EXCLUDING YOUTH?
A global review of harm reduction services for young people

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Introduction

UNICEF estimates that there are nearly 2.2 billion children and young people under 18 years of age, accounting for more than a third of the world's population.[1] The UN Convention on the Rights of the Child requires that state parties take 'appropriate measures' to protect this age group from the illicit use of drugs. However, the 'war on drugs' often trumps young people's rights.[2,3] This chapter will provide a global snapshot of the harms experienced via injecting drug use (IDU) among young people aged under 18 and existing harm reduction responses targeted at this population.

Alcohol, cannabis and 'club drug' use remain much more prevalent than IDU among this population. However, this chapter focuses specifically on youth injecting, which continues to represent a significant blind-spot in terms of research and public health responses. The chapter begins by outlining recent trends in IDU among young people. As part of the Global State of Harm Reduction 2012 survey, new international data were collected from civil society and researchers, and this chapter reports our analyses of these data to provide a unique and timely study of legal age restrictions and other barriers to young people accessing harm reduction services. This chapter also highlights case studies of best practice for meeting the needs of this population in different settings, to inform our recommendations for improving policies and services to reduce drug-related harm.

Young people who inject drugs: prevalence and harms

Although overall levels of youth drug use appear to be stabilising or decreasing in many high-income countries[4,5,6] surveys of the general population conceal the drug-related harms experienced by the most vulnerable groups of young people. This includes young people who are not in education and street-involved youth – populations whose drug use is less likely to be transitory and more likely to progress onto more problematic patterns of use, such as IDU.[7] The impact of current economic recessions is likely to further increase the vulnerability of young people,[8] and record levels of child poverty and youth unemployment have already led some commentators to describe a new 'lost generation' of young people devoid of jobs and hope. [9]

Furthermore, drug use is a universal and globalising phenomenon. Young people in Western Europe and North America represent a small fraction of the total global youth population: more than four-fifths of the world's children and young people aged 18 years and younger live in low- and middle-income countries in Eastern Europe, Asia, Africa and South America. Recent reports have drawn attention to a 'historic high' in youth drug use globally,[10] and IDU has spread to new regions. For example, the Pangaea Global AIDS Foundation estimates that there are now over 25,000 people who inject drugs (PWID) in Tanzania, and that over 40% of this population is living with HIV.[11] HIV transmission via unsafe injecting in sub-Saharan Africa is a relatively new phenomenon, and young people are likely to be among the most vulnerable.[12]

While IDU still only represents a small proportion of drug use reported by under-18s overall, in many regions of the world the age of initiation of injecting now appears to be decreasing.[13] Those young PWID who are sharing injecting equipment can transmit blood-borne viruses including HIV and Hepatitis C. These youth are also at greater risk of other preventable diseases such as tuberculosis. Research consistently shows that young injectors are more likely than older ones to report sharing equipment with other injectors and less likely to access needle and syringe exchange services.[14,15] Young people also often have a lack of knowledge and misconceptions about HIV transmission.[16]

According to UNICEF in 2011,[16] globally young people account for 2,500 new HIV infections every day. Failures to meet targets on reducing HIV transmission among young people is in a large part due to unsafe injecting practices and the criminalisation of these behaviours. It is estimated that in countries such as Belarus, China, Italy, Poland, Spain and Russia more than half of HIV infections are due to unsafe injecting,[17] much of this among youth. More generally, young people are also often the first to experiment with new substances, and are often highly connected to dense drug-supply networks, making them highly susceptible to new drug-related harms.

Young people who inject drugs: current responses and data gaps

Despite increasing global coverage of harm reduction services,[18,19] there remains a lack of youth-focused harm reduction services, and a potential gap between the age of initiation of injecting and the age at which services are accessible to young people. Current responses remain dominated by prevention and punishment discourses.

In some regions, strict age restrictions on access to these services have been highlighted as a major barrier, as young people are denied access to evidence-based interventions such as needle and syringe exchange programmes (NSPs) and opioid substitution therapy (OST). Criminal laws increase that risk and other barriers to young people accessing harm reduction services have also been identified, including appointment-based service provision and a lack of youth-work expertise and training among practitioners.[20] Furthermore, youth participation in the design of policies and programmes remains rare.

However, to date, there have been no attempts to map out and synthesise these barriers globally. The Global State 2012 data collection questionnaire offers a novel lens through which to study age restrictions and other barriers to NSP and OST access among the youth population. Data were collected by surveying civil society organisations and key researchers working in the harm reduction field around the world to explore region-by-region developments in harm reduction since the previous Global State report was released in 2010. In the 2012 survey, specific questions were asked for the first time about the barriers to young people accessing services and legal age restrictions in different countries and regions (for more information see the Introduction to this report). Data on young people were available from all the Global State regions except for the Middle East and North Africa, which is, therefore, not included in these analyses.

Harm reduction services for young people: a global snapshot

Overall, of 85 countries reporting at least one NSP or OST site, data on the existence of age restrictions were available for 77 countries. Of those countries that reported data on age restrictions, 18 countries reported an age restriction for accessing NSPs, and 29 for accessing OST. Most commonly the age restriction was 18 years, but in some cases it was much higher (e.g. Georgia, Norway and Sweden). Even in countries with no legal age restrictions, the application of other requirements, such as compulsory parental consent or evidence of previous failed attempts at detoxification or other drug treatment modalities, and 'aiding and abetting' laws limit access to harm reduction services for young people. Table 1 provides more information on the existence of age restrictions by country, and the survey responses have also been synthesised in narrative form and are presented, region-by-region.[a]

a Please see section 2: Regional Overviews for a comprehensive list of countries considered as part of each of the world regions.

Country/territory with at least one reported NSP or OST site	Legal age restriction for accessing NSP (age in brackets)	Legal age restriction for accessing OST services (age in brackets)
ASIA		
Afghanistan	Data n/a	No
Bangladesh	Data n/a	Yes (18)
Cambodia	No	Yes (18)
China	Yes (18)	No
Hong Kong	No NSP	No
India	Yes (18)	Yes (18)
Indonesia	Data n/a	Yes (18)
Macau	No	No
Malaysia	No	No
Maldives	No NSP	No
Mongolia	Data n/a	No OST
Myanmar	No	No
Nepal	No	Yes (18)
Pakistan	Yes (18)	No OST
Philipinnes	Data n/a	No OST
Taiwan	Data n/a	Data n/a
Thailand	No	No
Vietnam	Yes (18)	Yes (18)
LATIN AMERICA		
Argentina	No	No OST
Brasil	No	No OST
Colombia	No NSP	No
Mexico	No	No
Paraguay	No	No OST
Uruguay	No	No OST
CARIBBEAN		
Puerto Rico	No	No
SUB-SAHARAN AFRICA		
Kenya	Data n/a	Data n/a
Mauritius	Yes (18)	Yes (18)
Nigeria	No NSP	Data n/a
Senegal	No NSP	Data n/a
South Africa	Yes (18)	Data n/a
Tanzania	No	No
EURASIA		
Albania	No	No
Armenia	No	Data n/a
Azerbaijan	Data n/a	Yes (18)
Belarus	No	Yes (18)
Bosnia and Herzegovina	No	No
Bulgaria	No	Yes (18)
Croatia	No	No
Czech Republic	Yes (15)	Yes (15)
Estonia	Yes (18)	No
Georgia	No	Yes (21)
Hungary	No	Yes (18)
Kazakhstan	No	Data n/a
Kosovo	No	No
Kyrgyzstan	No	No
Latvia	Data n/a	Data n/a
Lithuania	Yes (18)	Yes (18)
Macedonia	Yes (18)	Yes (16)

Country/territory with at least one reported NSP or OST site	Legal age restriction for accessing NSP (age in brackets)	Legal age restriction for accessing OST services (age in brackets)
Moldova	Data n/a	Yes (18)
Montenegro	Data n/a	Data n/a
Poland	No	No
Romania	Yes (18)	Yes (16)
Russia	No	No OST
Serbia	Yes (15)	Yes (15)
Slovakia	No	Yes (18)
Slovenia	No	Yes (16)
Tajikistan	No	No
Turkmenistan	Data n/a	No OST
Ukraine	Yes (14)	Yes (14)
Uzbekistan	Data n/a	No OST
WESTERN EUROPE		
Austria	Data n/a	Data n/a
Belgium	No	Yes (18)
Cyprus	No	No
Denmark	No	No
Finland	No	No
France	Yes (18)	Yes (15)
Germany	Yes (18)	Yes (18)
Greece	Data n/a	Data n/a
Iceland	No NSP	Data n/a
Ireland	No	No
Italy	No	No
Luxembourg	Data n/a	Data n/a
Malta	Data n/a	Data n/a
Netherlands	No	No
Norway	Data n/a	Yes (25)
Portugal	No	Yes (18)
Spain	Yes (18)	Yes (18)
Sweden	Yes (20)	Yes (20)
Switzerland	No	No
Turkey	No NSP	Data n/a
United Kingdom	No	No
OCEANIA		
Australia	No	No
New Zealand	Yes (16)	No
NORTH AMERICA		
Canada	No	No
United States	No	Yes (18)

Asia

Despite a scale-up in services overall in the last two years, it was reported that harm reduction services in Asia almost always target male, adult PWID. A major barrier to service provision targeted at youth in the region appears to be their relative invisibility as a drug-using population. Few or no data are collected on this population in most countries in the region at present. Young people are, therefore, rarely a focus for intervention, and the vast majority of programmes lack any clear strategy for reaching and engaging under-18s. Even in Bangladesh, which has relatively high levels of NSP coverage in South Asia according to recent reviews,[19,21] there are no data on, or provision for, younger PWID. Furthermore, many young injectors in Asia are using methamphetamine and pharmaceutical drugs (e.g. benzodiazepines), and their needs will not be addressed through OST.[22]

Legal age restrictions are also a barrier in the region. For example, in Nepal and Pakistan harm reduction projects can only work with those aged 18 and above, despite Article 33 of the UN Convention on the Rights of the Child requiring that state parties take 'appropriate measures' to protect under-18s from drug-related harms. This is of particular concern in Pakistan, where the age of initiation into drug injecting is decreasing, according to a recent rapid assessment exercise.[23] Meanwhile, in China and Vietnam, despite an expansion of harm reduction service provision overall, age restrictions prevent under-18s from accessing these new services.

It was reported that legal age limits are a common reason for refusal by services, as they provide an objective way of rationing limited supply in the region. Stigma was also reported to be a major barrier, and many young PWID in the region deny they are dependent on drugs and need harm reduction services. At present, there is a mandate to disclose one's identity, and service-users often have to effectively 'register' with authorities, as is the case in China. This is a clear impediment to accessing OST services and may disproportionately affect younger people. Furthermore, most OST clinics have yet to be integrated into general health services, with the consequence that those accessing treatment can easily be identified and stigmatised.

The 'Opening Doors' project: increasing access to youth-friendly harm reduction in Asia[b]

'Opening Doors' is a response to current legislation across Asia which mostly prohibits access to harm reduction services for young people, as well as the stigmatising and punitive nature of current treatment approaches which exacerbate social exclusion. The project is funded by Aids Fonds, a Dutch NGO, and is a partnership between Access Quality International and the National Drug and Alcohol Research Centre, University of New South Wales, Australia.

Where community options do exist, young people have tended not to engage with these adult-oriented services. Informed by the World Health Organization's model of 'youth-friendly health services',[24] the primary aim of the project is to increase access to harm reduction services for young PWID and those who are at risk of initiating IDU. The target age group is 10–25, with special attention paid to the engagement of difficult-to-reach young people. The project has been implemented in three sites so far: Bangkok, Thailand; Kunming, China; and Kathmandu, Nepal.

In all three sites, participatory focus group research with young PWID has been used to identify local needs, engage them in service design and increase access to locally appropriate harm reduction services. For example, in Kunming, the main drug of concern remains heroin, with significant unmet needs identified following consultation with young people. The project site in Kunming has aimed to increase participation in 'youth-friendly' methadone maintenance therapy (MMT), alongside other activities such as counselling groups, employment assistance, visits and recreation.[25]

An evaluation undertaken by Youth Vision in Nepal in 2010 suggested that there had been a significant increase in the engagement of young people with harm reduction services after adopting the 'Opening Doors' approach. Young people accessing the services also reported improved mental health, less involvement with crime, a reduction in sharing of injection equipment and increased condom use. The projects have helped to establish new partnerships between the health, education, vocational training and employment sectors, building greater capacity for youth-focused harm reduction interventions in the region in the long term.

Latin America

Sporadic and isolated efforts largely characterise the development of harm reduction services in Latin America at present. Similar to Asia, a lack of harm reduction services for young people under 18 was reported in this region. Youth-focused approaches to reducing the harms associated with IDU are rarely an acceptable public health strategy in either South or Central American countries, and national drugs policies do not support this approach. Harm reduction responses which do emerge are normally led by NGOs, and it was reported that even where these do exist stigma, discrimination and criminalisation pose significant barriers to service use, especially for young people.

Despite these barriers, new examples of youth-focused harm reduction projects were reported. For example, in Rio de Janeiro a project was established in 2010 in an area known as 'crack land' where young people gather to use drugs. Work so far has focused on sensitising the health care system to the needs of these young PWID, including the development of a new course to train health workers, and the provision of syringes, pipes, lip balms and condoms. This project was supported by the federal government, the National Health Ministry, the Secretariat of State for Rio de Janeiro, the Federal University of Rio and the UN Office on Drugs and Crime. Also, in Mexico, the state authorities now buy and distribute syringes through centres for youth integration and in some CAPASITS (state provider of HIV, AIDS and STI services) sites.

Sub-Saharan Africa

Even more so than in Asia and Latin America, Africa is a region characterised by a paucity of both data on the number of young PWID and harm reduction services for this group. In East Africa, there are major concerns at present of both increasing IDU in general and also earlier initiation, with reports of young people as young as 11 in Kenya and as young as six in Tanzania injecting drugs.[26] Harm reduction services that target young people in East Africa, particularly in the coastal areas where IDU is concentrated (e.g. Mombasa, Dar es Salaam and Zanzibar) are urgently needed. Such services must also meet the needs of young women who are injecting drugs, who are subject to multiple vulnerabilities.[27] Although there is no official data on the prevalence of IDU and service provision for young people, anecdotal information from some parts of West Africa suggests a rapid rise in IDU among youth and a severe harm reduction service provision gap.[28] As HIV infection through IDU increases in sub-Saharan Africa, young people are a particularly vulnerable population.[12]

b The 'Opening Doors' project has developed a toolkit on enhancing youth-friendly harm reduction, available at: http://ndarc.med.unsw.edu.au/resource/opening-doors-enhancing-youth-friendly-harm-reduction-toolkit.

Eurasia

Many countries in Eastern Europe report high HIV prevalence rates among young people through the sharing of injecting equipment and unsafe sexual practices.[29] Some positive legislative changes which aim to improve harm reduction services for young people were reported in this region. For example, in Serbia a new law allows juveniles aged 15 and over to have exclusive privacy over their medical records and consent rights regarding their health issues, which means no parental consent will be required to access NSP and OST. There are now no legal age restrictions for accessing NSP in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Hungary, Kosovo, Slovakia or Slovenia. However, since NSPs are often anonymous and client ages unrecorded, it is hard to assess whether PWID under 18 are being reached by these services.[30]

In other countries in the region, age restrictions remain a barrier to accessing harm reduction services. The Czech Republic and Macedonia both have legal age limits for NSPs, allowing only PWID who are at least 15 and 18 years old, respectively, to access sterile injecting equipment. Access to OST is also often subject to strict age regulations. For example, in Bulgaria and Hungary the minimum age for participation in OST is 18, and it is 21 in Georgia. The written consent of a legal representative or a parent of a minor is required prior to starting OST in Bosnia and Herzegovina, Romania and Kosovo, which also poses a significant obstacle.

Additional barriers to service access in the region include stigma, fear of the police, and a lack of funding. NSPs are also rarely, if ever, tailored to young people's needs. There are also a lack of youth-focused OST programmes, and to become eligible in many countries young people have to prove they were not successful in previous detoxification treatment.

Western Europe

The prevalence of injecting heroin and other drugs remains rare among young people in this region – typically only being reported by 1–2% or less of young people in general population surveys – while alcohol and cannabis remain the primary drugs used by young people.[5,6] The incidence of new cases of HIV among PWID is also low in Western Europe, although incidence is still relatively high in some countries (e.g. Portugal), and recent increases have been observed in others such as Sweden.[30] Furthermore, the burden of morbidity associated with IDU is not evenly distributed: certain groups of vulnerable young people are most at risk of transmission of HIV or Hepatitis C and other drug-related harms due to social and structural factors such as poverty and social exclusion.[8]

There is a mixed picture in terms of the application of age restrictions to accessing harm reduction services in Western Europe (see Table 1). For example, legal age restrictions were reported to limit access to evidence-based harm reduction services for vulnerable young people in Belgium, Germany, Norway, Portugal and Sweden. Alternatively, in countries such as the UK, specialist services to safeguard children and young people from harm were reported to have been developed, and 'minors' are not excluded from NSPs (although guidelines make it clear that the service providers should inform their parents and the local child protection agency). Likewise, community-based pharmacological interventions such as OST are now available for young people in the UK and have been developed to recognise the different context of working with young people.[31]

As in other regions, stigma, marginalisation and law enforcement practices were reported as significant barriers to HIV prevention, care and treatment for young people who use illegal drugs. This included a reluctance from young PWID to carry syringes due to social stigma, and who often adopt dangerous drug storage and concealment methods for fear of consequences of police action. Increasing incarceration of young people who inject drugs is also a major public health challenge, as access to harm reduction measures is usually limited or non-existent and HIV/Hepatitis C risk behaviours are more prevalent in prison settings.[32]

Oceania

In Australia, government support for harm reduction service provision and scale-up, and debates on drug policy reform, have become increasingly challenging. In most cases there are no age, gender-based or other criteria that restrict access to NSPs in Australia, although the only operational drug consumption room (DCR) in the country, which provides injecting equipment for use in its service, prohibits access to the service for those under the age of 18. Additional barriers which can prevent young people accessing services in Australia were also reported, including fear of stigma, the limited hours of service operation, limited service availability outside of major cities and discriminatory attitudes of staff towards younger people. While young people under 18 are not precluded from OST, doctors are discouraged from prescribing pharmacotherapies to 'minors' in Australia. Furthermore, if a 'child', that is a person under 18, is accessing injecting equipment or OST, staff are required to report this to the local child protection agency, which may be a further barrier for some young people.

In New Zealand, the minimum legal age for accessing NSPs is 16. Although there is no legal age restriction for OST, for those under 18 parental/caregiver support and consent is preferred. For those under 16, assessment and consent are also needed from an addiction medical specialist and/or a child and youth psychiatrist.

North America

Injecting drug use often starts at a young age in North America.[33] Age restrictions and limited access to NSPs for under-18s represent significant barriers to access to harm reduction services in this region. In the USA, although restrictions vary by state and by type of treatment setting, anyone under 18 must have undergone at least two documented attempts at detoxification or outpatient psychosocial treatment within 12 months in order to be eligible for OST. This inevitably limits the potential for young people to access evidence-based harm reduction programmes.

Cost is also likely to be a barrier to treatment in the USA, as Medicaid insurance can only be used to pay for MMT in some states, and even then it is often time-limited. It was reported that private insurance payment is also usually preferred by PWID to avoid exposure and stigmatisation, but this is unlikely to be an option for young PWID. Additional barriers include lengthy waiting lists for methadone clinics in some USA regions (particularly in regions far from urban centres), regulations around OST programme attendance and regular testing for other drug use, all of which are likely to pose barriers for young people.

No legal age restrictions for accessing NSPs or OST in Canada were reported. Outreach and frontline workers provide sterile equipment to young people who show evidence of use or need, although many youth in Canada still go without services, particularly in rural regions and central/northern Canada.

The TRIP! Project: Youth-Led Harm Reduction in Canada

TRIP! is a youth-led harm reduction project that has been providing peer outreach to the dance music community in Toronto, Canada for over 15 years. TRIP! aims to include young people who use drugs, street-involved and lesbian, gay, bisexual, transgender and queer (LGBTQ) youth in direct service development and delivery, and to encourage safer drug use and safer sex to reduce associated harms including the transmission of HIV, Hepatitis C and other sexually transmitted infections (STIs). TRIP! does outreach work via a variety of venues, including nightclubs, bars, warehouses, bridge parties, house parties, street parades and multi-day festivals. During outreach events, young people can pick up info-cards on dance drugs, routes of administration and safer sex, as well as a variety of harm reduction supplies including condoms, lubricant, straws, needles and syringes.

In addition to outreach, TRIP! engages youth through social networking to circulate messages about safer partying practices. Online surveys are employed to monitor patterns of drug use, injecting, and 'high-risk' behaviours. TRIP! has found that youth tend to be most honest when responding to anonymous online survey questions. As a result, an annual online survey is used to obtain accurate drug use data within this community. Information generated by this type of youth engagement allows TRIP! to monitor and identify emerging health and safety issues, as well as publish alerts about dangerous or new substances and laws affecting the communities.

While young PWID represent a minority of those with whom TRIP! works, injecting is an emerging trend within the Toronto community of young people who use drugs. The 2010 TRIP! survey found that 9% of young people were injecting drugs, with 3% considering doing it in the future. Young people who used crystal meth and ketamine were more likely to inject, with 17% of meth users and 13% of ketamine users reporting injecting. Furthermore, 83% of TRIP! youth reported having tried prescription opioids, often to deal with the come-down and other side effects reported from chronic ketamine use.

It is important to recognise the value of such projects in both increasing young people's 'voice' and also in building the existing network of safer nightlife organisations locally, nationally and internationally to share information and create a peer support network. According to the 2009 Toronto Teen Survey, many youth distrust health workers, instead turning to their friends (53%), siblings, and infolines (55%) for health questions.[34]

Increasing young people's visibility in harm reduction

IDU represents a small minority of youth drug use, but it is an acute problem affecting those most at-risk young people, and it is a much overlooked aspect of the global response to injecting-driven HIV epidemics. Young people are excluded from harm reduction services in every region of the world. Few NSPs or OST programmes target and work with young people. This was a recurring theme in the responses to the Global State of Harm Reduction 2012 questionnaire. Young people face all the same barriers to accessing harm reduction services that adults do – limited coverage, stigma and criminalisation – and these are further compounded by legal age restrictions and other barriers such as a lack of funding for youth-focused services.

At the international-level, the nine core harm reduction interventions recommended by the WHO, UNODC and UNAIDS[35] are not youth-focused, and it appears that key issues regarding young people, IDU and HIV may be falling between the priority areas of different international organisations such as UNAIDS, UNICEF, UNESCO and the WHO. Furthermore, while 'know your epidemic, know your response' has become the rallying cry of UNAIDS,[36] when it comes to young people and injecting we do not yet 'know our epidemic'. Where surveys do monitor prevalence and trends of drug use among young people, they are almost always still based on school samples, and PWID remain largely invisible in the official statistics on youth drug use.[7]

This chapter provides a much-needed global snapshot of legal age restrictions and other barriers to harm reduction services for young people. However, this picture is incomplete, and improved data collection should also be an international priority, as should significantly increased investment in youth-focused harm reduction. This review of harm reduction services for young people suggests the following priority areas:

Avoid legal age restrictions: Removing the barriers caused by legal age restrictions should be a priority, especially where the age of initiation to IDU is decreasing. Removing such restrictions is an important first step towards developing youth-focused services because, although OST provision for young people may raise specific medical concerns and abstinence-based treatments may be more appropriate in some cases, an age restriction on these harm reduction services will likely also mean there is nowhere else to go.

Youth-led, youth-friendly harm reduction: Young people may not identify with more adult-orientated models of treatment and should be involved in designing new services to meet their specific developmental needs. Our case studies highlight how it is possible to use participatory and peer-led methods to engage young PWID to inform more appropriate youth-led and youth-friendly services. International guidelines for OST (for those using opiates) and NSPs for children and young people are also required, as are clear child protection protocols and rapidly applicable legal tests for capacity to consent to treatment and to receive treatment without parental consent.

Improving data collection: Street-based surveys of young people should be more widely implemented to complement existing monitoring systems (e.g. school-based surveys), alongside rapid assessments of youth injecting and its adverse health outcomes. Furthermore, it is important that data on epidemiology and service coverage among PWID be disaggregated by age. To this end, existing recommendations by UNAIDS, WHO and other multilateral agencies to improve country-level data collection via age disaggregation are particularly relevant.[35,37] Removing legal age restrictions may also allow for an improved understanding of patterns of injecting through the collection of age-disaggregated client data.

Investment in young people most at risk: It is imperative that there is sufficient funding and training to support new responses focused specifically on the special needs of young people at highest risk from drug use. UNAIDS has already identified that this is a major problem in Asia, where 90% of the resources for young people are spent on low-risk youth, who represent just 5% of those who go on to become infected with HIV.

Structural interventions – the holistic approach: Social policies and interventions which address the broader 'risk environment' – for example, by addressing poverty, trauma, homelessness and social exclusion – are also needed and may have the greatest impact on reducing drug-related harms at a population level.[38] This is also in line with a children's rights-based approach.[39] Harm reduction in this context is about keeping at-risk youth alive and safe, while also addressing the causes of their vulnerability.

Finally, we would also emphasise that context is key: what works in the United Kingdom and Canada, where child protection services are strong, may not work in Nepal or the Ukraine. Irrespective of context, however, failing to find solutions represents a missed opportunity to protect and improve the health of the next generation of young people across the world. To do so, further questions must be asked about what information is already available, and where further investigation is required about IDU among young people and about the most appropriate responses to reduce drug-related harm among this population.

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