RATT
Eastern & Southern Africa

REDUCING NEW HIV INFECTIONS AMONG ADOLESCENT GIRLS AND YOUNG WOMEN IN THE EASTERN AND SOUTHERN AFRICA REGION: WHAT DOES THE EVIDENCE SAY?

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A POLICY BRIEF

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1. BACKGROUND

HIV continues to be a major global public health issue, and the Eastern and Southern Africa (ESA) region is the epicentre of the epidemic. Prevalence (20.7 million) and incidence (730,000) estimates of HIV in ESA are the highest of any region in the world [1]. Although the number of new HIV infections in ESA has declined by 30% since 2010 [2], this decline has been slower among adolescent girls and young women (AGYW). In 2017, women aged 15 to 24 years accounted for 26% of new HIV infections in the region [3]. Recent estimates indicate that HIV incidence among AGYW in ESA is approximately two-fold higher compared to males of the same age **(see Fig. 1 and 2)**. Lowering rates of HIV infection among AGYW in the region requires implementation of evidence-based strategies that address the structural and social drivers that heighten the risk of HIV infection among AGYW [4].

Structural and social drivers of HIV refer to physical, social, normative, cultural, community, economic, legal, or policy aspects of the environment that influence HIV risk behavior and vulnerability [5]. These issues act as barriers to, or facilitators of, HIV risk prevention initiatives. HIV risk among AGYW in fragile communities is further compounded by a political and economic context characterized by poverty, violence, and inequalities [6]. The COVID-19 pandemic and its consequences (e.g., financial insecurity) may also exacerbate HIV risk among AGYW [7]. To end the HIV epidemic, it is crucial that we address the broader social-structural determinants of health and the holistic needs of AGYW living in ESA.

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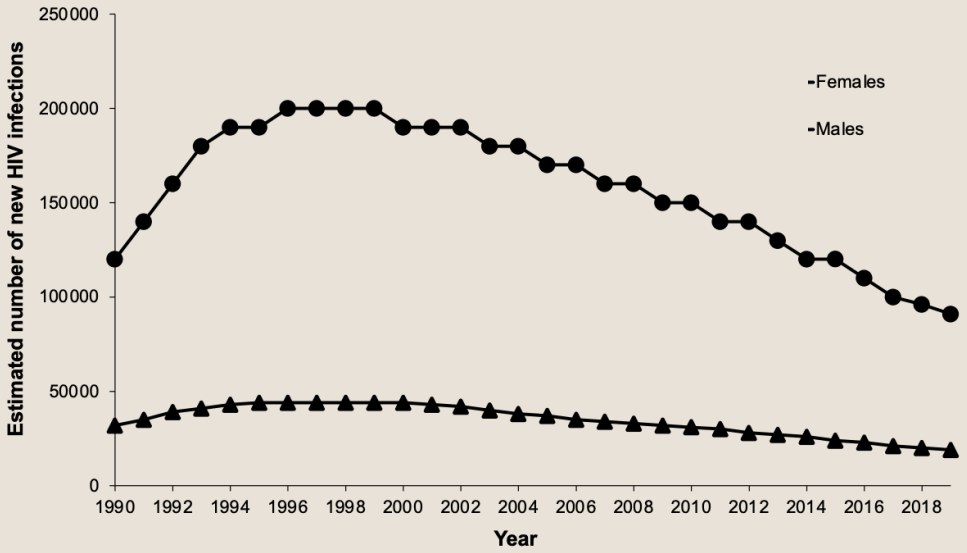

Fig. 1: Estimated number of new HIV infections among 10- to 19-year-olds in Eastern and Southern Africa.

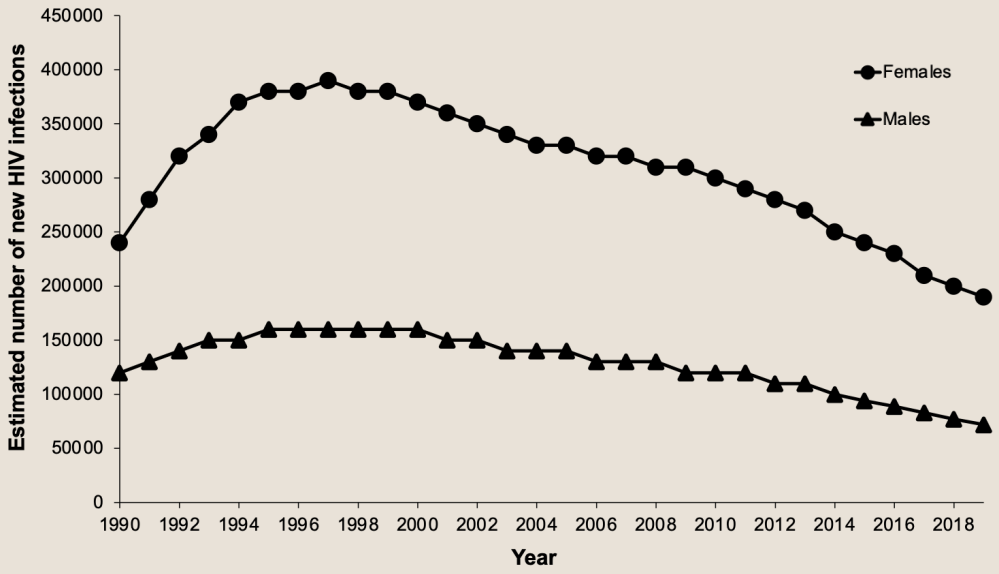

Fig. 2: Estimated number of new HIV infections among 15- to 24-year-olds in Eastern and Southern Africa.

2. RISK FACTORS FOR HIV INFECTION IN ADOLESCENT GIRLS AND YOUNG WOMEN

Although risk profiles may differ according to individual and contextual characteristics, well-known behavioral risk factors for HIV infection among AGYW include (i) biological factors, (ii) age-disparate relationships, (iii) early sexual debut, (iv) child marriages, (v) gender-based violence and IPV, and (vi) inadequate access to quality sexual and reproductive health (SRH) information and services.

Biological risk factors that increase susceptibility of AGYW to HIV transmission include cervical ectopy (which is particularly pronounced at younger ages), high levels of genital inflammation, and the presence of co-infections such as other sexually transmitted diseases (e.g., HSV-2). The per-act transmission risk for women during vaginal sex is higher due to the larger surface area of the vagina compared to the penis which facilitates greater ease of transmission from men to women [8].

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Age-disparate relationships are common in countries within ESA [9]. Evidence suggests that, particularly for women under 25 years of age, having an older sexual partner is a primary risk factor for HIV infection [10]. In general, partnerships with older men provide greater exposure to HIV because sex is more frequent, condom use is less consistent, and HIV prevalence is higher among men than adolescent boys [2,11]. Moreover, some young women enter sexual relationships with older men primarily to obtain material and financial benefits [4]. Young women who engage in 'sex for money' tend to have older sexual partners, a higher number of sexual partners, and are more likely to engage in sexual intercourse while under the influence of alcohol. Men who engage in high-risk sex are generally more violent and controlling over their sexual partners [12]. As a result, young women who engage in sexual partnerships with older male partners are more likely to be victims of physical abuse and psychological trauma [13].

Girls who experience sexual intercourse at an early age are less likely to have acquired key sexual competencies, such as the ability to negotiate safe and consensual sex [14]. Early sexual debut, including that which takes place within child marriages, is an important risk factor for HIV infection among young women. Sexual activity at an earlier age is associated with an increased likelihood of engaging in unsafe sexual practices later in life, including inconsistent contraceptive and condom use, having multiple sexual partners, and engaging in casual or transactional sex, all of which are risk factors for contracting HIV [15]. Child brides have limited power in marriages to negotiate safe sexual practices and are more vulnerable to IPV. They also tend to have lower levels of education than their unmarried peers, which may contribute to poor knowledge about safe sexual practices [16].

A general trend in ESA is that young women have inadequate access to quality SRH information and services [17]. For adolescents, legal restrictions pertaining to age of consent pose significant barriers to accessing healthcare services. Many countries within the ESA region have set the age of consent to access HIV testing and counselling services well above the typical age young women begin sexual activity and above the legal age of consenting to sex [4]. As a result, the ability of young women to seek services and make independent choices about their sexual health is often dictated by legislature and the decisions of their parents or legal guardians [18].

3. INTERVENTION APPROACHES FOR HIV PREVENTION

Youth-friendly healthcare services can reduce HIV-related stigma and discrimination. Evidence suggests that young people including AGYW prefer to utilize services from youth-friendly healthcare facilities, which can increase their access to resources that support safe sexual practices (e.g., condoms) **[8]**. Health access points that integrate and link services (i.e., 'one-stop shops') serve an important function in enabling young women to conveniently access a comprehensive range of healthcare services.

Comprehensive sexual education (CSE) is a life skills and evidence-based educational approach with a thorough curriculum that covers all aspects of sexuality. CSE that is age-appropriate and gender-sensitive can enhance the knowledge, skills, and efficacy of young women to make informed decisions about their sexuality. Some progress has been made towards providing CSE in the region, as highlighted by the endorsements offered by Ministers of Education and Health from 20 countries in ESA to support CSE. However, available programs still need to address challenges that are limiting the quality and effectiveness of CSE, including issues of inclusiveness and mode of educational content delivery [19].

Financial security reduces HIV risk behavior among AGYW **[8]**. Research exploring the effects of cash transfer programs on adolescents' engagement in risky sexual practices suggests that these programs play a vital role in reducing the likelihood of early sexual debut among female adolescents. Girls who reside in households that receive child support grants (CSG) have a lower likelihood of engaging in transactional and age-disparate sex **[20]**. 'Care' social protection programs have been found to reduce HIV risk among AGYW, both as stand-alone interventions or in combination with cash provisions **[21]**. Country-specific cash transfers that are complemented by other HIV prevention programs and psychosocial support mechanisms are integral to the HIV prevention response targeting AGYW. For example, one cash transfer program in Malawi reduced the school dropout rate of girls by 35%, a 40% reduction in early marriages, a 30% reduction in teenage pregnancies, and a 64% reduction in HIV risk **[22]**.

Gender-based violence and IPV increase risk of HIV among AGYW **[8]**. IPV may be prevented by creating climates that are intolerant of partner violence and sexual abuse, taking steps to empower women, and changing masculine social norms and attitudes towards women **[23]**. HIV prevention efforts need to improve school attendance of young girls (e.g., Keeping Girls in School program) and integrate school-based programs that address IPV and sexual violence, along with gender-equitable community-based interventions. Gender-based violence programs (e.g., SASA!, Stepping stones) has been effective in changing social norms that perpetuate violence against women in several Southern African countries **[24]**.

A relatively new biomedical opportunity for HIV risk reduction is pre-exposure prophylaxis (PrEP). The success of PrEP depends on long-term adherence. More research is needed to understand and develop better adherence support programs. These efforts should be accompanied by positive messaging to improve

awareness of attitudes toward PrEP and amendments to age of consent to HIV testing and accessing SRH services, which will allow young women the autonomy to make independent decisions about their healthcare. When delivered as a package of context specific services, these initiatives serve as an effective HIV prevention strategy. One such example is the DREAMS initiative, which uses a core package of evidence-based approaches to address structural, individual, and community risk factors for HIV among AGYW. Evidence from PEPFAR data shows significant declines (between 25% to 40%) in new HIV infections among AGYW in nearly all DREAMS intervention districts **[25]**. However, more context-specific research is needed to understand how multipronged HIV prevention interventions mitigate HIV risk.

These interventions require sustainable local and international funding, yet there is a concern that declines of funding for HIV prevention interventions will leave the most vulnerable people behind, that is, young people and AGYW. Mobilising domestic resources and intersectoral co-financing are two options that will enable governments to budget for interventions and reduce funding gaps by optimizing allocation of existing resources across sectors **[26]**. Identifying areas in which HIV prevention programs can be aligned with the United Nations Sustainable Development Goals may lead to synergistic interventions that provide AGYW with a holistic range of opportunities for improved health and well-being. Exposure to multiple provisions and interventions, such as cash transfers, household employment, quality education, gender equality initiatives, and violence prevention services, are likely to reduce risk of HIV infection and bring about greater health benefits for AGYW.

4. RECOMMENDED HIV PREVENTION STRATEGIES FOR AGYW

Comprehensive approaches that integrate components oriented toward addressing the underlying drivers of the HIV epidemic will be most effective at preventing HIV among AGYW. To achieve this, we propose the following recommendations:

1. Scale up programs that are responsive to the complex arrangement of behavioral and social-structural factors affecting HIV risk among AGYW.
2. Identify and increase long-term funding for HIV prevention programming that is driven by the domestic needs of affected countries.
3. Develop, implement, and promote community mobilisation interventions alongside key stakeholders (e.g., government, non-governmental organisations, and civil society) to foster more equitable gender norms, reduce intimate partner violence, and provide economic opportunities to young women.
4. Combine interventions designed to keep adolescent girls in school longer with other HIV prevention interventions (e.g., psychosocial support, CSE) that form part of a multifaceted HIV prevention strategy. Carefully monitor and evaluate processes for interventions involving AGYW to gain an improved understanding of the approaches that are effective at preventing HIV among AGYW.

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