who have sex with men share with other young key populations.[56](#)

Young MSM are often unable to respond effectively to homophobia because of their age – they have no income, no employment, and they are dependent on family for housing. If they get kicked out, and they often do, they end up on the street where they may be forced to trade sex for food, shelter or protection.

- *Young man who has sex with men, Jamaica*[57](#)

Young people who inject drugs

Current methods of gathering and reporting data make it impossible to calculate a reliable global estimate of the number of young people who inject drugs.[58](#)

HIV prevalence among young people who inject drugs worldwide is estimated at 5.2%.[59](#) However, it is much higher in certain countries. A secondary analysis from biological and behavioural surveys found 23% HIV prevalence in Greece, 17% in Myanmar, 34% in Pakistan and 25% in Thailand among young people who inject drugs.[60](#)

A significant proportion of young people who inject drugs become infected with HIV within the first 12 months of initiation. In Ho Chi Minh City, Viet Nam, 24% of people who inject drugs under 25 years had started injecting within the previous 12 months, and of these, 28% were infected with HIV.[61](#) An East European multi-country study of injecting drug users (aged 15 to 24 years) found that up to 30% reported their age at first injection as less than 15 years old.[62](#)

Young people who inject drugs are more likely than older people to lack knowledge about safer injecting practices and HIV prevention, and to be unaware of risks to their health.[63](#)

There are often age restrictions on accessing harm reduction services, forcing young people away from services and denying them help to overcome their addiction.[64](#) Someone who starts injecting

drugs in their youth should be prioritised for harm reduction services, not denied them.

HIV prevention programmes for young people

Young people are often forgotten in national HIV and AIDS plans which typically focus on adults and children. Consequently, there are a lack of youth-friendly health services.⁶⁵

Ethical and legal issues make it difficult to conduct studies and research on people under 18, limiting what data is available about how HIV affects young people.⁶⁶ Despite this, there is now a global effort to collect disaggregated data on adolescents and young people across three 5-year age bands around: 10-14, 15-19 and 20-24.⁶⁷ However, these age groups are not well defined internationally and even vary within countries, making data collection and its reliability very complex.⁶⁸

The risks of HIV infection, the challenges of accessing services and the solutions to these challenges change at different stages of someone's life. As a result, UNAIDS recommends the adoption of a 'life-cycle approach' to HIV prevention, which responds to the changing contexts that people face at different ages.⁶⁹ A life-cycle approach means examining the biological, social and behavioural factors that independently, cumulatively and interactively affect adolescents' and young people's vulnerability to HIV and the lives of those living with HIV.⁷⁰

Age-appropriate services

Young people respond much better to HIV and SRHR services that are specific to their age group.⁷¹ Research shows that targeted counselling to encourage behaviour change among young people is more effective than only handing out commodities such as condoms.⁷²

CASE STUDY: Spreading HIV knowledge through football

Tackle Africa trains football coaches across Africa to deliver interactive HIV and SRHR education to young players on the pitch. The informality of the football pitch allows young people to discuss intimate issues more freely, and the game itself means young people can play out the consequences of different decisions in an enjoyable and safe way. Tackle Africa's partner in Kenya, Moving The Goalposts (MTG), works primarily with 10 to 14 year-old girls from rural areas who have low literacy levels. Health messaging is simple and depersonalised with each session focusing on one key piece of information to take away, for example 'getting tested is the only way to know your HIV status'. Sessions for older players are more complex in terms of football and health messaging.⁷³

CASE STUDY: Youth friendly HIV services in Lesotho

AVERT has been in partnership with Phelisanang Bophelong (PB) since 2015, helping young people (aged 15 to 24) in Lesotho access youth-friendly HIV services and engage in open discussions with peers and parents about SRHR. In 2016, 3,600 young people received HIV

testing and counselling from PB, with more than 2,500 getting tested for the first time. PB also provided SRH information to more than 5,600 young people.

PB trains community-based volunteers to run youth groups linked to clinics and also runs a group for young prisoners and an LGBT group peer-led by an LGBT young person. The groups use WhatsApp to mobilise and support each other outside of youth group meetings, which has proved a useful way to share information safely and quickly.

Engaging parents, caregivers and guardians in the response

The influence, power and control that many adults have on the lives of young people means that engaging various stakeholders such as parents, health providers and community leaders is key to HIV prevention for young people.

Engaging schools in the response

Schools have the potential to provide detailed education on HIV and AIDS and other SRHR issues. More progress needs to be made to ensure there is equality in access to schools by both girls and boys, and to prevent them from dropping out.⁷⁴

However, a study of schools in rural Zimbabwe published in 2016 found many teachers felt they lacked formal SRHR skills (e.g. knowledge about HIV, how to talk to pupils about sex, counselling skills). Teachers defined their role predominantly in terms of the transmission of factual knowledge and the exercise of discipline, with the notion of care and support not fitting easily into this framework. Many were overwhelmed by the extent of pupil's needs relative to the lack of resources available.⁷⁵

Engaging young people in the response

Young people have the potential to be great peer educators, and to help in the design of HIV-related services and programmes. Technology and social media are consistently being proved as effective ways to engage young people in sharing HIV knowledge.

The use of peer educators and social media have been combined by the Y+ Programme, a platform for young people living with HIV to talk, find a mentor, become a mentor and advocate for the needs of young people.⁷⁶ Similarly, ACT!2030, is a youth-led social action initiative which aims to inspire a new wave of activism in the HIV response using social media and online technology to advance young people's SRHR. It is active in 12 countries: Algeria, Bulgaria, India, Jamaica, Kenya, Mexico, Nigeria, Philippines, South Africa, Uganda, Zambia, and Zimbabwe.⁷⁷

Transitions to adulthood

In early adulthood, programming should take into account that young adults will have less support from their families and communities as they transition to working and living independently.⁷⁸

Enabling adolescents to graduate from school with the skills and experience to participate in the workforce can significantly affect HIV outcomes. This is because unemployment or working in poorly paid jobs can lead to economic vulnerability, which may in turn motivate young people to engage in

selling sex or embark in age-disparate, transactional relationships.⁷⁹

Barriers to HIV prevention among young people

Low HIV and sexual health knowledge

If young people are able to access comprehensive sexuality education (CSE) before becoming sexually active they are more likely to make informed decisions about their sexuality and approach relationships with more self-confidence. CSE is also known to increase adolescent girls' condom use, increase voluntary HIV testing among young women and reduce adolescent pregnancy, especially when linked with non-school-based, youth-friendly SRHR services, provided in a stigma-free environment.⁸⁰

In 2015, UNAIDS and the African Union included age-appropriate CSE as one of five key recommendations for improving the HIV response. In the same year, many countries in Asia and the Pacific, West Africa and Europe were revising their policies and approaches to scale up CSE.⁸¹

However, many young people do not receive adequate HIV and sex education.⁸² For example, in population-based surveys conducted across East and Southern Africa between 2011 to 2016, just 36% of young women had comprehensive and correct knowledge about HIV and 30% of young men.⁸³ In West and Central Africa, this figures stands at just 24%.⁸⁴

Opportunities to obtain knowledge about HIV, AIDS and sexual health are extremely limited for young people not in school.⁸⁵ Youth clubs have the potential to provide HIV knowledge, but their small, localised reach means their impact is limited on a large scale.⁸⁶

Lack of access to HIV services

Reluctance to acknowledge adolescents' and young people's exposure to sex can lead to age restricted laws that govern access to SRHR services including HIV testing and treatment. In 2016, at least 63% of the 108 countries where there was data required young people to have the consent of parents or legal guardians to access SRHR services. ^{87 88} In 71% of the countries parental consent was needed for young people to take a HIV test.⁸⁹

Many SRHR health services are also unappealing or unfriendly to adolescents and young people. Many young people report that healthcare workers have negative attitudes towards young people seeking SRHR services, particularly those having sex under the national age of consent, engaging in same-sex relationships or using drugs.⁹⁰ This deters them from seeking contraception, STI check-ups and HIV testing.⁹¹

Some young people are also fearful of stigma from their partners, families and communities, making them unwilling to come forward for HIV testing.⁹² Other SRHR services deny access to people who are not married.⁹³

HIV testing and counselling (HTC) for young people

Historically, national AIDS programmes have struggled to persuade people at higher risk of HIV to periodically test for HIV. This has been especially the case among adolescents and young people, who often underestimate their HIV risk.⁹⁴ Results from surveys conducted between 2011 and 2016

showed that only 10% of adolescent boys and 12% of adolescent girls in sub-Saharan Africa had tested for HIV in the last 12 months. [95](#)

Among people who tested positive for HIV within Demographic and Health Surveys conducted in 19 low- and middle-income countries (mostly in sub-Saharan Africa) between 2011 and 2015, only 50% of people aged 15 to 19 years had ever been tested for HIV and received the results, suggesting the other 50% were unaware of their HIV-positive status. In comparison, 76% of people aged 20 to 24 years living with HIV and 78% of people aged 25 to 29 years living with HIV had tested and received the results.[96](#)

Increasing access to HTC is vital to prevent further transmission of HIV among young people. Mobile and community testing initiatives are a successful way of reaching young people who are less likely to voluntarily visit a static testing centre.[97](#) HTC has proved very successful as a form of HIV prevention in Eastern and Southern Africa.[98](#)

For example, a study in South Africa found that HIV testing and counselling (HTC) among 4,000 young people meant 41% fewer cases of HIV transmission in a four year period.[99](#)

In Fortaleza, Brazil, the Youth Aware project focuses on mobile outreach to expand HTC and improve linkages to care. Of 1,410 people tested by the mobile unit during an 18-month period ending in June 2015, 609 were aged 13 to 19, 102 were adolescent men who have sex with men, and 264 were aged 13 to 19 who were in conflict with the law.[100](#)

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Barriers to HIV testing for young people

The World Health Organization (WHO) 2013 guidelines for HTC for adolescents highlight the programmatic barriers currently preventing adolescents from accessing HIV testing, and what can be done to overcome them.[101](#)

In many countries, the age of consent for testing for HIV is high at around 18 to 21, leaving people younger than this having to obtain parental consent. This is much more likely to result in a young person not getting an HIV test when discussions with parents around sexual relations and HIV are

necessary. For many orphaned young people, parental consent is not an option and so they are denied access.¹⁰² Age of consent laws to HIV testing should be removed.

HTC services must be open at appropriate times (after school/college), and be at appropriate venues where young people feel safe enough to go alone.¹⁰³ Healthcare workers must be trained to meet the needs of young people, in order that they do not face stigma, judgement, or a breach in confidentiality. Young people need extra support to transfer to treatment if they test positive, as they may otherwise get lost in the treatment cascade.¹⁰⁴

Treatment and support for young people and adolescents living with HIV

Antiretroviral treatment for young people

Access to ART for young people is unknown because data is disaggregated into children under 15 years and adults over 15 years.

Global reporting of the numbers of adolescents on ART began in 2014. However, as of 2017 not all countries are reporting to this level of age specificity. As a result, just 41 countries were able to report adolescent ART data for 2016. On average only 36% of adolescents in these countries receiving ART. Throughout west and central Africa and Latin America and the Caribbean no country was reporting an ART coverage among adolescents over 61%.¹⁰⁵

However, these countries only account for a small proportion of all adolescents living with HIV globally in 2015 and so data does not yet paint an accurate picture of the global situation.¹⁰⁶ South Africa is one of the countries now reporting data. Among the estimated 867,290 young people (aged 15 to 24) living with HIV in the country in 2013, 14% accessed ART. Of those on ART, around 83% were retained in care and 81% were virally suppressed, which means they are in good health and much less likely to transmit HIV. Overall, it is estimated that 10% of young people living with HIV in South Africa in 2013 were virally suppressed.¹⁰⁷

For those who do access treatment, there are some common barriers to its effectiveness.

Adhering to antiretroviral treatment

Despite the availability of effective treatment, adolescent-specific services are rarely available and often healthcare providers have little experience of providing services for young people. They may not understand the needs of adolescents living with HIV and may have judgmental attitudes towards those who are sexually active.

A failure to follow good practice and provide age-appropriate care in this area has resulted in poor rates of retention among adolescents compared to other age groups. A systematic review found that only 62% of 12 to 24-year-olds achieved 95% or greater adherence in 2015.¹⁰⁸

In 2014, treatment adherence was greatest in Africa and Asia (84%), and lowest in North America (53%). One reason for this difference is the variation in ages of maturation. It is generally thought that young people mature earlier in Africa and Asia, where they start working and have relationships at a younger age. Taking on these responsibilities may contribute to young people being more responsible for their own healthcare, and adhering to their treatment.¹⁰⁹

A study of 160 HIV clinics in Kenya, Mozambique, Rwanda and Tanzania found that young people aged 15 to 24 years were more likely to drop out of care, both before and after beginning HIV treatment, than adults. Young men were especially likely to drop out of care. However, drop out was considerably lower for adolescents who attended clinics that provided sexual and reproductive health services (including condoms) or provided adolescent support groups.[110](#)

Another study investigating the factors which affect was conducted at two public ART facilities in Johannesburg, South Africa. Overall, the factor most frequently reported as a barrier to care was long travelling distance to the clinic (61% agreed it was a potential barrier to care), followed by the possibility that the adolescent's attendance at clinic visits would be noticed by friends or members of the school (33%), having an elderly caregiver (32%), high transport cost of the trip to the clinic (32%), and long waiting queues at the clinic (31%).[111](#)

Other studies have identified a number of interventions that can have a positive impact on adolescents' adherence to ART, including: counselling and education; use of adherence support devices such as beepers; financial incentives; peer support; and directly observed therapy.[112](#) However, more research is needed in this area and overall adherence support must be scaled up for young people to sustain treatment as a form of prevention, and stop onwards transmission to others.[113](#)

Case study: USA review finds more to be improved with young adult HIV care cascade

In the United States of America (USA), a review of published literature investigated reasons why 13-29 year olds were much less likely start ART, be retained in care, and achieve viral suppression compared with adults.

It was estimated that, of the 54% of ART-initiated youths who were able to achieve viral suppression, only 6% (compared to 30% of adults) would be able to sustain suppression due to a number of lifestyle factors specific to young people which affect their adherence to treatment. These included:

- a lack of support
- behavioural and conduct problems
- inconvenient/inconsistent social routines
- forgetting medication doses
- unstable housing
- not being fully involved in treatment decision-making
- substance abuse
- psychological barriers including depression and anxiety

More positive findings suggested that simplifying treatment regimes, using directly observed therapy and cell phone reminders have the potential to reduce these challenges and to improve adherence among young people living with HIV.[114](#)

Transitioning from paediatric to adult care

In North America and Europe, there is a large jump at 18 years of age, when people living with HIV are moved from paediatric to adult services and allocated a new doctor.

In other regions, defining the age at which that an adolescent is ready to move onto adult services is less simple and remains a problem among many service providers. For instance, an analysis of 218 facilities of adolescent HIV treatment services across sub-Saharan Africa found that there was no consistent working definition of adolescence among a quarter of the facilities investigated. As a result, half of the facilities reported no transitioning protocols for moving adolescents from primary to adult care services.[115](#)

Young people who have been living with HIV since birth can face challenges in the transition from paediatric treatment services—where parents and guardians have primary responsibility for their care—to adult treatment services, as they will need to take much greater responsibility for their own care.

In a recent study, the risk of ART ceasing to work (known as 'virological failure') increased more than fourfold at the time of care transition (18–19 years of age). Risk factors associated with viral failure were low educational attainment, poor knowledge of HIV and lack of independence regarding HIV treatment adherence.[116](#)

As with any other long-term health condition, the transition to adult services should be carefully managed with full involvement of the young person as abrupt changes can be confusing and destabilising.[117](#)

Increased drug doses

For young people who may have been taking treatment for some time, changing ARV regimens and doses during adolescence is another complex issue that results in young people not adhering to their treatment. As young people grow, their dosages must be increased to reflect increases in their weight and height.[118](#)

Treatment access for newly diagnosed young people

For adolescents who were not diagnosed in childhood and who may have acquired HIV during adolescence, laws and policies on the age of consent for HIV testing prevent many adolescents from knowing their HIV status and therefore accessing HIV treatment.

Late diagnosis of HIV is a particular issue for adolescents who also belong to other key populations (for example, if they inject drugs), as they are often reluctant to seek testing and treatment services because of stigma and discrimination.[119](#)

Even after diagnosis, a young person may skip HIV medication or avoid attending viral load monitoring sessions to avoid disclosing their status. In 2016, UNAIDS found that in more than half (59%) of the reporting countries from East and Southern Africa, people younger than 18 years still require parental consent to access HIV treatment – a major barrier for adolescents faced with stigmatising attitudes towards a lifelong illness.[120](#)

The future of HIV among young people

After a long-standing failure to address the HIV epidemic among young people, there are now clearer guidelines from WHO for strengthening programmes focused on young people living with, and at-risk of, HIV.¹²¹

With the number of young people due to double in Africa by 2050, increased efforts will be needed to avoid new infections among young people from rising. That is because, even if the progress in reducing the HIV incidence rate among young people is maintained, the estimated number of new HIV infections among adolescents is projected to climb to 270,000 annually by 2025 and 300,000 annually by 2030. If progress were to slow, these numbers could climb even higher.¹²²

In some areas, progress is already being made. For example, the age of sexual debut is rising, the number of sexual partners among young people is falling, and the uptake of voluntary medical male circumcision is most popular among people younger than 25.¹²³

Still, young people are routinely forgotten in national strategic plans to tackle the HIV epidemic, especially those that also fall under other key affected populations.¹²⁴ They are not targeted with age-appropriate HIV prevention programmes and data about their vulnerability is not collected. As a result, young people are often forgotten and excluded from national HIV responses.

The medical advances that have transformed HIV treatment have yet to alter the stark reality for young people, particularly in sub-Saharan Africa and for young people from key affected populations. Larger, more rigorous studies of young people in all their diversity are needed to better understand HIV incidence and HIV care.¹²⁵

Engaging young people is key to protecting their health and addressing the HIV epidemic as a whole.¹²⁶ Enabling young people to be meaningfully engaged in the design and delivery of integrated SRHR and HIV programmes, as well as understanding the way in which age and other contexts such as gender and sexuality impact on access, are key to the provision of effective interventions.¹²⁷

Social media and associated technologies are already substantially integrated into the lives of young people in much of the world, including in low- and middle-income countries. Useful and promising initiatives have been introduced to take advantage of this growing connectedness and provide HIV awareness messaging and reminders to take ARVs, among other interventions.¹²⁸ More interventions that fit into the already complex and challenging lives of young people have great potential for strengthening young people's ability to respond more effectively to HIV.

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Tools and resources:

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01 May 2020