An estimated 2.1 million adolescents (10–19 years) were living with HIV in 2012 in low- and middle-income countries. Data on young adolescents (10–14 years) are limited, resulting in little information on progress toward preventing new infections or averting deaths for the adolescent age group.

In sub-Saharan Africa, the percentage of young people (15–24 years) demonstrating comprehensive and accurate understanding of HIV rose by five percentage points for men and by three for women from 2002 to 2011, although knowledge levels remain low (36% for young men and 28% for young women). The percentage of young people reporting condom-use the last time they had sex also rose during this period for both women and men.

Persistent challenges to effective HIV prevention for adolescents and young people include inadequate access to high-quality, youth-friendly HIV and sexual and reproductive health services, and sexual violence against young women and girls. In addition, some young people are hindered in their ability to obtain essential services by limited protection for young people’s confidentiality and right to medical privacy. Inadequate access to comprehensive sex education, shown to be effective in delaying sexual debut and increasing condom use among young people who are sexually active, also undermines efforts to protect young people from acquiring HIV.

New strategies have emerged to reduce young people’s vulnerability to HIV, including social cash transfers that create incentives for safer behaviours. Recently, a randomized controlled study in Lesotho found that a programme of financial incentives reduced the probability of acquiring HIV by 25% over two years. In a separate randomized controlled study in Malawi, cash transfers for schoolgirls were found to reduce new HIV infections by 60%. There is clear potential for cash transfers to support HIV prevention for young people, and continued research on the HIV prevention role of such programmes is recommended.

SCALING UP VOLUNTARY MEDICAL MALE CIRCUMCISION

It is projected that circumcising 80% of all uncircumcised adult men in the countries with high HIV prevalence and low prevalence of male circumcision by 2015 would avert one in five new HIV infections by 2025, with long-term prevention benefits for women as well as men. At the same time that priority countries scale-up voluntary medical male circumcision for adults, they are advised to roll out the routine offer of medical circumcision for newborn males.

Immediately following issuance of the recommendation for scale-up in 2007, progress in implementing voluntary medical adult male circumcision was initially slow, although there are encouraging signs that the pace of uptake may be increasing. However, scale-up of voluntary medical adult male circumcision varies considerably among priority countries (see Figures 1.3, 1.4).

As of December 2012, 3.2 million African men had been circumcised through specific services for voluntary medical male circumcision. The cumulative number of men circumcised almost doubled in 2012, rising from 1.5 million as of December 2011. Still, it is clear that reaching the estimated target number of 20 million in 2015 will require a dramatic acceleration.

Notes:
1. Implementation of voluntary male medical circumcisions (VMMCs) is done at different rates in the priority countries.
2. At the end of December 2012 just over 3 million VMMCs were reported in these countries, which amounts to the achievement of 15% of the estimated number needed to reach the 80% prevalence rate overall.
Progress has been most pronounced in the provinces prioritized for scale-up in Ethiopia (reaching 57% of the coverage target) and Kenya (63%). In five countries where voluntary medical male circumcision is stated to be a priority (Lesotho, Malawi, Namibia, Rwanda and Zimbabwe), coverage of voluntary medical male circumcision for adults is less than 10%.

Twelve countries submitted national mid-term reports that identified voluntary medical male circumcision as a priority. Five countries (Botswana, Malawi, Namibia, the United Republic of Tanzania and Zimbabwe) cited low male circumcision uptake as a challenge in their national response. Mid-term reports identified a variety of impediments to expedited scale-up, including financial constraints (Namibia), stock-outs of essential circumcision commodities (Uganda) and human resource limitations (Zimbabwe). Swaziland’s mid-term report makes no mention of voluntary medical male circumcision, even though the country has been identified as a key priority for scale-up. Moving forward, Lesotho has committed to increase resources for adult and neonatal medical male circumcision; Zimbabwe aims to provide improved circumcision training for nurses; and Uganda has pledged to intensify circumcision scale-up in the formal health sector and among district health systems.

There is evidence that programmes have had much greater success in reaching males younger than 25 years.26 As men in sub-Saharan Africa are at highest risk for acquiring HIV when they are in their twenties and thirties, men in these age groups are the top priority for scale-up. While voluntary medical circumcision confers a clear HIV prevention benefit on young men and should be continued, it has less immediate impact on new HIV infections than circumcision for men at greater risk. In an effort to reach men aged 25–29 years whose circumcisions would be more likely to result in immediate HIV prevention benefits, studies are currently underway to evaluate various innovative strategies to build demand for circumcision.

In 2013, WHO prequalified the first adult circumcision device for use in low-resource settings. The device, PrePex, requires no sutures or injected local anaesthetic and may be placed and removed by trained mid-level health providers including nurses. It is hoped that the device will accelerate scale-up by providing men with an alternative and by relieving demands on the limited number of surgeons available in priority countries.

**HIV PREVENTION FOR SEX WORKERS**

The epidemic continues to have a profound effect on female, male and transgender sex workers. Globally, female sex workers are 13.5 times more likely to be living with HIV than other women.27 In countries in West Africa, substantial proportions of new infections (10–32%) were estimated to occur as a result of sex work; in Uganda, Swaziland and Zambia, 7–11% of new infections are thought to be attributable to sex workers, their clients and clients’ regular partners.28 Median HIV prevalence among sex workers varies across the world, from 22% in Eastern and Southern Africa (eight countries) and 17% in Western and Central Africa (17 countries) to less than 5% in all other regions (see Figure 1.5). These surveys are typically conducted in capital cities and are not nationally representative, so the findings may not be applicable to the entire population. A separate analysis of available data found a pooled HIV prevalence among female sex workers of 36.9% in sub-Saharan Africa, 10.9% in Eastern Europe and 6.1% in Latin America.29 Median prevalence among male sex workers gleaned from published literature from 24 countries since 2006 is 14%.