5 PILLARS FOR HIV PREVENTION

Issue Brief 1

The Missing Piece of the Puzzle

RIGHTS+EQUITY+JUSTICE for HIV PREVENTION

Combination prevention for adolescent girls and young women

Adolescent girls and young women (AGYW) between the ages of 15 and 24 continue to face a disproportionally high risk of HIV infection in sub-Saharan Africa.

Combination prevention programmes are rights-based, evidence-informed, and community-owned. They combine biomedical, behavioural, and structural interventions. These are prioritised to meet the needs of particular individuals and communities in order to have the greatest impact.

These high rates of HIV are associated with a range of **structural drivers**[1]:

- POVERTY
- GENDER INEQUALITY
- HARMFUL GENDER NORMS
- LACK OF EDUCATIONAL and EMPLOYMENT OPPORTUNITIES

What are gender norms?

Gender norms are informal rules and shared social expectations based on gender. Typically, gender norms are harmful in that they can empower some groups of people based on their gender (men) while marginalising others (women). As such, they limit women and girls' development opportunities and undermine their wellbeing. Harmful gender norms include beliefs that a woman's place is in the home, that education is wasted on girls, that violence against girls and women is justified, or the shaming of women who express their sexuality.

This issue brief examines those barriers, focusing on the structural barriers, that impacts HIV prevention for AGYW, and provides ideas on strategic entry points for advocacy.

ARASA AIDS & Rights Alliance for Southern Africa

The 2020 targets

The HIV epidemic in East and Southern Africa: where are we now?[i]

In June 2016, at the United Nations High-Level Meeting (HLM) on Ending AIDS, countries pledged to leave no one behind and: **end the AIDS epidemic** as a public health threat by **2030** and **reach ambitious milestones** by **2020.**

- reduce AIDS-related deaths
- reduce new infections

} to less than 500 000[1]

The HLM, for the first time, set specific programme targets for HIV prevention, supported by 5 pillars:

Pillar		Target
adolescent girls and young women (AGYW)	1	reduce new HIV infections among young women and girls to under 100 000
key populations	2	ensure that 90% of people at risk of HIV can access prevention services
condom programming	3	make 20 billion condoms available annually in low and middle-income countries
voluntary medical male circumcision (VMMC)	4	provide 25 million more men with VMMC
pre-exposure prophylaxis (PrEP)[iii]	5	provide PrEP to 3 million people at risk of HIV

For adolescent girls and young women, the global target set by UNAIDS is:

90%

to be reached with combination HIV prevention.

While reductions in global AIDS-related deaths continue at a pace that puts the 2020 target within reach, the rate of new HIV infections is not falling fast enough to reach the 2020 target of under half a million new infections per year.

Out of all regions of the world, East and Southern Africa is in fact faring the best, with new HIV infections declining by 30% between 2010 and 2017.

In order to reach the global targets, SADC has committed to reduce the amount of new infections by 230 000 per year. This is a 75% reduction from the levels in the SADC region in 2010.

PROGRESS TOWARDS 2020 HIV PREVENTION TARGETS IN SADC

Progress is still too slow, and if the region continues at the current trajectory, it will fail to meet the 2020 targets.[iv]

[New HIV Infections per year]

1990 — 669 856

1995 — 1 276 730

2010 — 903 576

30% decline in new infections between 2010 and 2017

2017 — 590 590 | 532 946

2019 — 501 174 | 328 242

2020 — 456 466 | 225 890

[Political Declaration Target] [Projection on currrent trends]

Treatment as Prevention is not enough

The goal of getting people onto antiretroviral treatment has surpassed everyone's expectations. Treatment has been shown to be an effective means of HIV prevention.

Estimates shows that achieving UN treatment goals alone can only reduce 60% of new infections[iv]. We therefore need a renewed focus on primary prevention[2].

Principles of programme interventions for all 5 pillars

Effective and efficient prevention programmes have the following elements:[v]

- They are comprehensive and integrated
- They are smart: they ask, "What works?", "With which populations?" and "In which settings?"
- They respect and protect human rights
- They are gender-sensitive and/or gender-transformative[3]
- Services are delivered at community level
- They make use of local programme data to for continuous improvement.
- They can be scaled up.

The 5 HIV prevention pillars are components of an integrated response.

Why adolescent girls and young women?

Adolescent girls and young women continue to face a disproportionally high risk of HIV infection. In several countries in East and Southern Africa, the risk of new HIV infections peaks at age 15–24 years for girls and young women, about 10 years earlier than for males.

AIDS is the fourth highest cause of death in adolescent girls and young women in sub-Saharan Africa.[vii]

Still, it is important to remember that there is considerable variation in HIV incidence between countries, and even within countries. The eastern and southern parts of the East and Southern African (ESA) regions, in particular, experience very high incidence.[viii] Certain groups of adolescent girls and young women, such as those who face social exclusion, including young key populations, face additional vulnerabilities and challenges.

Despite the risks facing this age group, young people have low knowledge about HIV prevention: in most countries less than half the young people aged 15-24 surveyed have comprehensive knowledge about HIV prevention, and condom use with casual partners is low. Also, in many of the countries in the region, less than half of adolescent girls and women have had an HIV test.

Structural barriers for adolescent girls and young women

Structural barriers both increase the vulnerability of adolescent girls and young women to acquiring HIV, but also limit their access to HIV services.

structural drivers[4]:

- POVERTY
- GENDER INEQUALITY
- HARMFUL GENDER NORMS
- LACK OF EDUCATIONAL and EMPLOYMENT OPPORTUNITIES

These drivers interact to limit the power, and constrain the options available to adolescent girls and young women, which in turn renders them more vulnerable to gender-based violence and intimate partner violence, and increase the likelihood of engaging in age-disparate relationships and transactional sex. In addition, young people face many barriers to accessing sexual and reproductive health services, including HIV prevention, treatment and care.

In addition, a range of factors deter young people, and in particular AGYW, from accessing HIV prevention, treatment and care, as well as other SRH services. These include punitive responses towards adolescent sexuality, from parents, educators and health care providers; stigmatising attitudes towards young key populations; and restrictive policies and laws.

Some of these barriers are discussed here in more detail:

- Patriarchy and gender inequality
- Violence
- Age-disparate relationships
- Stigma
- Young key populations
- Policy barriers

Patriarchy and gender inequality

Patriarchal norms support ideas such as men being entitled to control their partners, including the 'right' to have sex whenever they want it. Unequal gender power dynamics in relationships not only reduce women's ability to negotiate around safe sex, but are also associated with gender-based violence. For young women, income inequality and lack of income (or lack of control over it) may contribute to transactional sex, early marriage and reduced ability to end abusive relationships.[ix]

Violence

Gender-based violence is a physical manifestation of patriarchy. In Southern and Eastern Africa, women who experience violence from an intimate partner are up to 50% more likely to acquire HIV than those who do not experience violence.[x] Young women who are economically marginalised, in controlling relationships with men, and who experience Intimate partner violence are challenged in their ability to protect themselves from HIV, including using condoms or pre-exposure prophylaxis (PrEP).[5xi] Research also shows that men who are violent towards their partners also tend to engage in a range of risky behaviours – such as having multiple sexual partners, being clients of sex workers, and drinking large amounts of alcohol - which increase women's risk of HIV.[xii]

Age-disparate relationships

The trend of sexual relationships where there is a large age gap, typically between young women and older men, has been shown to be behind the very high rates of HIV amongst AGYW. A study in KwaZulu Natal, South Africa showed that the primary source of HIV infection among young women under 25 years of age was older men aged 25-40 years.[xiii]

Stigma

The issue of stigma and discrimination, related to attitudes towards youth sexuality, remains a key barrier in many countries in the region. Judgmental or punitive attitudes of health care workers towards young people (based, for example, on the notion that adolescents and young adults should abstain from sex), is a deterrent to accessing services.[xivxvxvixvii] Young key populations face even greater stigma and discrimination.[xviii]

Young key populations

Young key populations face many vulnerabilities which increase their risk of acquiring HIV. For example, young sex workers more at risk than older sex workers, as they are least likely to know their status, have lower knowledge of HIV prevention, and are less likely to use condoms.[xix]

Often, sexual minority and transgender adolescents fall through the cracks of HIV and SRH service provision. ASHRH policies assume adolescents are heterosexual, while KP policies assume KP are adults. Similarly, adolescent health services are not sensitised or equipped to deal with key populations, while key population organisations do not provide services to adolescents, leaving already vulnerable young people with nowhere to turn.[xx]

Policy barriers

Laws and policies regarding adolescent sexuality and sexual and reproductive health can either increase or decrease their vulnerability to HIV, as well as enabling or deterring them from accessing sexual and reproductive health care.[xxi] UNFPA conducted a review of laws, policies and related frameworks in 23 countries in ESA that create either impediments to, or an enabling environment for, adolescent sexual and reproductive health and rights (ASRHR). The results of the review are summarised, along with recommendations to harmonise ASRHR. See box below.

Review of legal and policy barriers and enablers for ASRHR in East and Southern Africa

Age of consent to sexual activity

Many countries in East and Southern Africa do not have the minimum age of consent to sexual activity clearly set out in their bodies of legislation. There is a need for the enactment of unambiguous legislation that provides for the recognised age of consent to sexual activity.

Age of consent to marriage

All 23 countries have set the age of consent to marriage. However, there is disharmony between the national provisions and international standards, as well as between statutory and customary law provisions. The age of consent to marriage should be set at 18 years, without exception.

Age of consent to medical treatment

In many countries, the age of consent to receive medical treatment, including access to contraceptives and HIV counselling and testing, is not provided for in laws and policies. Lack of legal and policy provision can lead to confusion as to when young people can consent to receive health services, including medical treatment. This uncertainty creates a barrier to accessing sexual and reproductive health services and allows health-care providers to enforce their own belief systems regarding an appropriate age of consent.

Criminalization of consensual sexual activity between adolescents	The criminalization of consensual sexual acts between adolescents appears to be minimal across the region. However, criminalization can result in the stigmatizing of adolescent sexual development and prohibit adolescents from accessing services in fear of prosecution.
Criminalization of HIV transmission	Some countries in the region criminalise infecting others with HIV, be it intentionally or negligently. Countries need to be encouraged to revise these laws and do away with this criminalization.
Harmful cultural practices	The criminalisation of harmful cultural practices (such as female genital mutilation) is a promising start but there is a need to ensure that the legislative provisions translate into practice and are enforced against those who commit these offences. Legislation should explicitly prohibit cultural, religious or traditional practices that are harmful to the health of women, children, adolescents and young people.
Sexual and reproductive health and rights of vulnerable adolescents	Vulnerable adolescents include those, with disabilities, those who are living with HIV, who are sex workers, who are out of school, and/or who belong to the LGBTI community. The lack of provisions for vulnerable adolescents creates a barrier to accessing sexual and reproductive health. Policies should set up strategies that help to eliminate discrimination
Learner pregnancy and re-entry laws and policies	The majority of policies on the management of learner pregnancy approach the issue from a punitive perspective. Excluding learners who fall pregnant on account of their pregnancy limits the potential of young people and perpetuates gender inequality.
Provision of comprehensive sexuality education (CSE)	Every country is diverse and has religious, moral and traditional nuances that may influence how CSE is taught in its schools. However, these should not prevent the revision of existing curricula to incorporate core topics that are essential to maintaining quality and are in line with the East and Southern African Ministerial Commitment.[6]

Addressing structural barriers for AGYW

Reducing HIV incidence amongst AGYW requires a gender-responsive and evidence-informed approach that is grounded in human rights principles.

Effective prevention of HIV and sexually transmitted infections and advancement of broader sexual and reproductive health in young people needs tailored, flexible, and client-centred approaches to sexual harm reduction and comprehensive sexual education.[xxii]

Trying to persuade youth age 15-29 to have less sexual partners has not worked.[xxiii] Often judgmental attitudes towards youth sexuality deter young people from voicing their questions and concerns with adults. This makes it very difficult for them to access health care. The focus of HIV prevention programmes targeting young people should rather be on providing them with the skills and support to protect themselves, and to develop confidence and self-esteem.

HIV programs should be integrated with interventions to prevent and respond to gender-based violence, including intimate partner violence.

Programmes should aim to empower AGYW with socially protective assets - such as confidence, negotiating power, knowledge of sexual health and income - that will help them to navigate the HIV risks they face, and to thrive in their lives.

Community mobilisation efforts should aim to challenge and transform harmful social and gender norms. Community leaders can play a critical role in these efforts. The inclusion of men and boys is paramount for transforming harmful masculinities.

Removal of legal and policy barriers to young people accessing reproductive health services— such as restrictive age of consent laws governing access to family planning, HIV testing, condoms, and pre-exposure prophylaxis (PrEP) services - can enhance use of prevention services.

Secondary school attendance can be protective of HIV, for various reasons, including reducing financial vulnerability and dependence in the future, and in the short-term increasing access to information through age-appropriate comprehensive sexuality, gender, and HIV education. Thus interventions which have been proven to support girls staying in school should be scaled up and sustained.

Notwithstanding the focus on keeping girls in school, young women and girls who are not in schools or colleges should not be neglected. Not only are they often at higher risk, they are also harder to reach. An example of and HIV prevention targeting this group is from Angola, where slots on every radio and TV channel, providing non-stigmatising, youth-friendly HIV prevention messaging, and a mobile phone company has partnered with the Ministry of Health to create an app with which young people can engage with HIV prevention services.[xxiv]

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Resources

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About ARASA

The AIDS and Rights Alliance for Southern Africa (ARASA) was established in 2002 as a regional partnership of civil society organisations working in 18 countries in Southern and East Africa. Between 2019 and 2021, the partnership will work to promote respect for and the protection of the rights to bodily autonomy and integrity for all in order to reduce inequality, especially gender inequality and promote health, dignity and wellbeing in Southern and East Africa.

ARASA
53 Mont Blanc Street
Windhoek
Namibia
Tel: +264 61 300381 Fax: +264 61 227675
Email: communications@arasa.info

ARASA
AIDS & Rights
Alliance
for Southern Africa

End Notes

[1]Structural drivers of HIV refer to forces in the social, political, economic, legal and cultural environment, which exert an influence on individuals and groups.

[2]Primary prevention means activities which aim to prevent a person becoming infected with HIV. In contrast, secondary prevention is aimed at people who are already infected with HIV, to stop them from transmitting the virus to those who are HIV-negative.

[3]Gender-sensitive programmes recognise and respond to the different needs and constraints of individuals based on their gender and sexuality. These activities significantly improve women's and girls' and/or men's and boys' access to protection, treatment or care; however, in themselves, they do little to change the larger contextual issues that lie at the root of gender inequities. Gender-transformative programmes, on the other hand, actively seek to transform gender roles and create relations that are more gender-equitable.

[4]Structural drivers of HIV refers to forces in the social, political, economic, legal and cultural environment, which exert an influence on individuals and groups.

[5]Pre-exposure prophylaxis (PrEP) is the taking of a prescription drug as a means of preventing HIV infection in an HIV-negative person

[6]The East and Southern Africa Ministerial Commitment (The ESA Commitment) was adopted in 2013 by ministers from 21 countries in East and Southern Africa. The ESA Commitment recommends bold action in response to HIV and the education/ health challenges experienced by young people, including ramping up sexuality education and health services.

The Partnership to Inspire, Transform and Connect the HIV response (PITCH) enables people most affected by HIV to gain full and equal access to HIV and sexual and reproductive health services.

The partnership works to uphold the sexual and reproductive health and rights of lesbian, gay, bisexual, and transgender people, sex workers, people who use drugs and adolescent girls and young women. It does this by strengthening the capacity of community-based organisations to engage in effective advocacy, generate robust evidence and develop meaningful policy solutions.

PITCH focuses on the HIV response in Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Uganda, Ukraine, Vietnam and Zimbabwe. Partners in these countries also share evidence from communities to influence regional and global policies that affect vulnerable populations.

PITCH is a strategic partnership between Aidsfonds, FrontlineAIDS and the Dutch Ministry of Foreign Affairs.

PITCH Partnership to Inspire, Transform and Connect the HIV response

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Ministry of Foreign Affairs

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