Consultation on Strategic Information and HIV Prevention among Most-at-Risk Adolescents

2–4 September 2009, Geneva

Consultation Report

UNICEF
in collaboration with the Inter-Agency Task Team on HIV and Young People

Contents

Annexes

Acronyms

AIDS	acquired immune deficiency syndrome
Amfar	The Foundation for AIDS Research
APMG	AIDS Projects Management Group
ARAS	Romanian Association Against AIDS
CEE/CIS	Central and Eastern Europe/Commonwealth of Independent States
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Surveys
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
IATT	Inter-Agency Task Team
IATT/YP	UNAIDS Inter-Agency Task Team on HIV and Young People
IBBS	Integrated Biological and Behavioural Survey
IDU	injecting drug user
IHBSS	Integrated HIV Behavioural and Serological Survey
LSHTM	London School of Hygiene & Tropical Medicine
MARA	most-at-risk adolescents
MARP	most-at-risk population
MARYP	most-at-risk young people
MDG	Millennium Development Goals
MERG	Monitoring and Evaluation Reference Group
MSM	men having sex with men
NAC	National AIDS Council
NACP	National AIDS Control Programme
NCCWD	National Commission on Child Welfare and Development
NGO	non-governmental organization
NSP	needle and syringe programme
PCAP	Pesquisa de Conhecimento Atitudes e Pracitacs na População Brasileira
PMTCT	prevention of mother-to-child transmission of HIV
PSE	population size estimation
RDS	respondent-driven sampling
RHRN	Russian Harm Reduction Network
STI	sexually transmitted infection
SW	sex worker
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
VCT	voluntary counselling and testing
WHO	World Health Organization

Acknowledgements:

Background

Global and national data collection systems are increasingly being geared to collect strategic information on populations considered to be most-at-risk for HIV infection in response to the dynamics of HIV transmission.

Relative risk for HIV infection is determined by behaviour. The behavioural modes of HIV transmission are unprotected anal or vaginal sex and injecting drug use. Definitions of most-at-risk populations (MARPs) are based on the relative exposure to HIV through the frequency of these behaviours.

The Consultation on Strategic Information and HIV Prevention among Most-at-Risk Adolescents focused on experiences in countries with low and concentrated epidemics where HIV infection is concentrated among men having sex with men (MSM), injecting drug users (IDUs), and those who sell sex. HIV infection among MARPs in countries with low and concentrated epidemics may be as high as 40–50 per cent, whereas it is as low as 0.1 per cent in the general population.

Progress is being made to collect strategic information on populations considered to be most at risk for HIV infection, and HIV risk among adolescents and young people is being documented in a number of countries. Little attention has been given, however, to data collection regarding younger populations who are at risk.

There is still a need for better data collection mechanisms and evidence-based interventions regarding adolescents and young people. Disaggregated data (by age, sex and other characteristics) on risk behaviours, delivery, and use of services to and among most-at-risk adolescents (MARA) are crucial for informed programme planning and policy decision-making.

The expanded UNAIDS Inter-Agency Task Team on HIV and Young People (IATT/YP) emphasizes the need for strategic information and evidence-informed programmes tailored to local realities and developed with the participation of most-at-risk young people (MARYP), including adolescents.

The meeting aimed to facilitate the exchange of information across regions on country-level data collection regarding MARA; identify ways to use strategic information to improve HIV prevention among MARA; and suggest ways to build support for MARA programming among decision makers.

The consultation focused on MARA, defined as those aged 10–19 as a subset of MARYP, or those aged 10–24. As such, participants addressed the particular challenges in collecting data and working with 10–19 year-olds, although discussions did not exclude strategic information regarding 20–24 year-olds. Age-group delineations are according to UN-agreed definitions.

A key starting point for the meeting was the recent baseline research and ongoing programming carried out by UNICEF in the Central and Eastern Europe/Commonwealth of Independent States (CEE/CIS) region, in collaboration with the London School of Hygiene & Tropical Medicine (LSHTM).

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Consultation objectives

- Share information regarding the scope of work undertaken as part of the UNICEF CEE/CIS regional collaboration with LSHTM regarding strategic information on MARA, including indictors, data collection protocols, methodologies, survey findings and approaches to building national team capacity.
- Share lessons learned from selected country experiences across regions, including how young people have been involved in data collection and how gender-sensitive approaches have been used.
- Discuss how data have been used to design intervention packages and to build national support for intervention programmes.
- Identify barriers in data collection and service provision for minors and ways to overcome them for better programming.
- Share information on good practices on size estimation of MARA and MARYP.
- Discuss ways to leverage ongoing data collection and analysis, as well as methods to integrate existing evidence into policy planning and implementation for HIV prevention among MARA.

Expected outcomes

- Identify actionable steps to improve the collection and use of strategic information; increase political commitment for programmes with MARA and MARYP; and better engage different sectors to close existing gaps.

- Produce a summary of good practice and lessons learned in data collection; of effective advocacy for evidence-informed HIV prevention with MARA; and of the use of strategic information to improve HIV prevention with MARA.

Executive Summary

Opening the consultation meeting, Luiz Loures, Director of the Executive Director's Office, Joint United Nations Programme on HIV/AIDS (UNAIDS), pointed out that responses to HIV cannot operate in a vacuum. He noted that the attainment of several of the Millennium Development Goals (MDGs) is being hampered by the HIV epidemic. Furthermore, he stressed that strategic information needs to show how HIV is directly affecting progress towards the goals in order to broaden support for HIV prevention.

Participants addressed key issues around the need for strategic information and how data can best be used to improve HIV prevention among and for MARA. Strategic information should be used to plan interventions, monitor progress, understand the dynamics of stigma and marginalization, and provide evidence of the need to prioritize those who are most affected and most at risk.

The concepts of risk and vulnerability were outlined, and a rationale for focusing on adolescents was provided. UNAIDS defines risk as the probability or likelihood that a person may become infected with HIV. Vulnerability results from a range of factors outside the individual's control that reduce the ability of individuals and communities to avoid HIV risk. These may include lack of knowledge and skills; limited quality and coverage of services; and societal factors, such as human rights violations or social and cultural norms.

Participants defined MARA as 10–19 year-olds whose behaviours signify that they are most at risk for exposure to HIV infection. These behaviours include engaging in penetrative vaginal or anal sex without a condom and injecting drugs with non-sterile equipment that has been shared.

The consultation reiterated that at-risk adolescents are defined by their behaviours and that countries need to know their epidemic in order to understand which adolescents are vulnerable and at risk.

An overview of global monitoring and evaluation frameworks and global guidance for data collection was presented. This included details of existing coordination mechanisms and agreed-upon indicators. A summary of the available guidance for monitoring MARPs was also provided. The need to improve coordination, collaboration and monitoring capacity was highlighted. Programme planners and advocates for MARA were advised to take a strategically integrated approach to data collection and to make full use of existing data collection opportunities in all HIV programme areas.

Population size estimation (PSE) and coverage calculation methodologies were discussed, and examples of how countries have undertaken size estimation activities were shared. A UN definition of coverage was given as "the percent of those who need an intervention who receive that intervention." Coverage needs to consider reach (including regularity of reach), breadth and quality. It was noted that population size is difficult to determine and that PSEs are not always an 'exact science'. It is, however, critical that partners agree on the methodology to be used and that there is consensus on the final estimated number.

UNICEF Regional Office for CEE/CIS and LSHTM shared experiences and lessons from the multi-country HIV prevention programme for MARA. The programme, which formed a starting point for UNICEF's global focus in this area, has four components: getting the evidence on at-risk adolescents; building political and community support; removing barriers to service provision, access and use of services; and building partnerships. Regional experiences in programme coordination, capacity-building and data collection were shared. A summary of research methodologies and key findings was also provided.

A research toolkit, *Working Documents for Data Collection amongst Most-at-Risk Adolescents*, which was developed by the UNICEF regional team from CEE/CIS, was also shared with participants. It is a work in progress that contains data collection tools, guidance for conducting research on MARA, core indicators, survey questionnaires, a summary of findings from four countries, and guidance tools to develop monitoring and evaluation frameworks. The toolkit's introduction is included as Annex 3.

In the final session of day one, participants divided into regional groups to discuss country-level experiences, challenges and lessons learned in using strategic information for advocacy and policy development. The key outcomes from these discussions are summarized in Annex 2.

Throughout the course of day two, participants looked at how strategic information has been used to influence policies and programming for MARA. Country experiences were presented by Brazil, Pakistan, the Philippines, Romania, Serbia and Ukraine. The UNICEF CEE/CIS Regional Office provided a summary of the issues, challenges and lessons learned from a review of the multi-country programme. Participants again divided into regional groups to share experiences and lessons learned in building political will to support HIV prevention interventions for MARA. This group work resulted in a set of points that provide advice to countries planning to collect data on MARA (see *page 35*).

On the final day, participants identified 10 steps to strengthen the evidence base, increase political commitment to MARA and improve programming linkages across sectors. These are summarized as actionable next steps on page 9. Suggestions as to how these steps might be taken at national, regional and global levels, and as to who might be involved, were also given. The full details of these steps are included in Annex 1.

The meeting was closed by Michel Sidibé, Executive Director of UNAIDS, who emphasized the importance of the UNAIDS *Joint Action for Results Outcome Framework 2009–2011.*[1] While the framework identifies the empowerment of young people to protect themselves from HIV as a specific priority, all nine of its priority areas are relevant to MARA. Strategic information is urgently required to implement the framework and ensure that the rights of marginalized and at-risk adolescents are respected. It should be used to identify programmatic gaps; to develop focused, uncomplicated advocacy messages for HIV prevention among MARA; and to show that investing in HIV prevention among at-risk and vulnerable adolescents and young people is both feasible and cost-effective.

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[1] <http://data.unaids.org/pub/Report/2009/jc1713_joint_action_en.pdf>.

Supporting documents for the meeting can be found at: http://www.unfpa.org/hiv/iatt and click on "MARA Consultation" on the menu on the left.

Consultation Outcomes

Participants shared their country-level experiences – drawing on these to identify lessons learned and make suggestions for improved data collection in the future. These are summarized in 15 points, which can be found under Section A below. The recurring themes and key messages that emerged during the course of the meeting are highlighted in Section B.

A set of actionable next steps to increase the collection and analysis of data on MARA and strengthen inter-sectoral linkages for HIV prevention programmes for MARA were developed as the meeting's final outcome. These steps addressed the actions that need to be taken at global, regional and country levels. They are set out in Section C.

A. Lessons learned for improving data collection at the country level:

1. Establish support for data collection on MARA at national and local levels.
2. Include a range of government sectors and civil society partners from the start.
3. Partner with more than one individual in a department/sector to ensure continuity.
4. Develop ethical guidance for research in advance.
5. Map out and analyse existing data before planning new research.
6. Share experiences within and between regions.
7. Package the data carefully to ensure a positive, supportive response from key stakeholders.
8. Agree from the start on why data are being collected, how they will be collected, and who will use them.
9. Ensure national ownership of the data.
10. Support participatory approaches with MARA/MARYP throughout the process.
11. Attempt to mainstream data collection into national systems/routine data-collection processes.
12. Understand which adolescents are most at risk in the local setting.
13. Use findings from quantitative data to see what qualitative data may be needed.
14. Ensure that the leading research institute is credible and has the authority to lead the study.
15. Identify sufficient funding to ensure continuity.

B. Key messages from the consultation:

Data quality
- Better use can and should be made of existing data.
- There is limited – if any – data on younger adolescents. Countries should be encouraged to collect data on 10–14 year-olds.
- It is difficult to recruit adolescents under 18 into studies – both as respondents and as partners in the data collection processes. Ethical issues continue to pose a challenge.

Coordination and oversight

- HIV prevention among MARA is not a priority in countries with comparatively low HIV prevalence.
- Improved coordination and collaboration is needed between governments and partners to improve data availability.
- Country reports to the Committee on the Rights of the Child can be used to routinely and systematically report on the status of MARA.

Harmonization

- Data on MARYP should be incorporated into global reporting requirements. Data need to be consistently disaggregated by age (15–19, 20–24, 25+) and sex at global, regional and national levels. Partners, including The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), should be encouraged to request age- and sex-disaggregated data for populations under age 25.
- UN policy and guidance documents should include the concerns of adolescents younger than 18 years old.
- Data collection and programming on MARPs need to ensure that they include a specific focus on young people and adolescents.

Service integration

- Sexual and reproductive health services, as well as child protection services, should be used as entry points for HIV prevention.
- Legal barriers to providing services to minors are preventing MARA from accessing HIV prevention services.
- Effective approaches that bring together HIV prevention and child protection interventions, and improve coordination and collaboration at national and local levels, need to be identified and supported.

C. Actionable next steps

Please see Annex 1 for full details and steps for action at country, regional and global levels.

Improving the collection and analysis of strategic information.	- Systematically disaggregate data collection and analysis on MARPs by age cohorts 15–19, 20–24, and above 25. - Strengthen capacity and increase willingness to undertake PSE among MARA. - Improve coordination and harmonize approaches to data collection.

Generating political support for policies and programmes for MARA.	- Integrate MARA into existing systems, publications and reports. - Support a 'Research – Advocacy – Programming – Advocacy – Implementation' cyclical approach. - Foster effective partnerships.
Building linkages and strengthening partnerships across sectors and services.	- Use the evidence to promote a multi-sectoral response – know your epidemic, know your response. - Work with existing systems and processes while promoting parallel, mutually supportive approaches. - Strengthen knowledge management. - Expand partnerships.

Key Concepts

Why collect strategic information?

Information on marginalized, at-risk and vulnerable groups is needed to deliver effective interventions and track progress towards achieving universal access to HIV prevention, treatment, care and support. AIDS programmes cannot operate in a vacuum and strategic information should be used to show how HIV directly affects progress towards the MDGs.
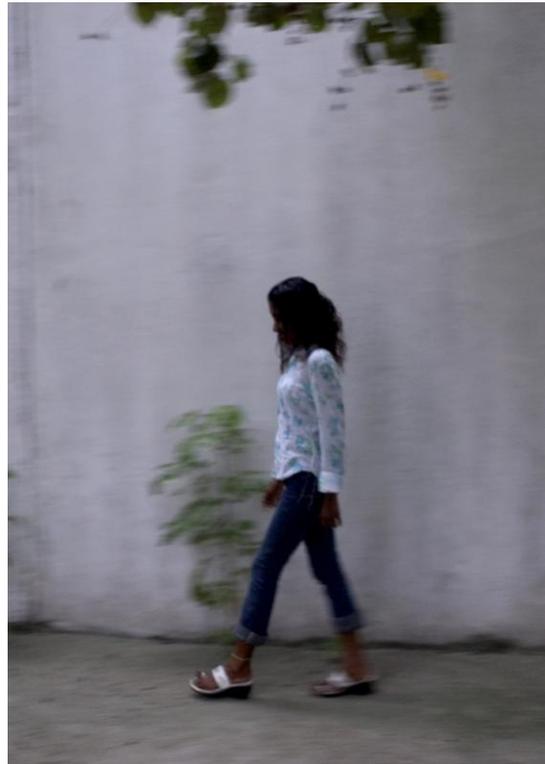
Strategic information is a core component of an effective HIV response for MARA and MARYP. Other components include policy development; capacity-building; building linkages between services and communities; and involving young people in programmes and decision-making.

Strategic information is necessary to inform:

- advocacy;
- policy development;
- strategic planning and programming;
- national and global monitoring and reporting;
- donor reporting; and
- programme monitoring and evaluation.

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The data can be used to better understand:

- which risk behaviours are taking place, among which adolescents, and when, where and why adolescents are or are not adopting them;
- what needs to be done to prevent adolescents from adopting risk behaviour;
- what prevents MARA from accessing the information and services they need;
- how best to promote harm and risk-reduction interventions;
- where, and how, to target interventions in order to reach most-at-risk, vulnerable and marginalized adolescents;
- how to integrate MARA into national AIDS plans;
- how well interventions are working and what, if any, changes are required; and
- what makes adolescents vulnerable and how this increases their chances of adopting risk behaviours.

When collecting information it is important to:

- agree why the information is being collected – how it will be used, and by whom;
- set out what information is needed;
- review and analyse data that are already available;
- focus on closing information gaps;
- ensure the data are programmatically relevant;
- collect qualitative data to complement quantitative data where necessary; and
- use sustainable and cost-effective approaches, e.g., integrating new indicators into existing surveillance and data collection systems.

Creating a Common Understanding of MARA/MARYP
Bruce Dick, World Health Organization (WHO)

Why focus on adolescents?
Adolescents require particular attention because at this stage:

- Their development may make them more vulnerable: They may be less knowledgeable, lack confidence and skills to make safer behaviour choices, be less concerned about the future, and more susceptible to positive and negative peer influence.
- They are less likely to identify themselves as being a member of an 'at-risk group' which can make them harder to reach.

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- They may be more easily exploited and abused.
- They are less likely to have access to or use available services because of a lack of awareness, limited resources or legal barriers to accessing services as a minor.
- They are in the main still children – interventions cannot respond to them in the same way that they do for adults.
- Their behaviour is less fixed, so risk behaviours are sometimes experimental and temporary.

Who are MARA?
MARA are defined as adolescents whose behaviours put them at risk of contracting HIV. These behaviours include penetrative vaginal or anal sex without a condom, and injecting drugs with non-sterile equipment that has been shared.

Some groups/individuals almost by definition adopt these behaviours, and working definitions of MARPs have been agreed, namely, SWs, IDUs and/or MSM.

It should be noted that UNAIDS defines SWs as adults over 18 years of age and affirms that all forms of the involvement of children (under the age of 18) in sex work and other forms of sexual exploitation and abuse contravenes United Nations conventions and international human rights law.[2] Children under 18 years of age who sell sex are victims of commercial sexual exploitation who cannot be viewed as SWs. All references to young SWs under the age of 18 in this report are made with the understanding of the above.

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[2] UNAIDS, *Guidance Note on HIV and Sex Work*, UNAIDS, Geneva, March 2009.

It is important to remember that the behaviours that define MARA often overlap; e.g., a person who uses drugs may sell sex in order to buy drugs. Evidence-informed advocacy and programming needs to be targeted to risk behaviours and to the settings where these behaviours are taking place. It is critical that countries 'know their epidemic' and understand what the data are telling them about who is at risk or vulnerable.

MARA are a subset of young people and a subgroup of MARPs. HIV prevention services for at-risk adolescents and young people will differ from services for the general population of young people. Services for MARA may not need to vary widely from those required by at-risk adults, but they will probably need to be delivered in a very different way that is age- appropriate and that incorporates child-protection interventions when required.

Risk is defined as the probability or likelihood that a person may become infected with HIV. Certain behaviours create, increase and perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown, multiple sexual partnerships involving unprotected sex, and injecting drug use with contaminated needles and syringes.

Vulnerability results from a range of factors outside the individual's control that reduce the ability of individuals and communities to avoid HIV risk. These factors may include: (1) lack of knowledge and skills required to protect oneself and others; (2) factors pertaining to the quality and coverage of services; and (3) societal factors such as human rights violations or social and cultural norms. These norms can include practices, beliefs and laws that stigmatize and disempower certain populations, limiting their ability to access or use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.[3]

Adolescents are more vulnerable when they lack knowledge and skills; cannot access services; are exposed to violence, exploitation and abuse; lack attachment to family; and are denied opportunities to participate in society. Vulnerable adolescents are more likely to adopt behaviours that increase their risk of HIV as a result of circumstances that are often beyond their control. MARA are not always the same people as those who are vulnerable. Different tools are required to collect strategic information on their experiences and the realities they face.

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[3] UNAIDS, *Report on the global AIDS epidemic 2008*, UNAIDS, Geneva, August 2008.

Available resources:

1. UNAIDS, *Joint Action for Results Outcome Framework 2009–2011*, UNAIDS, Geneva, May 2009, <http://data.unaids.org/pub/Report/2009/jc1713_joint_action_en.pdf>.

2. UNAIDS, *Guidance Note on HIV and Sex Work*, UNAIDS, Geneva, March 2009, <http://data.unaids.org/pub/BaseDocument/2009/jc1696_guidance_note_hiv_and_sexwork_en.pdf>.

3. International Harm Reduction Association, *50 Best Document Collection on HIV Prevention and Care for Injecting Drug Users*, IHRA, <http://www.ihra.net/HIVPreventionandCareforInjectingDrugUsers>.

4. International Harm Reduction Association, *50 Best Document Collection on Policing and Harm Reduction (Illicit Drugs)*, IHRA, <http://www.ihra.net/Policing>.

Global Guidance and Frameworks

Priscilla Akwara, UNICEF, and Igor Toskin, UNAIDS

Coordination mechanisms

The HIV/AIDS Monitoring and Evaluation Reference Group (MERG) provides guidance and support to UNAIDS and its partners. MERG works with Inter-Agency Task Teams (IATTs) and working groups on monitoring and evaluation-related activities in specific programming areas such as young people, children affected by AIDS, prevention of mother-to-child transmission of HIV (PMTCT), and paediatric HIV.

Harmonizing global indicators

MERG has an Indicator Technical Working Group, which provides guidance on prioritizing indicators and harmonizes AIDS indicators among international agencies and donors. This simplifies the reporting process and makes it possible to compare data across countries. Forty core national indicators have been agreed, including 25 UN General Assembly Special Session on AIDS (UNGASS) indicators and 15 additional recommended indicators. An indicator repository has also been developed, which will be regularly updated.

Monitoring MARA (IDUs, MSM, SW and populations in closed settings, such as prisons and detention facilities)

The core UNGASS indicators include eight indicators for MARPs, and additional indicators have also been developed. The supporting guidance for UNGASS reporting makes reference to adolescents and asks countries to disaggregate data for MARPs by sex and age (<25/25+). The guidance no longer differentiates between low, concentrated and generalized epidemics; therefore, countries are left to select the indicators that are relevant to their situation. A set of operational 'Monitoring and Evaluation Guidelines for Most-At-Risk Populations' is due to be developed by UNAIDS.

UNGASS reporting and MARPs

More countries are reporting on at least one indicator related to MARPs – and most of these are experiencing low or concentrated epidemics. The number of countries reporting on indicators regarding sex work more than doubled between 2005 and 2007. In 2007, indicators relating to IDUs and MSM were the least frequently reported.

The UNGASS reports from several countries confirmed that indicators on MSM, IDUs and SW were relevant to their national context, but stated that the data were not available. A number of countries (mainly in Africa) reported that indicators on IDUs were not relevant to their national context.

What More Needs to be Done?

1. Strengthen collaboration and coordination between government and partners to improve data availability and methods, as well as to build capacity.
2. Strengthen monitoring and evaluation in the context of MARPs, estimating the size of the targeted population, and monitoring the quality, coverage and intensity of services for such populations.
3. Increase capacity to estimate the size of the targeted population.
4. Strengthen the capacity of staff and funding for monitoring and evaluation activities.
5. Be strategic about comprehensive data collection and make full use of data-collection opportunities in all HIV programme areas.
6. Advocate for government and partners to dedicate a budget line to the implementation of monitoring and evaluation systems for MARPs.

Available resources:

1. UNAIDS, *Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators – 2010 Reporting*, UNAIDS, Geneva, March 2009, <http://data.unaids.org/pub/Manual/2009/JC1676_Core_Indicators_2009_en.pdf>.

2. UNAIDS et al., *Core Indicators for National AIDS Programmes: Guidance and Specifications for Additional Recommended Indicators*, UNAIDS, Geneva, April 2008, <http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf>.

3. UNAIDS et al., *A Framework for Monitoring and Evaluating HIV Prevention Programmes for Most-at-Risk Populations*, UNAIDS, Geneva, December 2008, <http://data.unaids.org/pub/Manual/2007/JC1519_me_Framework_en.pdf>.

4. Websites:
<www.unaids.org>
<www.who.int>
<www.childinfo.org>
<www.measuredhs.com>

Population size Estimation (PSE) and Coverage Calculation for MARPS and MARA

Dave Burrows, AIDS Projects Management Group (APMG**)**

Coverage

Coverage is often misnamed, misused and misunderstood. WHO, UNAIDS, and the United Nations Office on Drugs and Crime (UNODC) define it as "the proportion of those who need an intervention who actually receive it." Coverage has three aspects: reach (including regularity of reach), breadth and quality. This can be understood as follows: X per cent of IDUs in a specific area need to access needle and syringe programmes (NSP) of adequate quality on a regular basis in order to prevent/reverse an HIV epidemic among injectors, and clear definitions must be provided of 'adequate quality' and 'regular basis'.

- Low coverage exists when less than 20 per cent of IDUs have been regularly reached by NSPs (at least once per month for the past 12 months).
- Medium coverage has been achieved when more than 20 per cent and less than 60 per cent have been reached.
- High coverage has been achieved when more than 60 per cent have been reached.

The AIDS Projects Management Group (APMG), The Foundation for AIDS Research (Amfar), the United Nations Development Programme (UNDP) and WHO are developing methodologies that will make it possible to calculate coverage – including regular coverage – required for interventions to be successful, and to measure targets and breadth of services for MSM and those who sell sex. This may provide an opportunity to increase data on MARA and MARYP, but they have not yet been identified as a specific group in these global processes.

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PSE

PSE is increasingly used for national AIDS plans and projects financed by GFATM. Programme planners need to know the size of the population to estimate coverage over time and plan scale-up. PSE is used to determine the denominator for all calculations related to coverage.

Population size is difficult to determine and size estimation is not always an 'exact science'. Stigmatized, hidden populations are often difficult to count and standard surveys don't tend to reach them. Some PSE methodologies use

existing data, and this makes it more difficult to estimate the population size of MARA and MARYP, as most data are not disaggregated by age.

PSE methods

The Consensus/Delphi Method asks key informants to estimate the number of people in an at-risk population at the national and/or local level. Findings from these consultations need to be triangulated with other PSE methods.

The Multiplier Method is recommended by many agencies, including UNAIDS and WHO. It combines an existing data source (e.g., data on the number of IDUs accessing health services, or data on drug treatment and/or overdose deaths) with survey data from as broad a sample as possible. Single multiplier exercises can be inaccurate, so UNAIDS recommends using several separate processes and averaging the results to produce a mean estimate.

Multiplier formula
X (population) = multiplier x benchmark

    Example:
        1,000 ISUs entered drug treatment in 2007 (benchmark)
        10% of ISUs surveyed said they entered drug treatment in 2007 (multiplier)

       ➢ X = 1000 x 10/100 (=10)
       ➢ X = 10,000 IDUs

Respondent-driven sampling (RDS) serves a number of important uses and is a recommended sampling strategy for hard-to-reach populations.

Social-networks size estimation is a new methodology currently being introduced. It still needs to be evaluated and, to date, appears to be costly and time-consuming, though it may be very useful in countries with highly developed research capacity.

PSE in Armenia
Armenia wanted to include specific programmes for MARA in the GFATM proposal. This required a statement about projected coverage after six years, so PSEs for at-risk adolescents were needed. There was not enough time for the Ministry of Health to conduct a separate study. Instead, an estimated figure of 5 per cent of all adolescents was agreed to on the basis of household and school surveys, which showed that at least 5 per cent of adolescents engaged in risky sexual behaviour or illicit drug use. The proposal noted that a full PSE would be carried out as part of the grant activities. The proposal was approved by GFATM.

UNAIDS is in the process of finalizing guidelines for size estimation and plans to include text on methods to collect data on different age groups. UNAIDS is also conducting size estimation trainings in all regions. Such trainings will be used to help countries model their HIV epidemics, estimate the size of the epidemics and assess the modes of transmission. They will also serve to increase capacity to

understand where the next 1,000 new HIV cases will likely come from. UNAIDS will work with these countries to see how they can include data on adolescents in this exercise.

Lessons learned

- PSE is most efficient and effective when it is kept simple. It is advisable not to incorporate additional research questions, e.g., on risk assessment, into the process. PSE can be relatively cheap and can be conducted fairly quickly if it is done as a stand-alone activity.

- If possible, set up a reporting mechanism that allows for repeated PSE over time, e.g., every six months, using a simple process with just a few questions. This makes it possible to track changes in numbers of MARPs over time.

- GFATM is the biggest funder of AIDS programmes. The fund requires national statistics on population size and coverage, so some kind of PSE must be done. This can be done at varying levels of detail – the main point is to demonstrate how the number has been reached. This is particularly important in terms of setting targets.

- Agreement on a number often matters more than the specific accuracy of the number. If partners can agree on the methodology to estimate population size and obtain consensus on the final estimated number, the process can move forward with reduced delay. Consensus-building at the local and national levels is key. It is important to give sufficient time and respect to the process.

- Start small rather than not at all. PSE at the national level can be a very lengthy process. Use the information available to get started. It may be better to begin at the local level, e.g., with cities, and then use that data as a starting point. PSE on MARA in Romania, for example, has found that most IDUs are concentrated in the capital city. Programmers there have used data from harm reduction services and available data on IDUs to estimate the population of at-risk adolescents.

- Consider why PSEs are being done, who is going to use the results, what needs to be measured and how useful that information will be in informing the HIV response. For example, measuring the percentage of people ever reached – or reached in the past year – with an intervention is not helpful, since reaching young MSM or adolescents who sell sex once with a condom or once with an educational intervention is unlikely to have any impact on the epidemic.

Available resources:

1. World Health Organization et al., *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*, WHO, Geneva, 2009,
<www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf>.
This publication includes a number of questions on coverage and quality of services.

2. World Health Organization et al., *Guide to Starting and Managing Needle and Syringe Programmes*, WHO, Geneva, 2007,
<www.unodc.org/documents/hiv-aids/NSP-GUIDE-WHO-UNODC.pdf>.

3. The AIDS Projects Management Group (APMG) is developing a manual for quality measurement and improvement processes with the Russian Harm Reduction Network (RHRN) based on the above *Guide to Starting and Managing Needle and Syringe Programmes*. The manual and instruments should be available in early 2010.

Building the Evidence Base in CEE/CIS
Nina Ferencic, UNICEF, and Joanna Busza and Megan Douthwaite, LSHTM

UNICEF is working with national partners in the CEE/CIS region to build the evidence base and develop an HIV prevention programme for at-risk and vulnerable adolescents in seven countries: Albania, Bosnia and Herzegovina, Moldova, Montenegro, Romania, Serbia and Ukraine.

The programme aims to integrate MARA into national AIDS plans, strategies and monitoring systems. It has four key components: obtaining evidence on MARA; building political and community support; removing barriers to service provision, access and use of services; and building partnerships. These are being achieved by implementing advocacy and providing support to local activists; facilitating UN partnerships; supporting systems and encouraging system change where relevant; building capacity; financing; and promoting the inclusion of marginalized adolescents and young people.

LSHTM has provided technical assistance to collect baseline data on at-risk and vulnerable adolescents in the seven countries; ensure each study is as comprehensive as possible; encourage the use of the data to plan interventions; and inform regional advocacy.

The Research Cycle
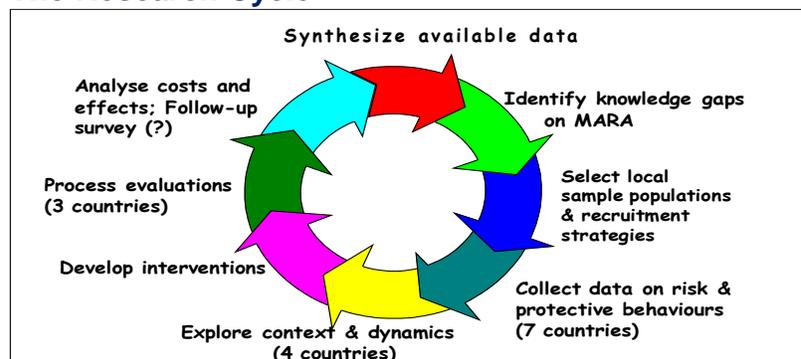
Quantitative data have been collected in all seven countries, and qualitative data have been collected in Moldova, Romania, Serbia and Ukraine. Three countries (Moldova, Romania and Ukraine) are also gathering data for process evaluation. All of the countries are in the process of designing or implementing evidence-informed interventions.

Methodologies
Research teams in each country had to consider a number of questions to identify which methodology was most appropriate for data collection in their local context. These questions included what data on MARA already existed, who had

contact with the target groups, and how the data would be used – what the main purpose was, what the advocacy objectives were, and what the plans and goals for the anticipated interventions were.

Experience has shown that RDS is a straightforward sampling approach for collecting information on IDUs because of the patterns their networks tend to follow. Where other populations are well networked, it can be an effective methodology. It should always be preceded, however, by good formative research to establish if the populations are well networked.

Sampling

Sampling methods adopted in each country differed according to context, with a mix of respondent-driven approaches, network recruitment and venue-based methods used:

1. Venue-based sampling reaches at-risk populations in places where they are known to 'hang out' or where, for example, sex is known to be sold.
2. Institution-based sampling reaches populations in prisons, for example, or children who have been taken off the street and placed in social welfare institutions.
3. Chain referral relies on a contact to recruit his or her peers to the study. This includes RDS, network recruitment and snowball sampling.
4. Convenience/opportunistic sampling tends to be used when populations are particularly hard to reach. The most common access point is through services for a particular population, such as SW, but the results may be biased since this is a select group and little is known about how they differ from others who have not been reached.
5. Combined sampling uses a number of sampling approaches together, excluding RDS.

Indicators

Research teams from the seven countries participated in a research design workshop, during which they agreed on a set of programme indicators. The process was guided by the need to include standardized core indicators that allow for inter-country comparison; ensure that each study could incorporate UNGASS indicators; integrate risk and vulnerability measures; include all HIV risk behaviours; and ensure flexibility so as to include additional, country-specific topics.

Guidelines for compiling indicators and colour-coded questionnaires for both males and females have been developed. These collect data for the core indicators, additional highly recommended indicators, and other suggested topics. The core indicators include eligibility criteria, demographic profiles, HIV knowledge, injecting drug use, sexual behaviour, MSM behaviour, access to and use of services, and experience of being institutionalized or in detention.

Diversity of study populations and methods in the CEE/CIS region

	Studies focused on vulnerability
Young IDUs in Albania, Moldova, Romania and Serbia	Young people in Roma settlements in Montenegro
Young SWs in Albania and Romania	Institutionalized settings in Bosnia, and Herzegovina and Moldova
Young MSM in Albania and Moldova	Children living and working on the streets in Ukraine

Findings

Risk: Diverse injecting drug-use patterns were found across the study samples. SWs who inject drugs may have riskier behaviour compared with other IDUs due to poor access to harm reduction services and poorer service use. All studies found high rates of early sexual debut. Knowledge of services was higher than service use. Pharmacies appeared to be acceptable sources of injecting equipment and condoms.

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Vulnerability: Younger cohorts of IDUs in some settings have poorer knowledge of HIV transmission and are less likely to seek formal services. Detention and harassment by police are regular events, and adolescent SWs report more forced sex compared with older peers and are less likely to use condoms consistently. Girls report unmet needs for reproductive health, particularly in Montenegro among Roma girls.

Please see http://www.unfpa.org/hiv/iatt and click on "MARA Consultation" on the menu on the left for additional findings. Further details can also be obtained from the UNICEF Regional Office for CEE/CIS.

Lessons learned

1. It is critical that research teams have the credibility and support from governments to undertake this type of research.

2. Ethical guidance on conducting research with MARA provided by the UNICEF Regional Office for CEE/CIS supported the development of ethical guidance at the local level.

3. Study design, data collection and analysis need to remain flexible and must be able to adapt to new questions and findings.

4. Studies may need to include data on 20–24 year-olds to obtain a large-enough sample size. Data on adolescence can then be collected by asking retrospective questions to older study participants and by pulling out findings on younger cohorts during the analysis phase.

5. A subregional approach that brought the seven countries together was useful for specific tasks in the process, such as developing core indicators, training research teams to use software and comparing country study designs and results. On the whole, however, technical assistance was more effective when a focused, country-specific approach was used. In-depth research in a smaller number of countries may be better than standardized capacity-building approaches in several countries.

6. The whole process took time in the CEE/CIS region. In all, it has taken more than three years to conduct a baseline study, undertake qualitative research, implement programmes and conduct evaluation research.

Available resources:

1. UNICEF Regional Office for CEE/CIS, *Research Toolkit: Working Documents for Data Collection amongst Most-at-Risk Adolescents*, UNICEF Regional Office for CEE/CIS, Geneva, 2009.

2. UNICEF Regional Office for CEE/CIS, *Guidance on Ethical issues in conducting quantitative research with adolescents engaging in HIV risk behaviour*, UNICEF Regional Office for CEE/CIS, Geneva, 2007.

3. UNICEF Regional Office for CEE/CIS, *Guidance on programming to prevent HIV infection in most-at-risk-adolescents in Central Eastern Europe and the Commonwealth of Independent States*, UNICEF CEE/CIS, Geneva, revised 2009.

Country Experiences in Obtaining Evidence and Building Political Will

This section summarizes the main activities that were outlined by the presentations on country-level experiences. Each country presentation can be found at http://www.unfpa.org/hiv/iatt and click on "MARA Consultation" on the menu on the left. The challenges, lessons learned and recommendations from each country presentation have been consolidated into the next section to supplement the presentation on lessons learned from programming for MARA that was given by the CEE/CIS Regional Office.

Ukraine: Data collection and programming for MARA

Olga Balakireva, Ukrainian Institute of Social Research, and Olena Sakovych, UNICEF Ukraine

When Ukraine's programme began in 2006 there was very little awareness of the need to focus on at-risk adolescents. The Government did not have a strategy, coordination was poor and mandates were unclear. Non-governmental organizations (NGOs) agreed that there was a problem, but felt they could not openly target their services to adolescents because of the prevailing challenges and lack of guidance available for providing services to minors.

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Ukraine decided that baseline evidence on adolescents living and working on the streets was needed to inform advocacy interventions, develop strategic action plans and design local- level interventions.

During the last three years, strategic information has been used to integrate MARA into the National HIV/AIDS Programme 2009–2013. Relevant indicators for at-risk adolescents have been included in the national monitoring and evaluation system. National ethical principles on research among children have been endorsed and changes to AIDS legislation are underway.

Six different approaches to providing services are being pilot-tested. Three of these are being implemented primarily by NGOs: providing targeted outreach services on the street (primarily counselling and referral services) to reach adolescents who are selling sex; making drop-in centres for drug users more adolescent-friendly; and providing a safe house for adolescents living and

working on the street. Local authorities are taking the lead in three other areas to improve the capacity of clinics treating sexually transmitted infections (STIs) and AIDS centres to respond appropriately to MARA; strengthen referral systems for MARA; and provide psychosocial rehabilitation services for at-risk and vulnerable adolescents.

All six models promote collaboration between the Government and partners from NGOs. Monitoring and evaluation frameworks have been developed to track changes over the next two years.

Key steps to collect data and develop programmes undertaken by Ukraine
- Introduced the MARA concept of and established a national working group on at-risk children.
- Mapped stakeholders and the places where MARA congregate.
- Formalized key partnerships with the Government and research institutions.
- Conducted desk research and secondary analysis of available data.
- Conducted gender analysis and training.
- Conducted policy and legislation review and training.
- Undertook a baseline study regarding adolescents living and working on the streets.
- Conducted stakeholder analysis and capacity assessment.
- Conducted qualitative research based on earlier findings.

Brazil: Collecting strategic information and the programmatic response
Nara Vieira, National AIDS Programme, and Daniela Ligiero, UNICEF Brazil

Strategic information on adolescent vulnerability to HIV is routinely collected through the health information system and through schools. Strategic research on MARPs and the armed forces is also conducted. Since military service is mandatory in Brazil, the armed forces are an additional source of data regarding young men aged 17–21. Research has, therefore, been conducted on young MSM in the armed forces. A knowledge, attitudes and practices survey (Pesquisa de Conhecimento Atitudes e Praticas na População Brasileira, or PCAP) is also conducted on 15–24 year olds every four years. The data from these sources are disaggregated by age, sex, mode of transmission and region. Data confirm that HIV transmission is increasing among adolescent MSM and adolescent girls.

Civil society organizations are influential in developing HIV and AIDS policies and strategies. They are active participants in municipal, state and federal AIDS councils, which define programmes, resources and priorities. Their involvement has meant that the HIV response has been based on a human-rights approach that focuses on vulnerability reduction and risk behaviours.

Participation is being used as the entry point to put HIV prevention regarding MARA on the national agenda. Adolescents living with HIV are being supported to join the dynamic AIDS movement, which is predominantly adult-focused. MARYP are now represented on the National AIDS Council (NAC).

The available data are being used to advocate for increased attention to be given to younger at-risk and vulnerable populations. A five-year *National Plan for Men having Sex with Men* has been developed in close consultation with civil society. The plan includes a section on adolescents, in response to findings that transmission patterns for adolescents differed from those for adults. Condoms are being distributed through schools, and qualitative research was used to show the positive impact of this approach. Questionnaires have been distributed that encourage adolescents to assess their own levels of risk and promote voluntary counselling and testing (VCT) for HIV. The questionnaires will be used to generate data on HIV testing trends for adolescents.

Philippines: Integrating MARA into the national Integrated HIV Behavioural and Serological Survey (IHBSS)
Gudrun Nadoll, UNICEF Philippines

The national AIDS response in the Philippines focuses on MARPs. In 2009, at-risk adolescents 15–17 years-old were integrated into the national IHBSS. Data are being used for baseline programming monitoring and advocacy for MARA. It is anticipated that the data will also be used to estimate the number of adolescents at risk, since the survey is directly linked to ongoing workshops to estimate the size of MARPs.

Steps to integrate MARA into the IHBSS
1. An evaluation of the 2007 HIV surveillance data found that the eligibility criteria regarding age were unclear and that study teams had not been trained to enrol minors.
2. Consultations were held with national partners to assess how children were reflected in national HIV strategies and policies.
3. The Council for the Welfare of Children's HIV Committee developed a policy guide on children's access to VCT, and drafted a strategy framework on children and HIV as a working document on the country's response to MARA.
4. Consultations with stakeholders to review the legal context of providing VCT to children concluded that adolescents 15–17 years-old can give their own consent to HIV testing if it is ensured that consent is 'informed'.
5. National partners agreed that at-risk 15-17 year-olds should be included in the IHBSS. Children younger than 15 were not included because this would require a different support system.
6. Researchers were trained to collect data on minors. Such training focused on children's rights, ensuring informed consent and referral.
7. Data collection methodologies included pilot RDS, time location and simple random sampling.

Pakistan: Building linkages and integrating MARA into protection and other sectors

Bettina Schunter, UNICEF Pakistan

MARA are included in the draft National HIV and AIDS Policy 2007, the draft National HIV & AIDS Prevention Act 2006, and in Government planning and costing documents. The process of developing the national HIV Prevention Strategy for Young People in Pakistan saw the National AIDS Control Programme (NACP) shift its focus to MARA. A number of capacity-building and programming tools have been developed to complement the strategy. These can be found at http://www.unfpa.org/hiv/iatt (click on "MARA Consultation" on the menu on the left). MARA are defined as those who inject drugs, are engaged in transactional or commercial sex, have sex with a partner who practices high-risk behaviour, and live on the street full-time.

Research is being used to inform programming and advocacy. A mapping/behavioural study of adolescents 10–19 years-old on the streets in seven districts has identified which adolescents are at risk and which are vulnerable to HIV. The findings have been used to develop an evidence-based best practice model for MARA and to include adolescents in the national agendas for MSM and SW.

The data will also be used to advocate for the inclusion of HIV prevention information, skills and services programming into child-protection programming. MARA are not separated from other vulnerable children in need of protection. Pakistan is looking to strengthen capacity to ensure services make the link between HIV prevention and child protection for at-risk adolescents.

Recommendations for incorporating HIV prevention into the eight elements of a protective environment have been identified:

1. Legislation	• Reduce age of consent for testing, counselling and other services. • Decriminalize sex work and drug use.
2. Attitudes	• Knowledge-gathering, advocacy and programming on adolescents and MSM. • Advocacy regarding the links between early marriage and risk of HIV.
3. Open discussion	• Dissemination of knowledge generated multi-sectorally.
4. Children's life skills	• Mainstream behaviourally specific life skills through static service points for out-of-school adolescents.
5. Capacity of community and family	• Build capacity of NGOs to make referrals and linkages to government services. • Build capacity of families to accept reintegrated children/at-risk adolescents.

6. Essential services and rehabilitation	• Increase number of drop-in centres, child centres and shelters. • Scale up essential HIV prevention services for MARA.
7. Monitoring and reporting	• Multi-sectoral stocktaking of existing initiatives, policy analysis and response by NACP and the National Commission on Child Welfare & Development (NCCWD). • Focal persons for NACP and NCCWD attend each other's meetings where relevant.
8. Government commitment	• Mainstream programmes dealing with sexual risk, STIs, HIV, referrals into commercial and sexual exploitation of children, trafficking, and sexual abuse. • Knowledge generation: integrate HIV risk-related issues into child-protection assessments.

Serbia: Ethical and protection issues in research and programming
Jelena Zajeganovic-Jakovljevic, UNICEF Serbia

Serbia has integrated data collection and analysis of 15–24 year-olds into surveillance on MARPs that is supported by GFATM. Research on minors has been guided by the principle of the 'best interest of the child'. This approach was used to ensure that participants and their parents were given detailed information about the study; psychologists were trained and available to provide support when necessary; and research teams used language that MARA would feel comfortable with. A referral system for emergency health and protection concerns was also established and a list of referral services and other education materials provided. Testing for HIV, Hepatitis B and Hepatitis C was also available for participants over 18 years of age.

New approaches have been developed to address parental consent when conducting research on adolescents. At the time of data collection, existing legislation and ethical codes did not provide the relevant guidance for this type of research. In addition, the ethical committees at the national level and within public health institutions had only been formed a few months before the research was undertaken. This meant that they did not have the relevant experience in this area. As a result, the research teams had to work closely with the designated ethical committee to agree on how to proceed.

The Ethical Review Committee of the Institute of Public Health, which had been mandated to conduct the research, began by conducting a review of the legal situation. Following this, the Committee agreed to use a new system that would obtain parental 'disapproval' and/or 'silent approval', as opposed to consent. Study participants under age 18 were asked to give a letter to their parents that explained the study. The parents were asked to sign the letter, indicating whether they agreed with their child's participation. Parents were also informed that if the letter was not signed and returned to the research point within seven days, consent would be assumed.

The Ethical Committee decided that minors could not be tested for HIV as part of national surveillance because the levels of support required to follow up a positive test result, including parental notification, could not be guaranteed in a research site.

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Efforts to provide clarity and develop guidance on ethical issues are ongoing. National and international standards are being compiled; legislation, guidelines and ethical codex are being analysed; and systems are being reviewed to identify opportunities for further data collection on MARA.

An essential package of interventions for at-risk adolescents has been agreed on. This includes information and counselling, condom provision, VCT for HIV, treatment for STIs, harm reduction, treatment for adolescents living with HIV, and child protection.

Addressing ethical issues in Serbia
1. Establish clear procedures for the approval of public health research.
2. Collate national and international knowledge and develop ethical standards for research.
3. Analyse legislation, ethical codes and guidelines, and identify opportunities to introduce new – or change existing – normative and professional standards. Clarify questions concerning informed consent and access to medical interventions, particularly HIV essential interventions.
4. Clarify the extent to which HIV prevention interventions need to be linked to child protection services to ensure that they are performed 'in the best interests of the child'.
5. Develop and endorse ethical codes and guides for research and HIV programming among children and adolescents, with a focus on at-risk adolescents at the national level.

6. Train ethical boards in child rights and other specific issues related to MARA.
7. Distribute HIV programming guides to relevant service providers.

Romania: Strengthening referrals through a voucher system
Valentin Simionov, Romanian Harm Reduction Network, and Eugenia Badiu, UNICEF Romania

Romania is pilot-testing a new system that uses vouchers to facilitate the access of MARPs (including adolescents) to an essential package of medical and social services for HIV prevention. This approach is being coordinated by the Romanian Association Against AIDS (ARAS), which is also using the vouchers to monitor access to the services. Seven NGOs are participating in this pilot voucher system. UNODC, UNAIDS and UNICEF are also providing technical assistance and funding.

Key programme components and activities
1. Conduct a baseline study into risk behaviours of adolescents.
2. Promote and support harm reduction interventions.
3. Strengthen referrals to medical and social services, including child protection services.
4. Pilot-test the voucher scheme for referrals.
5. Strengthen capacity of national partners to provide services.
6. Improve coordination and collaboration of different partners.

The pilot voucher system
The voucher system is coordinated by ARAS and implemented in partnership with hospitals and clinics that have a historical partnership with the association, as well as with child protection authorities. It was developed to make it easier for at-risk populations, including adolescents, to access medical and social care through an improved referral system that was more sensitive to the needs and circumstances of such populations. The vouchers are also being used to identify barriers to accessing services.

When a client needs to be referred to additional services, they are given a voucher(s) to be presented to the relevant referral hospital or clinic. The voucher includes information on the client's age, sex and health issue, as well as details of where the client has been referred to. Health and social welfare staff have also been trained to provide appropriate and friendly services to the clients who present the vouchers for services.

The voucher system has been a key tool in monitoring access to medical care services. ARAS collects the vouchers from service providers in the hospitals and clinics and analyses them to monitor the project. The monitoring data confirms that more at-risk populations are accessing the services.

Monitoring data collected through the voucher system:
- The referring institution and referral site collect and analyse routine project data from the vouchers.
- Client interviews are conducted with MARA.
- Interviews are conducted with service providers from the referring and referral sites.
- Quality of care 'spot checks' are undertaken at referral sites.
- Occasional case studies document the project experience.

The pilot project has been experiencing some challenges. At the service level, clients lose their vouchers, which interrupts services provision. At the systems level, access to medical care services remains limited, as clients have to show their identity papers and proof of medical insurance before services can be provided. Medical costs cannot be reimbursed without these documents. This means that despite the best efforts of the voucher system, legislative changes are also required to ensure MARA have access to medical treatment.

Challenges and Lessons Learned in Data Collection and Programming Regarding MARA

This section draws primarily from the presentation on 'Most-at-risk adolescents in CEE/CIS: Lessons learned from programming' given by Anja Teltschik and Paul Nary, UNICEF CEE/CIS Regional Office. The section has been supplemented with key lessons and challenges that were identified in the country presentations from Brazil, Pakistan, the Philippines, Romania, Serbia and Ukraine.

Challenges

Reaching MARA

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- Injecting drug use, selling sex and sex between men are often criminalized, making it harder and sometimes dangerous to reach adolescents engaging in these behaviours.
- Police crackdowns drive at-risk adolescents underground and erode their trust in service providers and the authorities. Field workers have to make the time to establish a relationship with MARA.
- Stronger networks among IDUs and MSM have helped to increase access to services for some adolescents, but experiences in a number of countries have shown it is particularly hard to reach young sexually exploited girls who sell sex.

Ethical issues

- The lack of local ethical guidelines makes it easier for service providers and politicians to avoid MARA and implement interventions for more 'acceptable' populations.
- International guidelines have a role to play, but local guidance that has been developed and approved by national partners is urgently needed.
- The lack of clarity and knowledge on how to deal with issues of informed consent and parental consent, and the legal implications of conducting research and providing services to minors mean service providers are often reluctant to take interventions forward.
- It is difficult to ensure that information collected on at-risk adolescents will remain confidential. This is true for both research and service provision.

Limited capacity

- While countries may have very capable research institutions, these tend to have limited experience at national and local levels in conducting research on at-risk adolescents. This is especially true of institutions seeking to estimate the size of hard-to-reach, socially excluded and mobile populations.
- Significant investment is needed to train researchers to conduct field work on MARA.
- Data collection requires time, commitment and funding.
- Child protection services have limited capacity and experience to provide specialized services for HIV prevention to at-risk and vulnerable young people.
- NGOs working with at-risk populations have limited capacity to work with adolescents.

Using existing data

- National surveillance data often include information on youth 15–24 years-old, but the analysis does not always include age-specific findings on adolescents and young people.
- There are very little data available on adolescents 10–14 years-old. Information on younger adolescents is difficult to collect.
- Use of available data is limited because the data are not being disaggregated by age and sex.
- It is difficult to compare data across countries because indicator definitions, data collection and analysis methods vary widely.

Poor coordination and collaboration

- There is little clarity between the health, HIV and social/child protection sectors regarding who is responsible for MARA.
- Coordination between the Ministries of Health and the Ministries of Social Welfare is generally poor.
- Vertical government programmes make it difficult to provide services and develop referral systems between the HIV and child protection sectors.
- Donor and UN organizations are not pooling their resources, nor are they planning and working together in this area.
- It is difficult to establish comprehensive responses that incorporate sexual and reproductive health in schools, as well as participation and access to services and supplies.

Differing agendas

- Governmental services responsible for enforcing child protection policies and legislation and providing social welfare services to families and children can differ profoundly in the approaches they apply to put policy into practice. Similarly, HIV prevention and harm reduction services provided by NGOs follow an approach that can be contradictory to the approach taken by state-run child protection services. This can make it

especially difficult to protect the rights of and provide adequate services to MARA.

State-run child protection services in the CEE/CIS, including the police, tend to follow a 'child rescue' approach that seeks to remove children from danger and risky environments. It can include, for instance, regular street raids to remove children living and working on the streets, by force if necessary, and return them to their families or place those without parental care in childcare facilities. However, street raids to find and rescue these children can have a negative effect, as research on children living and working on the streets shows. The effect is to drive them deeper into hiding, thereby making them harder to reach with outreach services and increasing their vulnerability to exploitation, abuse and HIV.

Social workers who have been trained in evidence-based prevention approaches and work in state-run social services providing social welfare services to families and children or in non-governmental HIV service organizations offering HIV prevention and harm reduction take another approach. This approach emphasizes the need to reach out and build up trusting relationships with at-risk and vulnerable children; reduce the risk and potential harm in their environment; provide them with access to services; and seek their cooperation in making decisions about their future whereabouts. They only remove a child from the street, for example, when the child is willing or if there is a medical emergency or other acute danger.

The lack of clarity and the conflicting policy and legislative approaches make it difficult for child welfare and HIV prevention sectors to work together and provide services to MARA.

In Ukraine, the Criminal Police for Minors works with the state-run child protection services to implement 'child rescue approaches' that remove children from dangerous circumstances. Regular street raids are conducted. Children living and working on the street are either returned to their families, moved to temporary shelters and childcare institutions (such as boarding schools), or placed with foster families. Unfortunately, there is limited capacity to deal with the specific needs of street children and other at-risk adolescents and, in many cases, these children are soon back on the streets. Ukraine does not have many foster families and few are trained to take care of at-risk and vulnerable adolescents. Boarding schools and other institutions are less inclined to take on vulnerable children who may, for example, be addicted to drugs. Their capacity to provide the necessary services for at-risk adolescents is severely limited. Children who have been returned to their families often run away again because the underlying problems that caused them to leave in the first place have not been resolved.

Unsupportive political and social environment

- Government bodies are not keen to discuss issues of exploitation, abuse, adolescent sex and drug use publicly.
- Even in settings where the law and governments are supportive, it is often the case that discrimination and homophobia still prevail at the community level.
- Limited long-term funding is available.
- At-risk and vulnerable adolescents are not seen as a priority.
- HIV prevention is often not seen as a priority by those working on social protection issues.
- Progress often depends on the motivation of a particular individual.
- Service providers from the government and NGOs are working in an environment where it is not always clear which services they are/not allowed to provide. This makes them reluctant to openly direct their services to at-risk minors.
- Service providers are not always motivated to provide services to MARA. The legal context and their own attitudes or lack of experience can be barriers to service provision.
- Children under age 18 who sell sex are considered to be taking part in criminal activities when they are, in fact, victims of sexual exploitation and abuse.
- Interventions for at-risk adolescents often mean service providers have to work in a criminal milieu.
- Corruption in the police and justice system and police harassment are widespread. That said, effective partnerships with the police are essential/critical if service providers are to reach MARA with effective HIV prevention and other child protection services.

Gaps in strategic information

- Equity analysis and how wealth, education, etc., might link with social exclusion and contribute to vulnerability is still required.
- Costings and cost-effectiveness research are not regularly conducted.

Lessons learned

Advocacy

- It takes time to introduce the concepts of most-at-risk and vulnerable adolescents to national partners. This process is should be started before data are collected and interventions are developed. In many contexts, strategic information and advocacy should be on the broader age group of at-risk young people (10–24 years-old), with age disaggregation for adolescents undertaken when needed. It is vital that stakeholders and decision makers recognize the problem and acknowledge the need to provide services for MARA and MARYP. Ongoing advocacy is needed at

local and national levels to keep at-risk young people on the agenda, and this requires a significant investment of time.

- Collaborating with partners to see what data are available and building consensus on additional data needed is part of the advocacy process. Over time, partners come to understand and accept the need for updated information on at-risk adolescents so that they are included in routine data collection processes.

- Strategic information has been critical for bringing partners on board. Partners have been persuaded to listen and have become more engaged when local data have confirmed that adolescents are engaging in risky behaviour. The data have helped to persuade partners to focus efforts and resources on HIV prevention for MARA.

- The lack of data should not stop service provision. Programme managers are advised to get started, collect what data are available, demonstrate the need for services and additional information, and then advocate for further data collection.

- Advocacy efforts need to focus on putting at-risk adolescents on the agenda of the ministry of health and local authorities, and on including MARA into the National Authority for the Protection of Child Rights.

- Programmes should consider how best to package information in a way that resonates with decision makers. In countries with low and concentrated epidemics, there may be comparatively few adolescents who are at risk of contracting HIV. When this happens, advocacy messages may need to see how they can include information on vulnerable adolescents to make the case for targeted HIV prevention.

Partnerships

- Coordination and partnership between UN agencies is essential when working with those who are most-at-risk, as many agencies are working with adolescents and young people, and separate MARPs.

- Careful consideration is needed when identifying the partnerships that will be most effective for MARA. There is also a need to understand what the capacity-building implications will be.

- Changes in government can interrupt and delay data collection and programming. It is important to attempt to establish partnerships with stakeholders that are less likely to be transferred or leave, even when there is a change in government.

- It is critical that partnerships with networks of people living with HIV are developed and strengthened in order to advocate for MARA and their access to services.

- Governments and civil society could work together more effectively. Governments could increase their capacity and commitment to take innovative interventions to scale. In many cases, NGOs would benefit from being more aware of which government services are available and how to link their services to them. Referral systems between government and NGO services can also be improved.

- Partnerships with community networks of MSM, IDUs and SW are central to the response because these groups have expertise and links to young people with risk behaviours.

- It is vital that programmes work with SW networks where these exist. SWs do not want to see children involved in sex work; not only does it abuse their human rights, but it is also bad for business. Adult SWs are keen to be engaged. They are potential allies and partners in data collection and programming who can provide insight and information on the key issues that are of concern to them. The UNAIDS *Guidance Note on HIV and Sex Work* is an important resource that makes it clear that children under age 18 who are involved in sex work are being sexually exploited.

- New partnerships can be built with lawyers to review legislation and social policies as part of advocacy for MARA. A strategic approach is required because the rights agenda is complex. Any review needs to ensure that the focus is firmly placed on identifying opportunities to work with vulnerable and at-risk adolescents rather than on finding barriers to providing services.

- GFATM provides a real opportunity for increasing strategic information regarding MARA. The submission of for funding round 10 may not take place until 2011 and this delay may work in favour of at-risk young people. Programme managers can take advantage of this opportunity to collect strategic information and use it to advocate for additional data collection and programming.

- All UN agencies working with at-risk populations should receive the same guidance on data collection on MARPs, including at-risk young people, to ensure consistency and improved collaboration among UN partners at the country level.

Building linkages across sectors

- The situation of at-risk adolescents is complex. Interventions ought to be flexible – finding ways to bring different sectors together if they are to respond adequately. At the moment, the child protection and HIV sectors don't tend to work closely together, even though they are serving the same adolescents. Partners

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need to agree on who is responsible for what. MARA should be able to access services from a range of sectors, but if there is no sense of accountability it is less likely that the services will be closely monitored and supported.

- System change is a key component. This should include the health, education, social services, child protection and police systems/sectors.

- Different sectors need to agree on how they can best work towards common objectives. Strategies for scaling up both protection and HIV prevention interventions should be developed for both the short and long term. Mechanisms for engaging NGOs and increasing their capacities also need to be addressed.

- Family planning and other sexual and reproductive health services should be part of all programmes for MARYP because sexually active adolescents and their partners require such services.

Referral systems

- Effective referral systems have agreed-upon procedures and protocols, which are closely monitored, promote individual case management and ensure that child protection partners are involved from the start.

- Staff in the referral system should have the knowledge and capacity to provide services to MARA. Programmers need to bring partners together to agree on how the referral system will work, what is more needed and who is responsible for what.

Ensuring sustainability

- Integrating the collection and analysis of strategic information about MARA into existing data collection and surveillance systems is a cost-effective, sustainable way of collecting information over time.

- HIV interventions have greater impact and are more likely to be sustained when MARA are integrated into existing coordination mechanisms, national plans and monitoring systems. This includes legislation review and revision where necessary.
- Data collection must be planned and carried out in partnership with the government if it is to be sustainable and included in the national strategy.
- In many countries, HIV programmes for MARPs are well established. Extending these services to provide access to young people is an important priority.

Priority approaches for HIV prevention regarding MARA from the CEE/CIS region

- Pull at-risk adolescents out of risk.
- Where relevant, prevent vulnerable adolescents from adopting risky behaviour.
- Make systems and services more responsive and relevant to at-risk adolescents; integrate HIV prevention for at-risk adolescents and young people into pre- and in- service training for service providers.
- Move from a 'child rescue' to a 'child protection' approach.
- Understand sexual and social networks.
- Work with parents and families.
- Work with MARA in the context of child and human rights.

Providing services to MARA

- Youth-friendly services do not automatically translate into services that are appropriate for and accessible to at-risk adolescents. Qualitative strategic information can be used to identify what is needed, and how this is best provided and by whom.
- Providing education, information, condoms and syringes is not enough. MARA need in-depth counselling and social support linked to child protection.
- It is important to win the trust of at-risk adolescents and their families in order to increase demand for and use of HIV prevention and child protection services.
- Promoting and supporting services for adolescents living with HIV is central to an effective HIV prevention approach. Adolescents who are HIV-positive have limited access to treatment and it is hard to ensure that those who are on treatment correctly adhere to the regimen.
- At-risk and vulnerable adolescents intermix, and tend to follow a leader and listen to their peers. These social dynamics can be better used to plan and provide services.

- RDS data have shown that young IDUs mix with older injectors. This may have implications for accessing at-risk adolescents for research and programming.
- Targeted outreach that is linked to drop-in centres increases coverage.

Monitoring and evaluation
- Sound monitoring and evaluation frameworks can be developed to learn what works, identify barriers and determine if a programme can be implemented elsewhere. Whenever possible, monitoring and evaluation frameworks should be put in place at the start of an intervention.

- MARA and MARYP need to be fully integrated into global guidance and reporting systems. The forthcoming *Operational Monitoring and Evaluation Guidelines for Most-At-Risk Populations*, for example, does not include specific guidance for younger populations. UNAIDS was asked to consider how this lack of age-specific guidance might be further addressed.

Knowing your epidemic
- Global guidelines and data collection systems should request age- and sex- disaggregated data. Guidance on data collection has minimized the levels of disaggregation at the global level to reduce the burden on governments. Countries are free to further disaggregate by age should they wish to do so. If global-level reporting requirements do not ask for further disaggregation by age, e.g., 15–19 year-olds, or 20–24 year-olds, then it is highly unlikely that this will take place in a systematic way that will allow for cross-country comparison.

- Regional systems and guidance may provide an opportunity to make regionally disaggregated data on MARA and MARYP more available. This would require standardized elements of data collection, analysis and reporting across the region. UNAIDS recognizes the value of regional analysis and is currently evaluating how this might be addressed. That said, the ethical considerations of collecting data on minors remain, and additional guidance will need to be readily accessible.

- Countries with generalized epidemics also need to identify which adolescents and young people are most at risk, since they are not only found in countries with low and concentrated epidemics. Data from Kenya, for example, have confirmed that injecting drug use is taking place. In countries with HIV prevalence, it is also important to focus HIV prevention on those who sell sex and their partners, because this is likely to reduce transmission.

Using existing resources

- Desk research and secondary analysis of existing data are quick and cost-effective approaches to identifying gaps and generating data for advocacy.

- Programme managers and service providers can learn a great deal from the experiences of harm reduction programmes that were established in situations where harm reduction was illegal. This includes how they were able to work with the police and operate within the context of existing legal constraints.

- UNAIDS can outline suggestions for data collection activities regarding young people and MARA more clearly. The next version of WHO's *Priority Interventions: HIV/AIDS prevention, treatment and care in the health sector* document, planned for March 2010, provides an opportunity to do this. For more information, see <www.who.int/hiv/pub/priorityinterventions/en/>.

Going beyond HIV prevention

- HIV is an effective entry point to raise issues concerning children living on the street and adolescent development because it provides a tangible starting point to address the broader challenges faced by adolescents on the street. Similarly, interventions to address the social and structural issues that affect adolescents in need of protection and support are a central part of HIV prevention interventions.

- HIV prevention can also provide an entry point for promoting broader system change by encouraging an integrated approach to service delivery that focuses on providing adolescents with information, skills, services and a protective and supportive environment.

Advice for Country-Level Data Collection

The following section is an outcome of the group work conducted on the first day of the consultation meeting, in which participants drew on their experiences to identify the most useful advice they could give to other countries planning to collect strategic information on MARA.

o Establish support for data collection on MARA at national and local levels. This can be done, for example, by creating a regional coordination board for data collection on at-risk adolescents as experienced in the CEE/CIS region. The board can guide the research process and work with law enforcement bodies to ensure they know about and support the data collection process. Agree on mechanisms to share information, respond to local concerns and facilitate communication between partners.

o Include a wide range of government sectors and civil society partners from the start. This could include the education, social protection and justice sectors, as well as the police. They may be important partners when interventions move from data collection to programme design and implementation.

o Staff turnover and other priorities may mean that individuals may leave while data collection is underway. Partner with more than one individual in a department/sector to ensure continuity over time.

o Develop ethical guidance for research in advance. Agree with research teams and key stakeholders on how to deal with confidentiality and on how, for example, field workers will respond if/when study participants reveal they have experienced abuse or violence, or if they believe they may be HIV-positive.

o Map out and analyse existing data before planning new research.

o Share experiences within and between regions.

o Data on MARA and MARYP can be very sensitive. Advocacy interventions need to consider how to package the data very carefully to ensure that the information provokes a positive, supportive response from key stakeholders. Carefully consider which messages would resonate with key stakeholders and use these as an entry point for presenting the data. Be strategic in developing advocacy messages – don't use an ad hoc approach.

o   Establish a clear understanding from the outset of why the data are being collected, and of how – and by whom – the information is intended to be used. Working with a diverse range of stakeholders, it is important to ensure that they see the need for the data and support the data's use in future programming.

o   Work with government to ensure national ownership of the data and government support for the data collection processes. If this is not done, the findings may not be released and/or follow-up interventions may not be supported.

o   Participatory approaches that work with MARA and MARYP should be supported from the outset and throughout the process. The participatory-action research approach may be useful in this context.

o   Where possible, mainstream data collection into ongoing HIV national surveillance and other routine data-collection processes. Work with government and NGOs to ensure that studies do not become 'one off' activities.

o   Understand which adolescents are most at risk in the local setting – don't assume they are only IDUs, MSM and SW.

o   Use findings from quantitative data to see what qualitative data may be needed.

o   It is vital that the institute leading the research is credible and seen as having the authority to lead the study. There may be political implications to the research, so it is particularly important that the government is on board.

o   Identify sufficient funding to ensure that there is continuity, thereby guaranteeing that interventions are able to move from data collection to delivering sustained programme responses.

Annex 1 – Group work: Actionable next steps at the global, regional and country levels

Actionable next steps for improving the collection and analysis of strategic information

	Global level	Regional level	Country level	Plenary comments
Systematically disaggregate data collection and analysis on MARPs by age cohorts: 15–19 years-old, 20–24 years-old and above 25 years-old.	• IATT/YP to develop rationale and guidance to advocate for systematic data disaggregation. • UNAIDS Executive Director to issue a directive to this effect. • HIV MERG to make recommendation for age disaggregation and monitor compliance. • UN agencies to lobby for GFATM to use this age disaggregation for younger age groups who are most-at-risk.	• Regional Directors communicate the need to prioritize age disaggregation for 15–24 year-olds.	• Ensure that the HIV/AIDS Working Group and UN agencies have the same advocacy message promoting age disaggregation.	• Countries should be encouraged to collect data on 10–14 year-olds, particularly on children affected by HIV/AIDS. At this point, however, it is better to focus on achieving systematic age disaggregation for 15–24 year-olds.
Strengthen capacity and increase willingness to undertake PSE among MARA.	• Develop simple guidance for PSE. • Provide technical assistance to regional bodies and partners at the country level. *Note that participants suggested that the UNAIDS Secretariat and/or the IATT/YP Strategic Information Working Group play a central role in taking these steps forward.*	• Encourage countries to do population size estimates. • Provide technical assistance to countries to undertake PSE.	• UN country team to advocate for and support the generation of PSE of MARPs, including adolescents. • UN country team to ensure age disaggregation of new/ongoing size estimations of MARPs.	• UN agency roles and how UNICEF can best contribute in the development of guidance for PSE and for MARA and MARYP would need to be determined, in discussions in with the IATT/YP and in line with the UNAIDS Division of Labour.
Improve coordination and harmonize approaches.	• The IATT Working Group on Strategic Information to find effective ways to lead on this. This includes sharing details of relevant plans and upcoming events. • UNAIDS Partnership Forum to include adolescents within the MARPs agenda.	• Establish a regional working group on MARYP, including adolescents.	• Establish a UN country team working group on most-at-risk young people, including adolescents.	

Actionable next steps for generating political support for policies and programmes for MARA

	Global level	Regional level	Country level	Plenary comments
Integrate MARA into existing systems, publications and reports.	• Ensure all global HIV prevention documents incorporate MARA. • Ensure all documents on MARPs include adolescents. • Global AIDS Report, *AIDS Epidemic Update* by UNAIDS, to further disaggregate data by age: 15–19 year-olds, 20–24 year-olds. • Global forums to systematically include a theme on at-risk adolescents. • World AIDS Day to address the issues of MARA/MARYP. • The Global AIDS Conference to include presentations/discussions on at-risk adolescents and young people.	• Ensure progress reports from UN agencies include a section on MARA.	• Include at-risk adolescents in national AIDS plans, and use strategic information to promote integration and implementation. • Specifically include MARYP (including adolescents) in the United Nations Development Assistance Framework (UNDAF) and develop a framework of cooperation between UN agencies. • Include MARA in UN country team plans and in the agendas of the Monitoring and Evaluation and Prevention groups.	• It is critical that age-disaggregated information on MARA are included in global HIV/AIDS reporting requirements if changes are to be made at the country level. • Ensure that interventions for MARA are reflected in all nine priorities in the UNAIDS *Joint Action for Results Outcome Framework 2009–2011*.
Support a 'Research – Advocacy – Programming – Advocacy – Implement-ation' cyclical approach.	• Hold a global consultation to operationalize work on HIV prevention regarding MARA.and MARYP.	• Adapt global approaches and frameworks to the regional context.	• Identify active groups in the country that are likely to bring about change. Give them a platform to generate this cycle (NGOs, opinion leaders, parliamentarians, etc.). • Build technical and funding capacity to support sustainability. • Identify mechanisms to sustain momentum.	• Good evidence is important for building political commitment, but it is important that the information is well packaged for it to have an impact.
Foster effective partnerships.	• Advocate for all UN agencies to make a public commitment to help MARA.	• Improve communication and coordination; ensure that regional decisions reach countries; and use the Regional Directors Forum. • Establish a regional IATT. • Mobilize the donor and development community.	• Ensure partnerships with technical experts and civil society. • Go beyond the UN – partner with organizations that have the capacity to address MARA. • Engage people living with HIV, bilaterals and donors.	• MARA are falling through the net. Their needs are so varied across sectors and thus it is hard to attribute 'accountability for ensuring that adequate HIV prevention interventions for them are in place.

Actionable next steps for building linkages and strengthening partnerships across sectors and services

	Global level	Regional level	National level	Plenary comments
Use the evidence to promote a multi-sectoral response – know your epidemic, know your response.	• Analyse the Convention on the Rights of the Child (CRC) and other human rights instruments in the context of MARA. • Advocate for country reports to the CRC to systematically include reports on MARA.	• Put MARA on the agenda of UN country representatives and deputy representatives.	• Conduct situation analyses. • Map at-risk adolescents and available services. • Analyse how the legal system could affect data collection and programming for minors. • Identify country-specific entry points for MARA programming. • Identify possible partners and map out their potential responsibilities.	
Work with existing systems and processes while promoting parallel, mutually supportive approaches.	• Ensure that the concerns of adolescents under age 18 are included in the relevant UN policy and guidance documents, such as options protocol on sexual exploitation, United Nations Population Fund (UNFPA) guidelines on sex work, and WHO guidelines on pharmacological therapies.		• Understand what is in place and look at how to build on the different elements. • Support interventions such as harm reduction that will have an immediate impact. In parallel with this, invest in Systems Change, which will have an impact in the longer term.	Identify how to use adolescent pregnancy and STI treatment services as an entry point, particularly in low/concentrated HIV-prevalence settings.
Strengthen knowledge management.	• An IATT/YP website could be used to facilitate information exchange and access to resources and tools.			
Expand partnerships.		• Emphasize partnerships with networks of people living with HIV.		

Annex 2 – Group work: Country experiences and lessons learned: Using strategic information for advocacy and policy development

	Country experiences	Lessons learned
What kind of strategic information has been most useful for advocacy and policy development?	**Africa** ▪ Nigeria and Mali found that epidemiological and budgeting data were most useful in advocating for at-risk adolescents. **Asia Pacific** ▪ Integrated Biological and Behavioural Survey (IBBS) data from Pakistan showed that 41 per cent of MSM were 15–19 years-old. This information was used to build support and advocate for a policy for MARA. ▪ An IBBS in Vietnam confirms that some populations who are most-at-risk are young. The IBBS report makes the case for MARA. ▪ India used the Integrated Behaviour and Biological Assessment and National Family Health Survey Round 3 data on young people's knowledge and behaviour to advocate for MARA and MARYP. ▪ VCT registers in the Philippines showed an increase in new HIV infections in young people. The Philippines has used this to advocate for services for MARA. **CEE/CIS** ▪ CEE/CIS used strategic information to get risk profiles (including early initiation of risk behaviours) on young drug users and other at-risk adolescents. Findings showed high prevalence of risk behaviours among adolescents and confirmed that the child protection system was not reaching MARA. The data were used to advocate for the provision of child protection services for at-risk adolescents and to highlight poor access to services. ▪ In Moldova, analysing the data for gender differences was critical.	o It is important to use data that are already available. Some countries have collected data on MARA and MARYP, but they have not mapped out how to use such information to maximum effect. o Strategic information comes from a number of sources, not just specific studies and surveys. Make full use of service-based data. Registry data from VCT and harm reduction services, for example, can provide valuable information. o National data are powerful for advocacy because the information belongs to the country. o Some countries, such as Ukraine, have been able to successfully advocate for at-risk and vulnerable adolescents without undertaking PSE. They have been able to use other data to make the case. Data showing the proportion of MARPs who were adolescents proved to be a powerful advocacy tool. o PSE may be less important for advocacy purposes and more important for programme planning and costing exercises. o National partners should understand the epidemiology of the epidemic and how this relates to MARA in the local context. Once this has been achieved it will be easier to advocate for interventions. o Strategic information should include costing details. This will help make the case for policies and programmes for MARA.

<u>Latin America and the Caribbean/Middle East and North Africa</u> ▪ Anecdotal evidence from Adolescent Friendly Services Centres indicates that registers for VCT in Iran showed more younger people are accessing services in sites that are linked to Adolescent Friendly Services. This is being used to make the case for expanded provision of Adolescent Friendly Services. ▪ A qualitative study into the causes of sex work in Yemen found that most had been raped in childhood and many had lacked parental care. The findings were used by Yemen's Ministry of Youth to advocate for improved social and leisure services. ▪ Brazil analysed public health-system data on modes of transmission, which showed HIV increasing among young MSM. Behavioural and prevalence data on young men (17–20 years-old) in the army were also used to guide policy. National plans now include a specific strategy for young adolescent MSM.	o Ethical guidelines would be useful advocacy tools for stakeholders and policymakers. Such guidelines could be used to increase understanding of what is needed to support and strengthen services for MARA.

Country experiences and lessons learned: Using strategic information for programme implementation

	Country experiences	Lessons learned
What kind of strategic information has been most useful for programme implementation?	<u>Africa</u> ▪ Risk and vulnerability analysis, including identifying what the risk behaviours are, where they are taking place, and which young people are at risk. Mali and Côte d'Ivoire have mapped adolescents, which can help to track the 'vulnerability chain'. ▪ Epidemiological data to know your epidemic. <u>Asia Pacific</u> ▪ Pakistan has used targeted mapping and a behavioural survey with street-based adolescents. ▪ National youth surveys have helped programming for MARA in India and Vietnam. <u>CEE/CIS</u> ▪ Data on service access, coverage and utilization were useful for reorienting service providers and administrators and improving service quality. It was used to understand the key access barriers, see how services might be adjusted to better respond to MARA, and to reorient resources from GFATM to address adolescents. ▪ Patterns of injecting drug use influenced decisions to conduct qualitative research as well as the design of interventions for young people who inject drugs. <u>Latin America and the Caribbean/Middle East and North Africa</u> ▪ Knowledge, Attitude and Practice study in Brazil investigated why young MSM engage in unsafe behaviour when knowledge levels are high. Findings showed that programmes needed to address the barriers to accessing condoms and services. ▪ A multi-country study in Latin America and the Caribbean found that teacher-led life skills interventions were not having an impact. This now raises the question on whether to stop or adjust the programme. ▪ Study findings in Yemen showed that school-based interventions were not reaching MARA, but that they did help vulnerable adolescents. Peer education was found to be the most effective approach, encouraging more open discussions and having a positive impact on peer educators themselves.	o Countries have found that IBBS have not been particularly useful for programming. o Operations research and programme evaluations need to be undertaken more frequently and systematically. o PSE is an important tool for planning interventions. o Quantitative data should be complemented with qualitative data to understand why a particular situation exists.

Country experiences and lessons learned: Involving MARA and MARYP

	Country experiences	Lessons learned
Contributions made by MARA and MARYP in data collection.	In addition to participating as study respondents, MARA and MARYP have contributed by: • Recruiting other adolescents into studies, primarily through snowball sampling methodologies. • Providing access to their networks and peers. • Providing input to developing research processes, including by suggesting and participating in some innovative approaches in small- scale surveys. • Validating study questionnaires and data collection tools. • Helping research teams understand the realities of life for at-risk adolescents and young people, and helping researchers develop tools that use their language and are relevant to their experiences.	o The participation of MARA and MARAYP in data collection has been quite limited to date. o Partnering with at-risk young people, including adolescents, offers an entry point to the realities of their day-to-day experience. o At-risk young people are an important resource. They can validate research models at the planning level, advise on information-gathering methods and provide much-needed enthusiasm and energy in the data collection process. o It is difficult to recruit adolescents under age 18, both as respondents and as partners in the data collection process. o More effort should be made to share findings with MARA and MARYP and include them in data analysis processes.
Contributions made by MARA and MARYP in building political support and planning programmes.	• In the Pacific, Iran and CEE/CIS at-risk adolescents and young people are members of advisory boards for research and programme implementation. • In Pakistan, MARA have participated in provincial and national consultations. India has held national-level consultations with adolescents and young people to bring together peer educators to share experiences in ongoing programmes for young people and to give suggestions to policymakers on improving the country's programmes for young people. • In the Philippines, young IDUs, young MSM, and children who have been sexually exploited have participated in national consultations to develop the National Operational Plan. • MARA/MARYP are peer educators and activists in most countries.	o Agree on how to partner with MARA/MARYP, as well as work out what this involves and where available resources are best invested. o Work with NGOs to identify how strategic information can and should be shared with MARA/MARYP.

Country experiences and lessons learned: Building political will for data collection

	Country experiences	Lessons learned
How have/are you building political will to support data collection regarding MARA?	Africa ▪ Findings from a desk review of MARA in Nigeria were used to develop a concept note on programming for MARA. The note was shared with the National AIDS Council, which has agreed to undertake operational research to inform targeted programming for at-risk adolescents. The terms of reference for the operational research are currently being drawn up. ▪ Efforts are being made to use the National Prevention Committee and Working Groups on Sex Work, Men Having Sex with Men, and Injecting Drug Use in Tanzania as entry points for interventions for at-risk adolescents. In Côte d'Ivoire, the government committees on prevention, vulnerable groups, and youth and HIV/AIDS are in the process of collecting basic information on MARA. Asia Pacific ▪ Countries in the Pacific are reviewing national strategic plans to assess the extent to which there is a focus on MARA. Sentinel surveillance has little data on at-risk adolescents. Discussions on further data collection are underway. ▪ Pakistan is using findings from the Mapping and Behavioural Study on MARA to make the case for increased focus on MARA. This includes data on 10–19 year-olds. IBBS findings on 15–19 year-olds are also being used. ▪ IBBS data from Pakistan showed that 41 per cent of MSM were 15–19 years-old. The data were used to build support for at-risk adolescents and to advocate for a MARA policy. CEE/CIS ▪ Local and Regional Community Advisory Boards have been used to build political support. ▪ Data collection on MARA has been integrated into GFATM activities. This has meant including at-risk adolescents in proposal development processes and ensuring age-disaggregation collection in GFATM data collection activities. Latin America and the Caribbean/Middle East and North Africa ▪ In Brazil, the process has been driven by civil society. Efforts have focused on strengthening civil society organizations and increasing their capacity to lobby the government for interventions on MARA. ▪ Iran is supporting adolescent-friendly services to demonstrate the need and demand for services for MARA. This has led to the government collecting data on at-risk young people through a Knowledge, Attitude and Practice study. ▪ Yemen is supporting the participation of MARA/MARYP in local councils.	o Bottom-up approaches that work with communities and civil society organizations to create/demonstrate demand for services are effective ways of building support for data collection. o It is important to be clear about what is meant by the concept of MARA if governments are to be convinced of the need to collect data. o Integrate data collection on MARA into GFATM-supported activities.

Country experiences and lessons learned: Building political will to support programmes for MARA

	Country experiences	Lessons learned
How have/are you used/using the data to build political will to support programming concerning MARA?	<u>Africa</u> ▪ Given that the region is experiencing a generalized epidemic, most interventions are focused on the general population – including young people. Data on young people are available through Demographic and Health Surveys (DHS) (which disaggregates data on 15-24 year olds) and a number of Knowledge, Attitude & Practice studies. Countries have not tended to address behaviours amongst most at risk adolescents specifically. <u>Asia Pacific</u> ▪ Vietnam is sharing data with policymakers – using findings to demonstrate the need for services. ▪ The Philippines used data to develop simple advocacy messages that can be communicated easily. <u>CEE/CIS</u> ▪ Ukraine developed an advocacy toolkit and country-specific fact sheets. ▪ Countries in the region have used MARA as an entry point to support system-building and system reform. ▪ Data showing the difference in service provision between MARA and MARPs are being used to make the case for adapting existing services so that they are more responsive to adolescents. <u>Latin America and the Caribbean/Middle East and North Africa</u> ▪ In Honduras, a Knowledge, Attitude and Practice survey showed evidence of unprotected anal sex among boys and girls. The evidence was used to start a campaign programme and to initiate discussions with the Catholic church. Data gathered from local communities in the Dominican Republic showed the problems children under age 18 had in accessing VCT. The policy was changed so that while an adult has to be present for the test, parents no longer have to be present when a test is conducted. ▪ A Knowledge, Attitude and Practice Study in Iran was undertaken in high-risk areas in six cities. The findings prompted the National AIDS Council to undertake a biological behavioural surveillance study among street children.	o Stigma and a reluctance to deal with adolescent-specific risk behaviours are hampering HIV prevention for MARA. o Countries with generalized epidemics need further dialogue with partners, and additional review of the data to promote the concepts of MARA. o In the CEE/CIS region, governments felt that UNICEF's commitment to addressing ethical issues was key to moving the research agenda forward. o Build political will at the local and national level. Local authorities are responsible for allocating staff and resources and it is important that they are convinced of the need to provide services to MARA. This requires strong partnerships and continuous advocacy. o Strengthen regional networks to build capacity and share resources.

ANNEX 3 – Introduction to research toolkit *working documents for data collection amongst most at-risk adolescents* UNICEF regional office for CEE/CIS

UNICEF Regional Office for CEE/CIS is working in select countries throughout the region to integrate MARA into national HIV prevention strategies and plans. This has meant supporting interventions to:

➢ Collect data on MARA and HIV prevention and build capacity in data collection.
➢ Advocate for policymakers to understand and respond to at-risk and vulnerable adolescents.
➢ Address ethical concerns, informed consent, barriers to service provision and reduction of stigma and discrimination.
➢ Develop targeted interventions across health, education, protection and social welfare sectors.

UNICEF and LSHTM have been working with national partners to strengthen capacity to collect data on MARA in programme countries. Valuable experience has been gained and a number of tools have been developed. This toolkit, which brings these resources together under one umbrella, is a work in progress that continues to be updated and revised.

What is in the Toolkit?

	Document	Content summary
Section A: Getting Started – Tools to get started with data collection.	Building Research Skills for HIV Prevention among Young People in Eastern Europe: LSHTM Technical Assistance	Outlines the work LSHTM has undertaken to strengthen national capacities for data collection and provides a summary of country research programmes.
	1. Pre-Project Assessment	Helps research teams and programme managers assess the research, policy and programming context to identify their research questions.
	2. Suggested job specification/TOR for National Research Team Leader	Outlines key responsibilities and suggests the key skills and experience required.
	3. Document four 'Protocol Format for MARA Baseline'	Provides a template for designing the baseline study and suggests the key steps that need to be taken.
	Document Five '10 Tips for Field Worker Training'	Gives guidance on selecting and training field workers.
Section B: Indicators	1. MARA Programme Core Indicators	Lists the core MARA indicators that are being collected in every country. Some of these are the same as the UNGASS core indicators.
	2. MARA Baseline Study Core Indicators	Describes how to compile select indicators for MARA.
Section C: Questionnaires	1. Core Survey Questionnaire for Girls	A sample of the questionnaire developed for girls and which has been adapted in each country to include additional indicators.
	2. Core Survey Questionnaire for Boys	A sample of the questionnaire developed for boys and which has been adapted in each country to include additional indicators.
Section D: Findings	1. Moldova: Injecting Drug Users	Key findings
	2. Montenegro: Displaced Roma	Key findings
	3. Romania: Female Sex Workers	Key findings
	4. Romania: Injecting Drug Users	Key findings

	5. Serbia: Injecting Drug Users	Key findings
Section E: Intervention Research & Development	1. Intervention Research: Developing useful Monitoring and Evaluation Frameworks	Guidance for intervention research to assess the feasibility, acceptability and value of interventions/activities that have clear aims and expected outcomes.
	2. Monitoring & Evaluation Framework Template	Template that countries can use for intervention research.
	3. Sample of a completed Monitoring and Evaluation Framework from Romania	Shows what the template can look like once the processes outlined in E.1 have been undertaken.

ANNEX 4 – Consultation agenda

Consultation on Strategic Information and HIV Prevention among Most-at-Risk Adolescents
2–4 September 2009
Kofi Annan Room, UNAIDS, Geneva

UNICEF, in collaboration with the Inter-Agency Task Team on HIV and Young People

Working agenda:

Day 1	Understanding the issues – Getting the data		
Wednesday, 2 September	**Time**	**Topic**	**Participants**
	8:30 a.m. – 9 a.m.	Registration/coffee	
Welcome	9 a.m. – 9:45 a.m.	Welcome and introduction Overview of objectives and expected outcomes	Moderator: Jo Sauvarin, UNFPA Asia Pacific Regional Office Presenters: Luiz Loures, UNAIDS, and Diane Widdus, UNICEF
Setting the scene	9:45 a.m. – 10:15 a.m.	Creating a Common Understanding of MARA/MARYP in the Context of the HIV/AIDS Epidemic ➢ Introductory presentation and discussion in plenary: ▪ Why focus on MARA? ▪ Risk and vulnerability	Presenter: Bruce Dick, WHO
	10:15 a.m. – 10:45 a.m.	The UNICEF CEE/CIS Regional Programme on MARA Overview presentation and discussion in plenary: ▪ Programming context for HIV prevention among MARA ▪ Collaboration with LSHTM ▪ Objectives and expected outcomes	Presenter: Nina Ferencic, UNICEF CEE/CIS Regional Office
	10:45 a.m. –11 a.m.	*Break*	

		Global Frameworks and Guidance for Data Collection on MARA/MARYP	

Global data frameworks and guidance	11 a.m. – 12:30 p.m.	➤ Presentations and discussion in plenary:
		   • Introduction to the global database and current indicators
		   • Challenges and lessons
		   • Update on existing guidance
		   • Size estimation for MARA/MARYP – good practice and country examples
		   • Measuring coverage
			<u>Presenters:</u>
			Igor Toskin, Monitoring & Evaluation Division, UNAIDS;
			Priscilla Akwara, UNICEF NYHQ; and Dave Burrows, AIDS Projects Management Group

	12:30 p.m.–2 p.m.	*Lunch*	

Methodologies, tools and findings	2 p.m. – 3:30 p.m.	Getting the Evidence on MARA: Data Collection in South Eastern Europe and Ukraine, and an overview of the findings
		➤ Summary presentation by LSHTM and discussion in plenary:
		   • A review of methodologies, tools and indicators
		   • Quantitative and qualitative data collection
		   • Building capacity of national research partners
		   • A summary of the findings
		   • Innovations, limitations, challenges and lessons
			<u>Moderator:</u>
			Ketan Chitnis, UNICEF Asia Pacific Shared Services Centre
			
			<u>Presenters:</u>
			Joanna Busza and Megan Douthwaite, LSHTM

	3:30 p.m. –3.45 p.m.	*Break*	

Country data collection experiences	3:45 p.m. –4:45 p.m.	Group discussions:
		
		Country experiences in data collection
		   • What is being collected
		   • Data collection tools
		   • Challenges and lessons
			<u>Moderator:</u>
			Samir Anouti, UNICEF MENA Regional Office

	4:45 p.m. 5:30 p.m.	Groups report back in plenary	
	5:30 p.m.	*Close*	
	6 p.m. – 7 p.m.	Welcome reception	

Day 2	Using the data – Influencing policy and programming for MARA		
Thursday, 3 September	**Time**	**Topic**	**Participants**
	9 a.m. – 9:15 a.m.	Brief review of Day 1 and plan for Day 2	<u>Moderator</u>: Thomas Munyuzangabo, UNICEF West and Central Africa Regional Office <u>Presenter</u>: Jane Ferguson, WHO
Country experiences in getting the evidence, building political will, and influencing policies and programmes for MARA	9:15 a.m. –11 a.m.	Panel presentations on country experiences and discussion in plenary Ukraine: Issues and Challenges in Getting the Data and Creating an Enabling Environment for Policy and Programming on MARA (9:15 a.m. – 10:00 a.m.) Brazil: Advocacy and Action for MARA from a Human Rights Perspective (10 a.m. –10:30 a.m.) Philippines: Addressing issues of child rights and informed consent in data collection (10:30 a.m. – 11 a.m.)	<u>Presenters</u>: Olga Balakireva, Ukrainian Institute of Social Research; and Olena Sakovych UNICEF Ukraine Nara Vieira, Brazil National AIDS Programme, and Daniela Ligiero, UNICEF Brazil Gudrun Nadoll, UNICEF Philippines
	11 a.m. – 11:15 a.m.	*Break*	
	11:15 a.m. –12:45 p.m.	Group discussions: Building capacity and political support for data collection and programming with/for MARA and MARYP ▪ Sharing country experiences ▪ Highlighting challenges and effective responses ▪ Engaging MARA/MARYP ▪ Identifying additional support needs	<u>Moderator</u>: Vivian Lopez, UNICEF Latin America and the Caribbean Regional Office
	12:45 p.m. – 2:15 p.m.	*Lunch*	
	2:15 p.m. –3 p.m.	Report on key highlights from group discussions	

Summarizing experiences – Getting and using the evidence; intervention development; and integration and linkages	3 p.m. – 4:15 p.m.	Summarizing the issues, challenges and lessons learned in CEE/CIS to date and discussing the implications for evidence-based programming ▪ Data collection ▪ Policy and legal barriers ▪ Advocacy ▪ Ethical concerns ▪ Referral systems ▪ Monitoring and Evaluation frameworks	<u>Moderator</u>: Nina Ferencic, UNICEF CEE/CIS Regional Office <u>Presenters</u>: Paul Nary and Anya Teltschik, UNICEF CEE/CIS; Valentin Simionov, Romanian Harm Reduction Network; and Eugenia Badiu, UNICEF Romania
	4:15 p.m. –4:30 p.m.	*Break*	
	4:30 p.m. – 5:30 p.m.	Country examples of addressing ethical issues and building linkages/integrating MARA into protection and other sectors	<u>Presenters</u>: Bettina Schunter, UNICEF Pakistan; Jelena Zajeganovic-Jakovljevic, UNICEF Serbia
	5:30 p.m.	*Close*	

Day 3	Moving forward – Towards better data, better prevention programmes and more effective linkages to child and social protection agendas		
Friday, 4 September	**Time**	**Topic**	**Participants**
	9 a.m. – 9:15 a.m.	Brief review of Day 2 and plan for Day 3	Moderator: Bruce Dick, WHO Presenter: Nina Ferencic, UNICEF
The way forward	9:15 a.m. –11 a.m.	Group discussions: **Group One** Strengthening the evidence base on MARA Next steps – strategic action on: ▪ Strengthening capacity for data collection on MARA ▪ Using existing data and current indicators ▪ Tools and resources ▪ Key partnerships **Group Two** Strengthening political commitment Next steps – strategic action on: ▪ Advocacy ▪ Upstream policy work ▪ Policy guidance, tools and documents ▪ Key partnerships **Group Three** Strengthening integration and linkages into broader systems Next steps – strategic action on: ▪ Building linkages between HIV prevention and broader health, social and protection sectors ▪ Integration of MARA into existing service provision ▪ Key partnerships	
	11 a.m. – 11:30 a.m.	*Break*	
	11:30 a.m. –12:30 p.m.	Groups report back – Next steps	
	12.30 p.m. – 1:30 p.m.	*Lunch*	
Conclusion	1:30 p.m. –2:30 p.m.	Summation and next steps	Presenters: IATT/YP

ANNEX 5 – List of participants

Region		Name		Title	Organization
		Last Name	First Name		
Asia Pacific	1	Schunter	Bettina	HIV/AIDS Specialist	UNICEF Islamabad Pakistan
	2	Nadoll	Gudrun	HIV/AIDS Specialist	UNICEF Philippines
	3	Sheehan	Margaret	Regional Adviser Adolescent Development & Participation	UNICEF Thailand
	4	Chitnis	Ketan	HIV/AIDS Specialist	UNICEF Thailand
	5	Le	Cu Linh	Chair	Dept of Demography, Hanoi School of Public Health (HSPH), Viet Nam
	6	Dutta	Devashish	HIV/AIDS Specialist	UNICEF India (Chennai)
	7	Kisesa-Mkusa	Annefrida	Chief, HIV & AIDS, and Adolescent Health & Development FPA/SPC	UNICEF Fiji
Eastern Europe and Central Asia	8	Nary	Paul	Programme Specialist, Adolescent Development (YPHD)	UNICEF Geneva
	9	Ferencic	Nina	Regional Adviser, HIV/AIDS	UNICEF Geneva
	10	Malyuta	Ruslan	Programme Specialist, HIV/AIDS	UNICEF Geneva
	11	Sakovych	Olena	Youth & Adolescent Development Officer	UNICEF Ukraine
	12	Teltschik	Anja	UNICEF Consultant	UNICEF Ukraine & Regional Office
	13	Balakireva	Olga		Ukraine Government
	14	Blanchet	Sandie	Deputy Representative	UNICEF Moldova
	15	Badiu	Eugenia	HIV/AIDS Consultant	UNICEF Romania
	16	Simionov	Valentin	Executive Director	Romanian Harm Reduction Network
	17	Zajeganovic-Jakovljevic	Jelena	Project Specialist, Adolescents	UNICEF Belgrade
	18	Homans	Hilary	UNICEF Consultant	UNICEF Geneva
Eastern and Southern Africa	19	Chuwa	Victoria	HIV/AIDS Specialist	UNICEF Tanzania
Middle East and North Africa	20	Anouti	Samir	Regional Adviser, HIV/AIDS	UNICEF MENA
	21	Yasrebi	Najin	HIV/AIDS Specialist	UNICEF Iran
	22	Al-Iryani	Buthaina	HIV and Youth Specialist	UNICEF Yemen

Americas and Caribbean	23	Lopez	Vivian	Specialist, HIV/AIDS	UNICEF TACRO
	24	Ligiero	Daniela	Chief, HIV/AIDS	UNICEF Brazil
	25	Vieira	Nara	Prevention Department	Brazil National AIDS Programme
West and Central Africa	26	Makiu	Edmund	HIV/AIDS Specialist	UNICEF Sierra Leone
	27	Munyuzangabo	Thomas	Adolescent Specialist	UNICEF WCARO–Senegal
	28	Konan	Kouame Jean	HIV/AIDS Specialist	UNICEF Ivory Coast
	29	Oyewale	Tajudeen	HIV/AIDS Specialist, Protection and Participation	UNICEF Abuja
WHO HQ	30	Dick	Bruce	Dept of Child and Adolescent Health and Development	WHO Geneva
	31	Ferguson	Jane	Dept of Child and Adolescent Health and Development	WHO Geneva
	32	Sabin	Keith	Senior Epidemiologist	WHO Geneva
	33	Pervilhac	Cyril	Strategic Information & Research, HIV/AIDS Dept	WHO Geneva
UNFPA	34	Kraus	Steve	Chief, HIVAIDS Branch Technical Division	UNFPA New York
	35	Sauvarin	Jo	Technical Adviser on HIV/ASRH	UNFPA Bangkok
UNODC	36	Ulirsch	Judith	Associate Expert	UNODC
UNAIDS	37	Mahy	Mary	Senior Epidemiological Adviser Epidemiology and Analysis Division	UNAIDS Geneva
	38	Raja	Jyothi		UNAIDS Geneva
	39	Scully	Tim	Special Youth Fellow	UNAIDS Geneva
	40	Toskin	Igor	Monitoring and Evaluation Unit	UNAIDS Geneva
UNICEF HQ	41	Widdus	Diane	Sr. Specialist, Adolescent and Youth Development	UNICEF NYHQ
	42	Robert	Pierre	Specialist, Adolescent and Youth Development	UNICEF NYHQ
	43	Noubary	Behzad	Specialist, Costing, M&E	UNICEF NYHQ
	44	Akwara	Priscilla	Sr. Adviser, Statistic and Monitoring	UNICEF NYHQ
	45	Bull	Nicola	Consultant	UNICEF NYHQ

Partners	46	Busza	Joanna	Senior Lecturer	Centre for Population Studies, LSHTM
	47	Douthwaite	Megan		LSHTM
	48	Burrows	Dave	Director	AIDS Projects Management Group
	49	Frimpong	Allen	International Network Coordinator	Youth Rise
	50	Abdul-Quader	Abu S.	Epidemiologist, Global AIDS Program	USG - Centers for Disease Control and Prevention

This is the report from a "Consultation on Strategic Information and HIV Prevention among Most-at-Risk Adolescents" (MARA). The meeting aimed to facilitate the exchange of information across regions on country-level data collection regarding MARA; identify ways to use strategic information to improve HIV prevention among MARA; and suggest ways to build support for MARA programming among decision makers. It was held on 2–4 September 2009, at UNAIDS headquarters in Geneva, Switzerland. The consultation was organized by UNICEF Headquarters and the Regional Office for Central and Eastern Europe and the Commonwealth of Independent States in collaboration with the Inter-Agency Task Team on HIV and Young People.

Electronic versions of this report, consultation presentations and data collection toolkit are available at http://www.unfpa.org/hiv/iatt and click on "MARA Consultation" on the menu on the left.

For more information about the consultation please contact:
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