

Assessment of Global Fund Investments for Adolescent and Young Key Populations in Four Countries in Asia

**MYANMAR, INDONESIA, CAMBODIA
& PAKISTAN**



**ASSESSMENT OF GLOBAL FUND INVESTMENTS FOR
ADOLESCENT AND YOUNG KEY POPULATIONS IN FOUR
COUNTRIES IN ASIA: MYANMAR, INDONESIA, CAMBODIA
AND PAKISTAN**

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Thank You

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ACRONYMS

7Sisters	Coalition of Asia-Pacific Regional Networks on HIV/AIDS
AIDS	Acquired Immune Deficiency Syndrome
APN+	Asia-Pacific Network of People Living with HIV
CCM	Country Coordinating Mechanisms
CBO	Community-Based Organisation
CSO	Civil Society Organisation
GF	Global Fund
HIV	Human Immunodeficiency Virus
IATT-YKP	Interagency Task Team on Young Key Populations LGBT Lesbian, Gay, Bisexual, Transgender
MSM	Men who have sex with men
NGO	Non-Governmental Organisation
PLHIV	People living with HIV
PWID	People who inject drugs
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually Transmitted Infection UN United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNOPS	The United Nations Office for Project Services
UNICEF	The United Nations Children's Fund
WHO	World Health Organisation
YKP	Young Key Populations
Youth LEAD	Youth Leadership, Education, Advocacy, Development

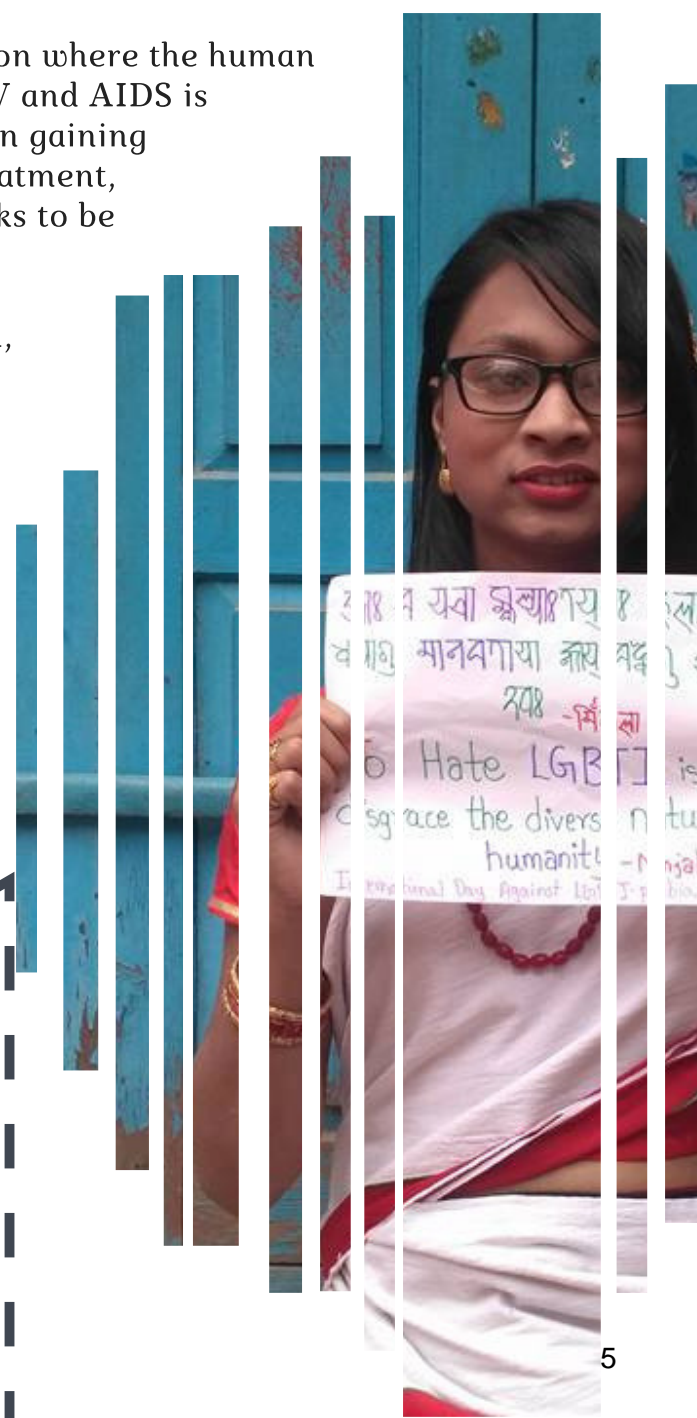


ABOUT YOUTH LEAD

Youth Leadership, Education, Advocacy and Development (Youth LEAD) works with and for young people who are members of populations that due to a variety of reasons including punitive laws, criminalization, societal discrimination and stigmatizing policies, are among the most likely to be exposed to HIV, but at the same time, whose meaningful engagement is key to a successful and comprehensive response to HIV (UNAIDS, 2014). For Youth LEAD, young key populations (YKP) include young gay men and other men who have sex with men, young people who inject drugs, young people who sell sex, young transgender people and young people living with HIV. Crosscutting populations like young women and girls are always considered YKP and are a major focus of Youth LEAD's efforts. Youth LEAD does not recruit members, but rather empowers young leaders who subsequently bring about change in their countries and in due time build capacity for future generations of leaders. Youth LEAD is not hierarchical and its remarkable family of dedicated focal points from across Asia and the Pacific is as integral to its direction and composition as the network's secretariat; the two are intertwined and interdependent.

Youth LEAD's vision for Asia-Pacific is for a region where the human rights of YKP are respected and the impact of HIV and AIDS is mitigated through their meaningful involvement in gaining equal and equitable access to HIV prevention, treatment, care, and support. In its mission, Youth LEAD seeks to be the catalyst of change and empowerment for YKP through capacity building, advocacy, and the expansion of partnerships between local, national, and regional YKP organizations. Youth LEAD advocates for greater participation and the meaningful involvement of YKP at all levels of HIV policy, programming, and decision-making processes.

Youth LEAD was founded in 2010 as a pilot project funded by UNFPA under the Coalition of Asia-Pacific Regional Networks on HIV and AIDS (7Sisters), including the Asia-Pacific Network of People Living with HIV (APN+), which hosted Youth LEAD and provided valuable fiscal support.



INTRODUCTION

Youth LEAD has been leading the advocacy and engagement of YKP in the Global Fund process in Asia. In 2014, the Global Fund Youth Guide Facilitator toolkit was developed and was piloted in Honduras, Nepal and Zimbabwe. Youth LEAD became one of the recipients of Special Initiatives Support of the Global Fund-CRG (Community Rights and Gender) managed by the Robert Carr Network Fund in 2015 and 2016. The Special Initiatives has primarily three objectives

- Strengthening global and regional civil society networks to support their country level constituencies and networks to meaningfully engage in Global Fund related processes and programs, including (but not limited to) national strategic planning, country dialogues, and concept note development;
- Developing the capacity of those communities currently marginalized to effectively engage at all stages of the Global Fund grant cycle, including National Strategic Plan development; and
- Empowering inadequately served populations to advocate for increased investment in community-led, rights and gender related programming to enable a more sustainable and effective HIV response at country level.

Youth LEAD intended to achieve first two objectives. The increased number of YKP in Country Coordinating Mechanisms (CCM) , inclusion of YKP issues in the final concept note, strengthened network led by YKP, increased discussion on YKP at the national level were few palpable results of the project. The countries where the project was implemented were Cambodia, Indonesia, Mongolia, Nepal, PNG, Pakistan and Vietnam in 2015 while added up Myanmar in 2016.

Youth LEAD has been awarded with the Special Initiative for 2016 as well and has implemented the project in same countries from 2015, which included Cambodia, Indonesia, Mongolia, Nepal, PNG, Pakistan and Vietnam while added up Myanmar (as Myanmar submitted the new concept note in mid 2016)

Studies, research and assessment for knowledge generation and evidence-based advocacy have been one of the strengths of the project. It has produced the regional manual for capacity development of young key populations, regional guidance note for CCM, principle recipients to effectively integrate the issues of young key populations in implementation and documentation of the best practice on engagement. Global Fund has recently accomplished its replenishment target of 12.9 b USD and countries have begun to prepare for the concept note development, which is now termed as Funding Request. The same process of country dialogue will begin to develop the funding request. Within two years of its effort, Youth LEAD has equipped its country partners with adequate capacity and evidence for meaningful engagement. However, sometimes doing the same things differently yields better result.

With these backdrop, Youth LEAD in preparation for the 2017 engagement aimed to assess the investment of the Global Fund in adolescents and young key populations in selected countries of Asia. The Global Fund Secretariat through CRG department has already convened the similar study at the global level titled Assessment of current Global Fund investments to address HIV and TB prevention, treatment and care needs of adolescents for better adolescent health outcomes. The study sampled six countries namely Cameroon, Indonesia, Kenya, Swaziland, Ukraine and Zambia and aimed to:

- To identify in a sampling of countries (6), the extent of the Global Fund's investments in adolescent health (TB and HIV) and to ascertain whether these investments contribute to improved adolescent health outcomes;
- To identify specific underfunded areas (against existing programming and strategic evidence) for adolescents in the reviewed sampling of Global Fund grants;
- To suggest a minimum of concrete and substantial recommendations on how the Global Fund structures and processes could help to address identified gaps to invest more strategically in adolescent health.

The proposed assessment by Youth LEAD aims to convene similar study in the selected countries of Asia. However, the assessment will magnify the GF response at the country level remaining within certain assessment criteria and scope of work. The outcome of the assessment will be utilized for advocacy during 2017 funding request development process at countries. The Youth LEAD secretariat recruited Jamie Uhrig as a consultant to assess Global Fund investments for adolescent and young key populations in Myanmar, Indonesia, Cambodia, and Pakistan.

The three objectives of the study were:

- 1) To document and analyze the Global Fund's investment in adolescents and young key populations in the selected countries, and to ascertain whether these investments contribute to improved adolescent and young key populations health outcomes;**
- 2) To identify specific underfunded areas (against existing programming and strategic evidence) for adolescents and young key populations in the reviewed sampling of Global Fund grants;**
- 3) To suggest at the minimum concrete and substantial recommendations on how the Global Fund structures and processes could help to address identified gaps to invest more strategically in adolescent and young key populations health.**

A literature review was undertaken and questions to explore the above three tasks were developed. Country focal points were contacted and asked to suggest key informants who were involved in programming for young members of key populations from the CCM level to the community level. These key informants were asked to reserve a time for a Skype or telephone call with the consultant. Information obtained from the key informants was collated, an analysis was made, and recommendations for individual countries and for all four countries were developed.

MYANMAR

BACKGROUND

The Myanmar national HIV strategic plan is clear that it considers activities for young members of key populations to be an integral part of the strategic plan. The National Strategic Plan on HIV and AIDS Myanmar - 2016-2020 states: “Within the priority populations described, young people are an important group and will be address (sic) within the priority population interventions”.

It goes on to say: “Younger members of priority populations (24 years and younger) are captured within the MSM, TG, PWID and SW groups. Adolescents and young people from priority populations are at significant HIV risk, higher than that of their older peers in these populations due to rapid physical, emotional and mental development, complex psychosocial and socio-economic factors and poor access to and uptake of services, particularly for those under 18.

Young people within these groups may require specific and more creative engagement strategies to promote uptake of services. Socio-cultural factors, including religious beliefs on sex before marriage, and a lack of clarity on the age at which young people can access health services without parental consent, can impede access to services. It is vital that young priority populations are reached with accurate information on HIV risks and prevention strategies, and have access to youth-friendly prevention, harm reduction, reproductive health, and care and treatment services.”

No scientific evidence was found by the consultant that younger members of key populations have higher incidence, higher prevalence, or are at greater risk of HIV acquisition than older members of key populations. The prevalence of HIV among younger members of key populations was consistently lower than among older members of key populations. This is probably due to less exposure as they have just begun to practice risky behaviours. The prevalence of HIV in younger members of most key populations is on a slow decline in Myanmar. This is an indication that incidence is decreasing as young members of key populations are constantly being replaced by new young members. If prevalence among this cohort is declining, then behaviour is changing and overall incidence is decreasing.

The only exception to the decline is among both young people and older people who inject drugs. There was an uptick in prevalence in Myanmar in this group in the last round of surveillance. This could indicate that the epidemic among people who inject drugs is not in control or it could be due to a flaw in the method used to measure prevalence. The next round of surveillance will clarify this.

The final concept note to the Global Fund is not available. The draft concept note to the Global Fund on which the new grants are to be based also takes note young members of key populations. It notes an information gap on “trends of behaviour of young key populations”. It states: “All priority interventions through intensified outreach component will improve penetration of key population networks reaching those that have not been reached”. These are the only two references to young members of key populations in the narrative part of the concept note. No intensified outreach component can be identified.

MYANMAR

PREVENTION

It is against this background that the two Principal Recipients have developed activities for the Sub-recipients to implement. The activities in Myanmar roughly follow the concrete guidance for key populations that has been disseminated by WHO and UNAIDS. Most of the activities for sex workers and men who have sex with men and transgender women are implemented by a few very large international non-governmental organizations. Activities for people who inject drugs are implemented by a smaller number of international and domestic non-governmental organizations. Two studies were conducted on young members of key populations in 2016 and the findings are presented below. One was commissioned by one of the Principal Recipients, Save the Children, and a second was co-commissioned by Save the Children and WHO.

The first study 'A supplementary report on the stories told about young and underage key populations in a formative assessment of HIV programming for sex and MSM in Myanmar' found that the young and 'underage' men who have sex with men and sex workers need attention in order to support organizations to support and protect them. This sentence is not fully comprehensible but it appears that the term underage refers to children or people under 18 years of age. Organizations interviewed in all four cities reported that they were either aware of or were serving young and underage sex workers and men who have sex with men. No figures were given. Two recommendations were made:

- 1) National organizations begin a discussion about legal and welfare needs of younger and underage sex workers and MSM and produce a strategy for social protection of young key populations;
- 2) Develop new sex worker and MSM orientation programmes that provide a standard orientation and prevention package to young sex workers and MSM in local places.

The study also made a recommendation for social protection for younger and child members of key populations. It states that a supportive social protection system is needed to provide safe places and alternatives to sex work and to reduce vulnerability to exploitation.



The second study 'HIV risk behaviour, experiences, responses, and service provision of young key populations (aged 10-24) in Myanmar' looked at prevention and treatment for all young key populations. Theme based recommendations were made in order of priority:

1. Strategic information - Promote the need to generate more strategic information on YKP by disaggregated collected data into 10-14 (when possible and appropriate) and 15-19 and 20-24 age cohorts, including by sex, risk behaviours (when possible and appropriate) and access to HIV and associated health services. Support and build capacity of those to undertake subset analyses of existing data sets, and promote annual monitoring and evaluation of any available relevant disaggregated collected data to better understand YKP.
2. Education materials, training and staff sensitivity - Develop culturally appropriate, evidence based module/s that show the natural tendencies of adolescents and YKP toward risk taking, sensation seeking and emotional and sexual changes during maturation. Promote training programs with identified suitable sectors in contact with YKP to improve staff empathy, sensitivity, and supportive of youth friendly services to match specific needs.
3. Community empowerment - Promote and increase community empowerment through CBO, self-help groups and networks to strengthen sustainability and promote connectivity with HIV services. Encourage community groups of YKP to be much more engaged in design of service operations (which needs not be exclusively health centric) and appropriate trainings, to ensure HIV services are attractive and meaningful to their lives.
4. Use of new technology and traditional methods of engagement - Further explore and strengthen the utilization of technological advances with internet, social media and mobile applications attractive to YKP to maximize service uptake and promote safety health messages. Routine monitoring and evaluation of the impact of new means to connect with YKP should be conducted, and traditional methods of engagement using PE and ORW should still be promoted.
5. Research - Support further quantitative and qualitative research on individual and structural drivers of HIV vulnerability among YKP to improve our understanding of interventions that work and match needs.
6. Policy and legal reform supportive of an enabling environment - Continue to advocate for an enabling environment to support a protective legal and policy framework, including flexibility with HIV Testing and Counselling for YKP - without age barriers to provide individual consent based on maturity - that will assist in the implementation of HIV prevention treatment and care interventions that match the health needs of YKP.

Neither of the two studies commented on what proportion of HIV prevention or treatment services reach younger members of key populations. These figures are unknown. The service provision figures for younger members of key populations for opioid substitution therapy or methadone are known. Data is presented below.

The Principal Recipient Save the Children is responsible for grants to international NGO sub-recipients. UNOPS is the Principal Recipient for Myanmar civil society organizations and governmental services. Staff members from both PRs were open and honest with this consultant during the study period when asked whether they could provide information on the proportion for prevention or treatment services. They said that the information was collected at the service provider level and that the data may be collated by service providers but it was not reported to either Principal Recipient.

A recommendation for a system-wide unique identifier has been made by consultants working on the development of the standard package of HIV prevention activities for key populations but there is as of yet no written national plan to put this recommendation into practice. PSI as a sub-recipient has a unique identifier system using iris identification technology. It requires a fixed machine to examine differences in the coloured part of people's eye so it can only be used in fixed locations such as drop in centres. As the age of consent for health issues in Myanmar is eighteen, there is anecdotal evidence that both clients and providers use eighteen as the lowest age that they provide or record on health records. A new health information system for the entire country is being implemented but it has not been rolled out yet. Year of birth is in the draft information entry form for this system so in future fully age-disaggregated data will be available.

Methadone data was available from the Principal Recipient UNOPS. Of those currently receiving methadone, 1,887 out of 10,290 or 18% are twenty-four years of age and under. One informant stated that half of drug users are young but it was unknown how many were opiate users and how many were injectors. The proportion of drug users who inject opiates and the proportion of young opiate injectors in the community is unknown so it cannot be known whether young drug injectors are over or underserved with methadone provided by the Global Fund grants.



MYANMAR

TREATMENT

There was an attempt to get more members of key populations into treatment. The International HIV/AIDS Alliance in Myanmar was the recipient of a Link Up grant with funds from the government of the Netherlands. Global Fund resources were not used. A recent peer reviewed article in a medical journal noted that it could not be shown that increased numbers of young men who have sex with men entered treatment due to Link Up. The authors of the article noted that low coverage of men who have sex with men by the intervention or the short timeframe of the evaluation may be responsible for this lack of effect. This is unproven. It is unknown what changes in programming were made as a result of this finding.

There is a special allocation for HIV in Myanmar that has been made by the Global Fund. This is listed as “Key Populations Impact” as is \$US 6.3 million. Some informants said that these funds have not yet been programmed but others said that they have been. Many stakeholders do not know about the existence of this allocation.

Data is collected on the age and key population of members of key populations who are on antiretroviral treatment. It is said by some informants that there is a fast track to get members of key populations on antiretroviral treatment. The data on age is not reported to the Principal Recipient. The consultant has requested this data from the National AIDS Programme but has not yet received a reply. A National AIDS Programme informant has, however, noted constraints in gathering and analyzing this information. Members of key populations do not always self-identify as such when they arrive at the treatment sites. There is no digital health record system in most of the treatment service delivery sites. The status of being a member of a key population may change over time. Additionally, members of one key population may also be a member of another key population. Self-reporting an inflated age to cover up the fact that a member of a key population is under eighteen was not noted to be a constraint by this informant.



RECOMMENDATIONS

Although the National Strategic Plan calls for specific strategies to increase the number of younger members of key populations who access prevention services, it does not appear that any new strategies have been developed. The information on the ages of people reached through outreach is collected but this information is not collated or reported. It is recommended that specific strategies be developed immediately so that they can be put into implementation plans immediately. A temporary method of data collation must be developed at the same time as the new national health information system is not yet fully developed or implemented. If these two programming changes cannot be completed in time there is the Key Populations Impact funding that can be used to develop and implement this programming.

There are three major international nongovernmental organizations, all sub-recipients with the Principal Recipient Save the Children, that provide most of the outreach services to key populations and young members of key populations. PSI and the International HIV/AIDS Alliance provide services to female sex workers, men who have sex with men, and transgender women. The organization that reaches the largest number of people who inject drugs is the Asian Harm Reduction Network. It is these four organizations that need to develop and implement programmes to increase the number of young members of key populations reached. These organizations already have outreach staff that are experienced but few of them are twenty-four years of age or younger. An attempt should be made to develop programmes that allow these outreach workers to reach more young members of key populations. A LOLIPOP-like programme for outreach similar to the one developed in Indonesia below could easily be implemented in Myanmar with no new resources.

For testing and treatment, data on age and key population is already collected but it is not collated or reported. A simple study could be made of the data that has been collected by the National AIDS Programme for the past year and over the first year of implementation of the new focused programming to determine if changes occur with the peer outreach that is focused on younger members of key populations. An attempt should be made to influence the development of the new national health information system so that age data can be broken down into one-year increments.

The age of consent leads to an artificial inflation of reported age by savvy young members of key populations who increase their reported age to the age of consent so that they can get services from health care providers. Health care providers cooperate in this age inflation. If the age of consent is not changed then there is little that can be done about this. It needs to be recognized that many community members who report the lowest possible age so that it is over the age of consent may be younger than their reported age.

Much of the work to influence programmes to increase access to prevention and treatment for young members of key populations can be undertaken at the HIV Technical Strategic Group level. There is a small closed version of this group and a larger open one. Either group needs young members of key populations to work on these issues.

INDONESIA

BACKGROUND

The Indonesia National Strategy and Action Plan 2015-2019 includes a section focusing on key populations including young key populations. Extensive knowledge, prevention programme exposure, condom use, and testing data are included in the plan. No scientific evidence in the plan was found by the consultant that younger members of key populations have higher incidence, higher prevalence, or are at greater risk of HIV acquisition than older members of key populations. No direct incidence studies have been performed. Prevalence among younger members of key populations is consistently lower than among older members of these populations or it is in the same range. This can be explained by less exposure as younger members have had a shorter time to engage in risk behaviours. This is shown in Image 1 below.

If methods of measuring prevalence in surveillance studies are consistent over rounds, rising prevalence can indicate an epidemic that is not in control. There is clear evidence that there is rising prevalence among the entire population of men who have sex with men and people who inject drugs in Indonesia. These epidemics are not in control. There is also evidence that prevalence is rising in younger men who have sex with men but the data has not been studied to determine if the rise in prevalence in younger men who have sex with men is rising faster than the prevalence among older men who have sex with men.

There are two specific references to young members of key populations in this strategic plan in Indonesia:

- 1) “Ensure the involvement of civil society, including people living with and affected by HIV and AIDS, young people, include young key affected populations and community-based organizations, also transgender and women group plays a more strategic role in programme planning, execution, reporting, monitoring and evaluation.”
- 2) “Develop a specific programme aimed at young gay, transgender, and other men who have sex with men. This should include appropriate approaches, community empowerment and prevention initiatives tailored to the specific characteristics of this group.”

The draft concept note currently being developed that cannot be directly quoted states that young members of key populations are at risk but does not provide evidence that they are at any greater risk than older members of key populations. No specific programmes or programming was included in the document obtained by the consultant.

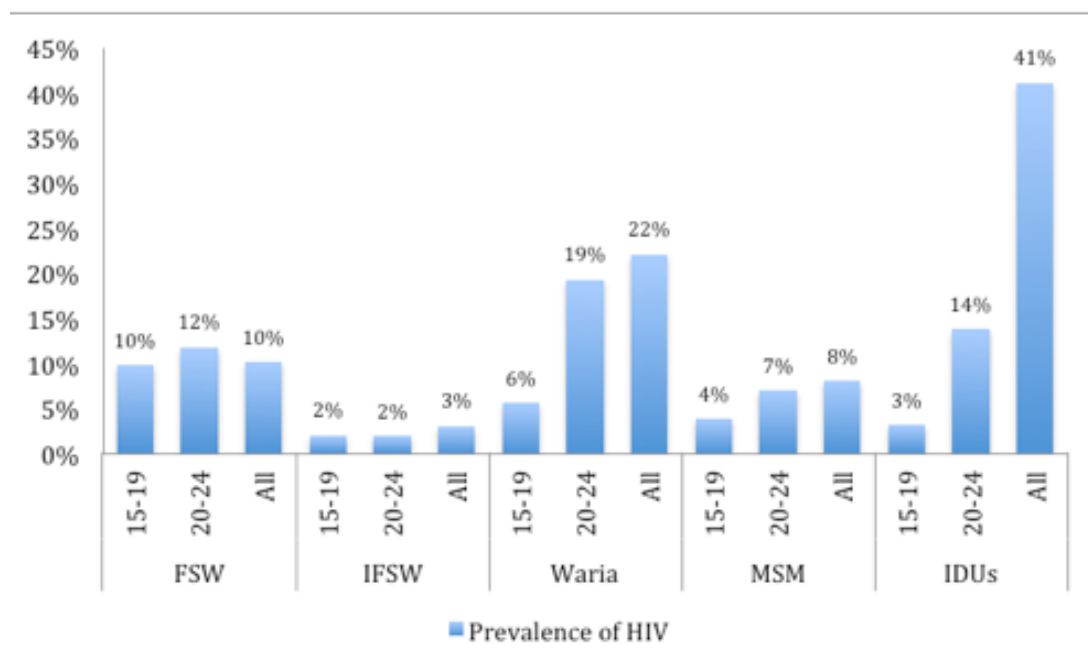


Image 1 – Prevalence of HIV among age groups of members of key populations in Indonesia

PREVENTION

There have been numerous discussions in Indonesia on the issue of whether younger members of key populations need targeted services or whether they can be served through services that reach all members of key populations. Informants noted that the reason for the lack of a concrete plan for young members of key populations was the lack of data. They said that decision-makers who worked on drafting the strategic plan and concept note stated that they did not have firm population estimates for young members of key populations. For this reason, it has been decided on more than one occasion that younger members of key populations would be provided services within the general key populations.

In response to the low access to prevention, testing, and treatment services by younger members of key populations, a network of young key populations, Fokus Muda, developed the Lolipop model programme in Bandung two years ago. UNICEF funded the pilot programme where Fokus Muda staff trained peer educators to reach young members of key populations and sensitized health care providers to the needs of young members of key populations. There were also advocacy and data components. A final evaluation has not been conducted so it is as of yet unknown whether Lolipop increased outreach to younger members of key populations or increased uptake of testing and treatment services by them. The project was not designed to collect data on these two outcomes in real time and only a final evaluation process when all the data is examined is planned.

Although it was not known if it was effective, the LOLIPOP model was expanded. Global Fund resources are currently being used to conduct LOLIPOP activities in Surabaya and Jakarta. LOLIPOP activities are currently being implemented by two Principal Recipients: the National AIDS Commission for female sex workers and Spiritia for all others. The activities are all included in the Global Fund module for people who inject drugs which has the smallest budget of all the modules.

The Principal Recipient, Spiritia, has funded six sub recipients to implement Lolipop-derived activities throughout 2016 and data is available to determine whether these activities increased coverage of prevention outreach and HIV testing of key populations. The programme was implemented in the cities of Surabaya, Denpasar, and West Jakarta. In Image 2 it can be seen that there were increases in outreach and testing demonstrable in all three sites among younger members of all three key populations by every one of the five implementers. It is evident that the greatest increases in service delivery were seen among men who have sex with men.

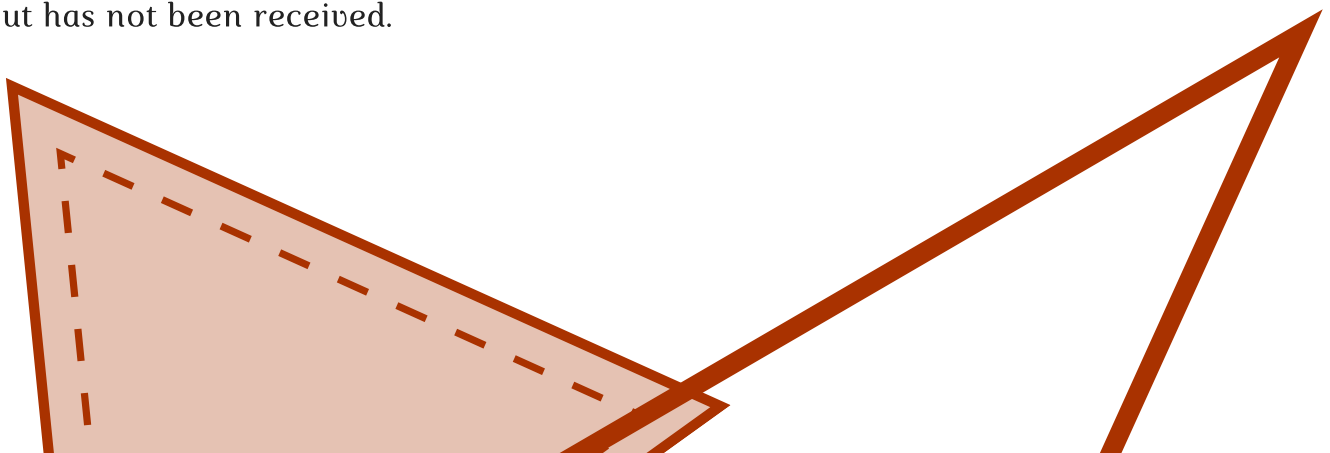
The proportion of the total number of members of key populations who are young members reached is not known by the consultant. This information would confirm that coverage of these two services among young members of key populations was adequate to have an impact on the trajectory of the epidemic. .

The status of the National AIDS Commission is currently unknown. A reorganization is taking place and the NAC may be absorbed into the Ministry of Health. Then its role as a Principal Recipient would need to be re-assessed. The staff person in charge of female sex workers at the National AIDS Commission stated that the Commission received no funds for Lolipop activities.

Some informants expressed frustration with the speed of innovation to reach young members of key populations with prevention and treatment services. New HIV infections in young members of key populations are occurring and there are anecdotes of late diagnoses and death. Most peer educators are not young and have had their jobs for many years. They reach mostly people their own age. Digital social media approaches to increase access and uptake are in their infancy. Organizations are seen by some to be risk averse when it comes to new approaches to reaching young members of key populations. The speed of growth in access to antiretroviral treatment is also slow. Although there has been no CD4 criteria for the initiation of antiretroviral treatment for any member of any key population for over two years, some doctors who initiate antiretroviral treatment still conduct CD4 cell count testing before they begin treatment. They also begin treatment without thoroughly counselling patients who have just tested positive, so people newly diagnosed do not accept their diagnoses and quickly discontinue treatment.

Some organizations are reluctant to work with those sixteen years of age as the age of consent is seventeen in Indonesia.

Methadone maintenance treatment is not expanding in Indonesia. It requires a community health centre to request it if the service is to begin. These centres do not often see the need for the development of methadone services as opiate use in communities is hidden. Data on methadone was requested from the Ministry of Health but has not been received.



INDONESIA

TREATMENT AND RECOMMENDATIONS

Treatment

Disaggregated data on age for treatment for key populations was also requested from the Ministry of Health but has not been received.

Recommendations

People who are interested in increasing access for key populations in Indonesia are in the enviable position of already implementing a programme to increase access to prevention services and testing. Although the LOLIPOP model has never been formally evaluated, it is clear from regularly-collected outreach and testing data that the LOLIPOP-like activities have increased the reach and uptake of these two services. The prevention outreach part of LOLIPOP is a success. Increasing the sites where LOLIPOP activities are implemented will lead to an increase in the number of younger members of key populations being served. This is recommended.

It is unknown whether these activities increase the number of young members of key populations that initiate and continue treatment. Data should be regularly collected so that a cohort cascade diagram can be developed for each site. There is concern that treatment is delayed or quickly discontinued among asymptomatic members of key populations. If this is found to be the case, efforts by treatment guides may be needed. The contribution of the three other elements of LOLIPOP: training of health workers, digital media, and monitoring and evaluation, is unknown. Increases in budget for them cannot be recommended.

It is unknown whether methadone and HIV treatment data can be obtained. Efforts to obtain this data failed.

The age of consent at 17 is rarely a constraint except for organizations working with young female sex workers.

		SEMESTER 1											
SSR	Location	OUTREACH						TESTING					
		15-19			20-24			15-19			20-24		
		MSM	TG	PWID	MSM	TG	PWID	MSM	TG	PWID	MSM	TG	PWID
YIM	West Jakarta	19	-	-	182	-	-	15	-	-	72	-	-
YSS	West Jakarta	-	6	-	-	48	-	-	-	-	-	5	-
KIOS	West Jakarta	-	-	17	-	-	20	-	-	16	-	-	16
YKP	Denpasar	23	1	1	120	9	7	19	1	-	59	6	4
PKBI	Surabaya	14	2	-	162	14	-	11	1	-	88	13	-
ORBIT	Surabaya	-	-	17	-	-	23	-	-	5	-	-	8
		56	9	35	464	71	50	45	2	21	219	24	28
		SEMESTER 2											
SSR	Location	OUTREACH						TESTING					
		15-19			20-24			15-19			20-24		
		MSM	TG	PWID	MSM	TG	PWID	MSM	TG	PWID	MSM	TG	PWID
YIM	West Jakarta	105	-	-	390	-	-	62	-	-	173	-	-
YSS	West Jakarta	-	38	-	-	167	-	-	2	-	-	4	-
KIOS	West Jakarta	-	-	26	-	-	38	-	-	21	-	-	31
YKP	Denpasar	40	-	2	439	29	15	20	-	-	147	5	5
PKBI	Surabaya	43	3	-	326	34	-	27	2	-	136	22	-
ORBIT	Surabaya	-	-	21	-	-	43	-	-	13	-	-	27
		188	41	49	1,155	230	96	109	4	34	456	31	63

Image 2 – Reach of outreach and HIV testing among young members of key populations by six implementing organizations in Indonesia

CAMBODIA

BACKGROUND

It is a challenge to find references to key populations in the current Cambodian national strategic plan. They are variously referred to as key populations, key affected populations, and even most at risk populations or MARPs. Though the word 'young' occurs many times in the National Strategic Plan for the Comprehensive and Multi-Sectoral Response to HIV and AIDS IV, July 2015 to December 2020, there are almost no references to young members of key populations. There is a statement that "Youth interventions should be more targeted toward most at risk young people ... and the Young Entertainment Workers". These are not defined. Young sex workers appear to be called young entertainment workers in Cambodia and a behavioural study was included in the plan. There is little specific action for young members of key populations except "Youth-friendly, gender sensitive interventions and services provided to young people engaged in risk behavior."

No scientific evidence was found by the consultant that younger members of key populations have higher incidence, higher prevalence, or are at greater risk of HIV acquisition than older members of key populations. Direct studies of incidence have not been performed. Cambodia is a case study of inconsistency in performing surveillance studies so it is very challenging to determine if any of the epidemics among key populations are out of control. There is limited data that shows increasing prevalence among men who have sex with men so that epidemic may not yet be in control. Prevalence among younger members of the key population of 'female entertainment workers' is lower than among older members of these populations. This can be explained by less exposure as younger members have had a shorter time to engage in risk behaviours.

The consultant has been unable to obtain a copy of the draft concept note that Cambodia will submit by May this year or the concept note for the Global Fund that is currently being implemented. A national assessment of services for young members of key populations was conducted in 2015 but the report is in the Khmer language and it has not yet been translated into English.



CAMBODIA

PREVENTION AND TREATMENT

Prevention

There is no specific programme and there are no specific activities for young members of key populations in Cambodia that are resourced through the Global Fund. Although information on age is collected during outreach for all members of key populations, the information is not required or reported by the Sub-recipients or Principal Recipients.

Staff at the Principal Recipient KHANA, however, were able to obtain the following data in Image 3 by analyzing their programme data:

Summary of KP reached by Month 2016 (July to December) Under Global Fund and Flagship Sites

Month	GF-NFM						
	FEW		MSM		TG		
	Under 25Y	Total	Under 25Y	Total	Under 25Y	Total	U
July	6,573	14,918	4,248	7,943	616	1,409	
August	7,118	16,483	4,237	7,809	755	1,659	
September	6,240	14,177	3,777	6,884	577	1,296	
October	4,510	9,839	3,850	7,182	661	1,446	
November	3,590	8,094	4,331	7,832	660	1,448	
December	3,449	8,202	3,130	5,715	586	1,302	

Image 3 – Number of contacts with members of key populations through outreach in the second half of 2016 by the Principal Recipient KHANA in Cambodia

It can be seen that over half of men who have sex with men and about a third to a half of female entertainment workers (female sex workers) reached for prevention services by outreach workers are under 25 years of age. The proportion of younger transgender women is slightly lower. The numbers reached are not exclusive so the 3,590 female entertainment workers (female sex workers) reached in November 2016 may be almost the same as the 3,449 women reached in December 2016.

Treatment

No data is available on HIV treatment or methadone. Efforts to obtain this data failed.

There were several programmatic constraints raised by informants. All implementers in the country are extremely careful not to work with any females working in the sex industry who are under 18 as they are concerned about being accused of human trafficking for sexual purposes. The age of consent for testing is also 18. The quality of services was also a concern: standard operating procedures have been developed but there is no programme of quality assurance.

There is at present no official seat on the Community Coordinating Mechanism for a young member of a key population.

CAMBODIA

RECOMMENDATIONS

People concerned with access to prevention services for young members of key populations in Cambodia can rest assured that half or more of all members of the key populations of female sex workers, men who have sex with men, and transgender women who are reached are twenty-four years of age or younger. This is remarkable.

It is unclear why this coverage of younger members of key populations is so high. There are probably several factors. The programme uses a unique identifier code for each member of a key population who is provided with prevention services and the birth year of each person is recorded and reported to the Principal Recipient. Outreach workers may be younger than in other countries and the average age of members of key populations in Cambodia may be younger as well. Female sex workers who work in beer gardens and karaoke bars, for example, are young, as younger women are seen as more effective in attracting customers to these establishments. Outreach workers use a simple risk assessment tool to reach the most at risk members of key populations in order to lead to a greater reach among them. The activities as they are being implemented for young members of key populations are succeeding and can be recommended as standard practice in Cambodia.

The age of consent in Cambodia is not a major issue, except that adolescents below 18 years of age may not get services. It is recommended that younger members receive testing and treatment services through a workaround that is effective in Cambodia. The Myanmar system of inflating ages could be used.



PAKISTAN

It was exceedingly challenging to get data on services for members of key populations in Pakistan. The national strategic plan was not available and the concept note currently being implemented uses the word young only twice to note that almost 80% of male sex workers were under 24 years of age. There are press reports that the prevalence of HIV among three key populations – female sex workers, men who have sex with men, and people who inject drugs – are rising. There is rising prevalence in all key populations in a draft report of a bio-behavioural surveillance study conducted in 2016/2017. The epidemics among all key populations are thus out of control. There is no age disaggregation of prevalence data in the draft surveillance report.

One of the two Principal Recipients was contacted but there was no data on the number of young members of key populations reached. Efforts to reach the other Principal Recipient failed.

142 out of 2,770 people who have initiated antiretroviral treatment are below 24 years of age, but it is unknown if they are members of key populations or other populations. This is low. Efforts to obtain further data failed. Oral substitution therapy is not used in Pakistan.

In the absence of more data, limited recommendations can be made for Pakistan. The only recommendation, in the context of HIV epidemics out of control among four key populations, is to advocate for the collection of data to the standard of Myanmar, Indonesia, and Cambodia



REGIONAL ANALYSIS

The terms of reference for the consultancy can be used as a framework for analysis.

The first one asks whether investments contribute to improved adolescent and young key population health outcomes. With respect to prevention, there are improved health outcomes that can be shown. Direct evidence lies in the decreasing prevalence among younger members of key populations in Myanmar, which indicates decreasing incidence. Possible evidence of an improved health outcome is reflected in increased access to prevention services among young members of key populations in Indonesia, which is easily demonstrated. More possible evidence is available from Cambodia where about half of all members of two key populations reached with prevention services are under 25. But there is no data to determine whether the health of younger members of key populations is improved due to testing and treatment. The data available from Pakistan is insufficient to demonstrate any health outcomes for young members of key populations.

There is clear evidence that overall HIV incidence in key populations is decreasing in Myanmar and among younger members of key populations who are experiencing decreasing HIV prevalence over time as shown by sentinel surveillance. The possible exception is among all people who inject drugs where prevalence has shown an uptick; this potential trend will be confirmed or disproven in the next round of sentinel surveillance. In Indonesia, there is increasing prevalence indicating epidemics are out of control among both men who have sex with men and people who inject drugs. These epidemics are more serious in some cities than in others. In Cambodia, there is evidence of increasing prevalence among men who have sex with men, but no clear evidence among other key populations. In Pakistan, there is increasing prevalence indicating out of control epidemics among all four key populations. In none of the four countries is the data available to know if health outcomes for younger members of key populations are improved through testing and treatment.

The data needs are not complex and do not require radical changes to monitoring and evaluation systems to change.

- 1) Birth date data rather than birth year range data must be collected. This allows data analysts to completely disaggregate data year by year.
- 2) A simple unique identifier system must be developed. This avoids undercounting and double counting of people who receive services.
- 3) Sentinel surveillance must use single birth year increments and be conducted consistently in the same sites for maximal usefulness. This allows data analysts to see if changes are occurring in the cohort of people who are all the same age over time.
- 4) And a cohort cascade diagram must be developed for treatment using data that is already collected. This allows programme implementers to mark progress towards the 90-90-90 targets and to know what populations are falling behind.

None of these is expensive to implement and all countries in the region could implement these changes.

With respect to the terms of reference on underfunded areas and addressing gaps to invest more strategically, there is no need to develop youth-specific separate programmes to address the HIV prevention and treatment needs of younger members of key populations. The only need is to ensure that these younger members are covered by the services at the same or higher level than older members. For prevention services, this already occurs in Cambodia and probably occurs in Indonesia. It is unknown whether it occurs in Myanmar and Pakistan. For treatment, it is unknown in all four countries. Youth-focused planning as it occurs in Cambodia and youth-specific tweaking as it occurs through LOLIPOP in Indonesia can both be effective. Myanmar, Pakistan, and all other countries in the region could implement them. Both Cambodia and Indonesia demonstrate that services to ensure access and increased coverage of services for young members of key populations do not require many new investments.



GENERAL RECOMMENDATIONS

1) Prevention - Whatever works to increase the total number of young members of key populations or the proportion of young members of key populations in key population services, or both, is recommended. In prevention, data from Cambodia and Indonesia represent two halves of the same coin. Almost half of the members of key populations receiving prevention services in Cambodia are young, but there is no method to determine if this is increasing or decreasing. The number of young members of key populations served with prevention services in Indonesia is increasing but it is unknown whether the number served represents a significant proportion of all members of key populations.

Both the expansion of LOLIPOP-like programmes in Indonesia and maintaining the current implementation methods for prevention in Cambodia can be recommended in these two countries. It would cost little to develop a LOLIPOP-like programme in Myanmar or Pakistan.

2) Treatment - Data on treatment and opioid substitution treatments is difficult to obtain as it is held by health services, but an attempt must be made to use it for improving treatment access for young members of key populations. Monitoring data collection by community-based peer educators usually stops as soon as an HIV test is made. There is little data on treatment anywhere. Cohort cascade diagrams for testing, initiation, and viral suppression are rarely used, though they are needed to improve treatment programme management. Outreach workers or other workers should be assigned to each newly-diagnosed person living with HIV for the first year of treatment to ensure a smooth treatment initiation and viral load suppression. Additionally, cohort cascade data should be obtained to develop the diagrams.

3) Age of consent - Every country can have its own 'work-around' to ensure access for members of key populations under the age of consent. The Myanmar age inflation system appears to work well there. In Cambodia, there is the concern on the part of implementers that their organizations may be caught up in 'sex trafficking' accusations when working with sex workers who have not yet reached the age of 18. The younger age cohort is simply reported as 'under 25'. Data from Indonesia is routinely gathered from members of key populations who are under the age of consent.

From a strategic perspective, the impact of programmes to improve the health of younger members of key populations may be greater if programmes are adapted to better serve the needs of these members than to spend resources on advocating for changes to the age of consent. The former will be sure to have an impact and the latter may not.

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