CALL FOR BOOK CHAPTERS FOR EDITED BOOK

Adolescence and HIV Prevention in Africa: Emerging Evidence and Intervention Strategies

INTRODUCTION

Adolescence [1] is characterised as a turbulent period because of the multiple and complex biological, behavioural and socio-cultural transitions that marks this phase of the human lifespan[2]. In high HIV burden contexts, adolescents need protection from HIV infection, however their relative youth and contexts that they grow up in severely limit their capabilities to prevent HIV[3]. In contrast to declining trends in HIV incidence in the general population, it is estimated that 39% of new HIV infections occur among adolescents annually[4], with HIV mortality and incidence rising in this age group[5]. Further, data indicate that it is more sustainable to promote HIV prevention programmes in young people than in other age groups[6]. Currently, adolescents face numerous challenges in accessing primary and secondary HIV prevention services.

HIV prevention is a matter of urgency; any strategy to eradicate HIV in adolescent populations will only be assured if we think carefully about issues that frame the debate on HIV prevention. In this light, we propose a new and engaging book *Adolescence and HIV Prevention in Eastern and Southern Africa: Emerging Evidence and Intervention Strategies* that addresses current perspectives in HIV prevention with adolescent populations. The book will focus on contemporary and emerging perspectives on epidemiology, policy and programmatic issues on HIV prevention in adolescent populations.

THEMES WILL INCLUDE:

- Current evidence on epidemiology of the HIV epidemic (in high burden regions like Eastern and Southern Africa-ESA);
- An assessment of the recent evidence base for 'what works' in HIV programming in specific adolescent populations;
- Recent policy shifts on HIV and development that are driving the HIV and health architecture of the region (e.g. the recent introduction of the SDGs; the UNAIDS Fast-Track Agenda; the unfolding SRH priorities in the region).

Additionally, the themes will include the complex dynamics of the global shifts in policy and funding and locally driven responses to the HIV epidemic. The book will also draw on examples from a range of primary and secondary data sources to illustrate promising practices and challenges in HIV prevention, demonstrating links between theory and practice in a more reflexive manner.

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[1]UNICEF (2013). Towards an AIDS-free Generation— Children and AIDS: Sixth Stocktaking Report, 2013. New York.

[2]Bekker op.cit

[3]Idele, P., Gillespie, A., Porth, T., et al., (2014). Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps. *Journal of Acquired Immune Deficiency Syndromes*, *66*, S144-S153.

[4]UNAIDS (2012). UNAIDS report on the global AIDS epidemic. Geneva.

[5]Bekker, L. G., Johnson, L., Wallace, M., &Hosek, S. (2015). Building our youth for the future. *Journal of the International AIDS Society*, *18*, (1).

[6]White, R. G., Glynn, J. R., Orroth, K. K., et al., (2008). Male circumcision for HIV prevention in sub-Saharan Africa: who, what and when? *Aids*, *22*(14), 1841-1850.

CALL SPECIFICATIONS

HEARD, in partnership with UNAIDS, UNDP, Swedish International Development Cooperation Agency (Sida), is seeking innovative contributions to a book project on *'Adolescence and HIV Prevention in Eastern and Southern Africa: Emerging Evidence and Intervention Strategies*'. The aim of the project is to bring together leading social scientists, public health experts, policy makers and the HIV affected community to translate recent momentous advances into action that will address HIV prevention gaps in adolescents in eastern and southern Africa. We welcome public health and social science based contributions offering new thinking, fresh approaches or evidence-based findings to enhance and accelerate HIV prevention. Indicative topics include, but are not limited to, the following:

1. EPIDEMIOLOGY OF ADOLESCENT HIV IN ESA: Recent evidence suggests that the global burden of HIV in young populations is in Eastern and Southern Africa, with 61% of adolescents aged between 10-19 years old living with HIV[7]. The estimated number of new infections in the region among adolescents aged 15-19 years was 1300 000 in 2015[8]. AIDS is the number leading cause of death among 15-19 year olds in Africa[9]. There is dearth of epidemiological evidence, particularly sex and age disaggregated data. There are challenges in tracking the epidemic at local levels, which are further compounded by low rates of HIV testing[10]. There is lack of data on adolescent key populations. Further social and behavioural data are plagued by lack of standardized and reliable measures with small sample sizes, especially among younger cohorts, thus limiting generalizability of findings. In addition, there is limited or no data on broader health and social issues of young populations (e.g., mental health, developmental adjustments to social environments and decision making skills). Solving this issue requires triangulation of different data sources to understand the social complexities of the epidemic in adolescent populations.

2. DEVELOPMENT PATHWAYS CONTRIBUTING TO HIV RISK: It has been widely noted that adolescents are at increased risk for HIV due in part to the multiple biological, behavioural, and socio-cultural transitions that are characteristic of this period of the lifespan[11]. Development psychologists have characterised adolescence as a turbulent period. However, debates have raged on in the field regarding the relative impacts of biology and environment. A life-course perspective on health of adolescents indicates that outcomes are affected by early childhood development and the biological and social-role changes that accompany puberty[12] [13]. More than any other life stage, adolescence health is strongly determined by social context. In ESA, the HIV incidence and prevalence in youth is worsened by practices like early sexual debut, transactional sex, age-disparity

[7] UNAIDS (2016). Global AIDS update. Retrieved from http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf

[8] UNICEF (2016). Seventh Stocktaking Report on Children & AIDS. Retrieved from https://static1.squarespace.com/static/5519047ce4b0d9aaa8c82e69/t/583ff5d215d5dbe2c951a860/1480586740198/For-Every-Child-End-AIDS-ST7-2016-Report-Web-1.pdf.

9 UNICEF (2016). Children and AIDS. Retrieved from http://childrenandaids.org/situation

[10] UNICEF (2016). *Collecting and reporting of sex- and age-disaggregated data on adolescents at the sub-national level*. Washington. Retrieved from https://data.unicef.org/wp-content/uploads/2016/11/Data-Abstraction-Guide-November-2016.pdf

[11] Bekker op.cit

[12] Berk, L. (2007). *Development through the lifespan*. Pearson Education India.

[13] deBeeck, H. O. Adolescent times of storm and stress revised.

in sexual relationships and child marriages[14]. The onset of these behaviours in adolescence affect the burden of HIV in their adulthood and the health and development of their children.

3. SOCIAL AND ETHICAL ISSUES IN RESEARCH AND INTERVENTIONS WITH ADOLESCENTS: Conducting research on adolescent is imperative to understanding the determinants of specific patterns of sexual behaviour and practices, predictors of onset of sexual activity and the health and psycho-social needs that result from these issues[15]. However, this is not easy. Some countries have policies regulating the minimum age for independent access to HIV testing[16]. The need for parental or guardian consent for HIV testing becomes a barrier for adolescents' access to HIV Testing and Counselling (HTC). Laws also relate to the age of sexual consent and access to SRH services[17]. In some cases, adolescents are sexually active at an earlier age and thus might require access to condoms, contraception and HCT, which might not be accessible given their age. Ethical guidelines have traditionally treated adolescents as a vulnerable group lacking capacity to give consent[18]. There is need to consider these issues to ensure an appropriate balance between autonomy of adolescents and parents' right to offer protection.

4. YOUNG GIRLS: WHAT WORKS IN HIV PREVENTION? Young girls aged 15-19 years are an important key population in the southern African setting. In sub Saharan Africa, 3 in 4 new infections in 15-19 year olds are among girls[19]. The latest available data from South Africa show a national HIV prevalence of 5.6% among adolescent girls aged 15–19 years[20]. The high incidence of HIV in adolescent girls sustains intergenerational transmission of HIV and contributes to the global HIV prevalence[21]. Current efforts to prevent HIV transmission among young girls is limited given the underlying gender-power dynamics and poor education levels present in the southern African context[22][23]. Despite the apparent need for HIV prevention in adolescent girls, there is a scarcity of evidence-based interventions targeting them[24].

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[14] UNESCO (2013). Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in Eastern and Southern Africa. Regional report.

[15] Folayan, M. O., Haire, B., Harrison, A., Odetoyingbo, M., Fatusi, O., & Brown, B. (2015). Ethical issues in adolescents' sexual and reproductive health research in Nigeria. *Developing World Bioethics*, *15*(3), 191-198.

[16] Sarumi, R. O., & Strode, A. E. (2015). New law on HIV testing in Botswana: The implications for healthcare professionals. *Southern African Journal of HIV Medicine*, *16*(1), 1-4.

[17] Nelson, R. M., Lewis, L. L., Struble, K., & Wood, S. F. (2010). Ethical and regulatory considerations for the inclusion of adolescents in HIV biomedical prevention research. *Journal of Acquired Immune Deficiency Syndromes*, *54*, S18-S24.

[18] Folayan et al., op.cit

[19] UNICEF (2016). op.cit

[20] UNAIDS (2014). Gap report. Retrieved from http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf

[21] Kaiser, R., Bunnell, R., Hightower, A., et al., (2011). Factors associated with HIV infection in married or cohabitating couples in Kenya: results from a nationally representative study. *PLoS One*, *6*(3), e17842.

[22] ibid

[23] Pettifor, A., Nguyen, N. L., Celum, C., Cowan, F. M., Go, V., &Hightow-Weidman, L. (2015). Tailored combination prevention packages and PrEP for young key populations. *Journal of International AIDS Society*, *18*(2), 19434.

[24] Dellar, R. C., Dlamini, S., & Karim, Q. A. (2015). Adolescent girls and young women: key populations for HIV epidemic control. *HIV and Adolescents: focus on young key populations*, 64.

5. THE MISSING HALF: HOW DO WE ENGAGE WITH MALE ADOLESCENTS IN HIV PREVENTION? In Africa, women have been historically the focus of HIV prevention, as they are considered particularly vulnerable to HIV infection because of economic and biological factors, their reduced sexual autonomy, and men's sexual privilege over them[25]. As a result, HIV prevention and treatment campaigns have focused predominantly on women, thus men have received considerably less attention in terms of HIV prevention and treatment programs[26]. Efforts to locate male adolescents' health-seeking behaviours are poorly understood in the AIDS epidemic. Evidence shows that adolescent males have limited access to HIV services resulting in poor health outcomes[27]. Socio-cultural norms that promote masculinity are linked to multiple sexual partners, violence against women and gender inequality[28]. While evidence suggests that well-implemented programmes targeting young men can potentially influence their attitudes, behaviours and their role as agents of change in the achievement of gender equality[29], programming for HIV prevention is still at an early stage. There is a need to reach young men with evidence-informed HIV prevention, HIV testing and counselling (HTC), and reproductive health package[30].

6. THE INVISIBLE ONES: HOW DO WE ACCESS YOUNG KEY POPULATIONS? Studies on how to reduce discrimination, exclusion and inequality among key populations is extremely limited, particularly in sub-Saharan Africa[31]. Young key populations (YKP),- people below 18 years – are inclusive of men who have sex with men (MSM), bisexuals and transgender people (LGBT), sex workers, as well as people who inject drugs (PWIDs) are most at risk for HIV infection. Evidence points out that YKP across ESA are likely to encounter more health risks owing to policy barriers to accessing HIV treatment and prevention services[32]. They often do not seek health services for fear of discrimination, marginalisation and possible imprisonment[33]. As a result, they are frequently a hidden group with challenges in obtaining reliable epidemiological data on their health care and creating demand for health services.

7. PROTECTING ADOLESCENTS: WHY THE NEED FOR SOCIAL PROTECTION? HIV-sensitive social protection has been increasingly viewed as being important to AIDS response primarily through addressing the economic and social determinants of vulnerability. Evidence on social protection suggests that cash transfers can contribute to HIV prevention by keeping girls in schools and impacting on gender

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[25] Gupta, G. (2002). How men's power over women fuels the HIV epidemic. *BMJ,* 324, 183–184.

[26] Higgins, J. A., Hoffman, S., & Dworkin, S. L. (2010). Rethinking gender, heterosexual men, and women's vulnerability to HIV/AIDS. *American Journal of Public Health*, *100*(3), 435-445.

[27] UNAIDS (2016). Male engagement in the HIV response —a Platform for Action. Meeting Report

[28] Higgins, JA, Hoffman, S & Dworkin, SL. op.cit.

[29] Barker, G., Greene, M., & Siegel, E. G. (2010). *What men have to do with it: Public policies to promote gender equality*. International Center for Research on Women (ICRW).

[30] UNAIDS (2016) op.cit.

[31]Temin, M. (2010). HIV-sensitive social protection: what does the evidence say. *Geneva: UNAIDS*.

[32]Conner, B. (2015). ''First, do no harm'': legal guidelines for health programmes affecting adolescents aged 10Á17 who sell sex or inject drugs. *HIV and Adolescents: focus on young key populations*, 78.

[33]Sawyer, S. M., Afifi, R. A., Bearinger, L. H., Blakemore, S. J., Dick, B., Ezeh, A. C., & Patton, G. C. (2012). Adolescence: a foundation for future health. *The Lancet*, *379*(9826), 1630-1640.

related drivers of risky sexual behaviour[34]. The successful implementation of the HIV sensitive social protection can potentially reduce HIV risk caused by economic and gender inequality by minimising income disparities and providing young girls with equitable access to economic resources. While social protection is seen as an important HIV mitigation strategy, we need to consider the multi-sectoral challenges in programme implementation.

8. GLOBAL SHIFTS AND CIVIL SOCIETY RESPONSES: WHAT ARE THE PROSPECTS FOR SUSTAINING THE PREVENTION RESPONSE? On a global level, the Millennium Development Goals (MDGs) was seen to be significant to the HIV response. In a post-2015 agenda, comprising 17 Sustainable Development Goals (SDGs), we note that HIV is not clearly stated as a priority goal[35] with the implication that HIV response may be seen as losing significance as a unique global emergency. Additionally, funding for HIV and AIDS advocacy campaigns around the world have apparently plunged over the years[36]. Global funding is essential for HIV prevention strategies as well as treatment especially in middle and low income countries where it provides funding for ARV access for nearly half all patients receiving life-long antiretroviral therapy (ART)[37]. Can this funding be sustained for adolescent programming? The civil society organisations have been critical in shaping global, regional and national HIV responses through cost-effective service provision in areas inaccessible to governments, advocating for the rights of key populations as well as lobbying donors to fund the AIDS response[38]. However, efforts to reduce the global burden of HIV requires constructive and sustained engagements with diverse stakeholders, otherwise, we are likely to go nowhere[39].

TARGET AUDIENCE: Academics and practitioners are invited to submit chapter proposals of 250-350 words. We are interested in submissions from diverse disciplines and settings. Chapters should situate the reader in the current literature reflecting up-to-date knowledge on evidenced-based practices, policy issues and models of HIV prevention, including programmatic scale-up challenges. Chapters should generate critical analysis, discussion and reflection for readers.

[34]Barker, G., Greene, M., & Siegel, E. G. (2010). *What men have to do with it: Public policies to promote gender equality*. International Center for Research on Women (ICRW).

[35]The Lancet HIV, 2016. HIV on the fast-track to sustainability. doi: 10.1016/S2352-3018(15)00249-0.

[36] http://www.theglobalfund.org/en/news/2016-09-01_Global_Fund_Report_Shows_20_Million_Lives_Saved/

[37]Kerouedan, D. (2010). The Global Fund to fight HIV/AIDS, Tuberculosis and Malaria Five-year Evaluation Policy Challenges. Field Actions Science Reports. *The journal of field actions*.

[38]UNAIDS (2011). HIV and Social Protection Guidance Note. New York.

[39] Poku, N.K. (2005). AIDS in AFRICA: How the poor are dying. United Kingdom: Polity Press.

PROPOSED STRUCTURE FOR BOOK

INTRODUCTION

PART 1: EPIDEMIOLOGICAL AND CONCEPTUAL ISSUES

- Epidemiology of Adolescent HIV in ESA: A generation in jeopardy
- Developmental pathways and HIV risk

PART 2: POLICY AND ADVOCACY ISSUES

- Recent strategic and policy shifts impacting on HIV Prevention (advent of the SDGS, the Comprehensive Sexuality Education movement, UNAIDS Fast Track Approach, All In Strategy) What do these recent policy and strategic shifts mean for the HIV prevention response?
- Why is civil society so important to the HIV prevention response? Where are the opportunities for advancing the prevention agenda.
- Social and Ethical issues in research and planning interventions with adolescents. What are the challenges? How should we navigate these complex areas in stepping up the HIV prevention response

PART 3: PROGRAMMATIC ISSUES

- Vulnerable adolescent populations: young girls, young men, young key populations. What does the emerging evidence say? What are the normative, legal and legislative barriers to accessing HIV prevention especially for young key populations?
- Social Protection programming for HIV prevention: How can SP programming mitigate HIV vulnerability? What are the challenges for scale-up and sustainability of programmes?
- HIV funding for Research and Programming: Is funding for prevention activities flat lining in the region? What shape and form should advocacy efforts take to leverage resources for prevention?

PART 4: LOOKING FORWARD

- Consolidating the evidence and charting future directions for research, policy and advocacy strategies.

CONCLUDING STATEMENTS

TIMELINES

THE TIMELINES FOR RECEIVING ABSTRACTS, COMMUNICATING ON DECISIONS MADE AND RECEIVING FULL CONTRIBUTIONS ARE AS FOLLOWS:

Abstract Submission: 31 July 2017
Notification of acceptance: 12 August 2017
Submission of chapter: 30 November 2017
Feedback on chapter: 31 March 2018
Final submission: 31 May 2018

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