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# **EMPOWER YOUNG WOMEN AND ADOLESCENT GIRLS:**

**FAST-TRACKING THE END OF THE AIDS EPIDEMIC IN AFRICA**



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# CONTENTS

|   |    |
|---|----|
| FOREWORD  | 2  |
| Three political commitments to Fast-Track the end of the AIDS epidemic  | 4  |
| INTRODUCTION  | 5  |
| THE AIDS RESPONSE IN AFRICA:<br>YOUNG WOMEN AND ADOLESCENT GIRLS LEFT BEHIND  | 8  |
| Eliminating mother-to-child transmission of HIV and keeping mothers alive   | 9  |
| Intimate partner violence and the association with HIV  | 11 |
| Core reasons why young women and adolescent girls<br>are vulnerable to HIV  | 12 |
| AFRICA: A DYNAMIC RESPONSE FOR A CONTINENT IN RAPID TRANSITION  | 15 |
| Africa has a fast-growing economy   | 15 |
| Africa's population is young and growing rapidly  | 15 |
| Africa is urbanizing fast   | 16 |
| FIVE KEY RECOMMENDATIONS TO FAST-TRACK THE RESPONSE<br>TO HIV AND END THE AIDS EPIDEMIC AMONG YOUNG WOMEN AND GIRLS | 18 |
| 1. Women's agency, participation and leadership   | 18 |
| 2. Strategies to reduce intimate partner violence and reduce<br>vulnerability to HIV                                | 19 |
| 3. Scaling up social protection and cash transfers<br>to reduce poverty and girls' vulnerability to HIV             | 20 |
| 4. Strategies to keep girls in school and comprehensive<br>sexuality education                                      | 21 |
| 5. Scaling up and integrating HIV with sexual and reproductive<br>health services                                   | 22 |
| Conclusion  | 22 |
| REFERENCES  | 24 |

## FOREWORD

Guaranteeing the rights and empowerment of Africa's women and girls in this generation is a moral obligation. It is a development imperative and a smart investment that will safeguard the health of women and girls in Africa and ensure sustainable and inclusive growth on the continent. Empowering women will Fast-Track the end of the AIDS epidemic.

Four decades into the HIV epidemic and response, we have made encouraging progress. More people living with HIV than ever before are accessing life-saving treatment; the number of deaths from AIDS-related causes has declined; fewer babies are becoming infected with HIV; and new HIV infections have fallen. Africa's leadership commitments, the tireless efforts of civil society—including the women's movement and networks of women living with HIV—combined with scientific innovation and global solidarity have helped to achieve these great strides. The response will be strengthened further by the commitment from Africa's leadership to end the AIDS epidemic by 2030, while promoting shared responsibility and unity.

Yet, despite this progress, adolescent girls and young women are still being left behind and denied their full rights. They are often unable to enjoy the benefits of secondary education and formal paid employment under decent conditions, which would allow them to build skills, assets and resilience. The threat of violence is pervasive – and not only in conflict and post-conflict situations. Many girls are married as children and assume adult roles of motherhood. Adolescent girls and young women are often prevented from seeking services and making decisions about their own health. This combination of factors drives both their risk of acquiring HIV and their vulnerability to HIV. The impact of HIV on young women and adolescent girls is acute: they account for one in five new HIV infections in Africa and are almost three times as likely as their male peers to be living with HIV in sub-Saharan Africa.

The variables and risks associated with sexual and reproductive health and HIV among adolescent girls and young women are tied to gender inequalities that are intricately woven into the sociocultural, economic and political fabric of society. Unleashing the potential of half the population of this region and tapping into the power of the largest youth populace in history will promote both sustainable progress in the HIV response and wider development outcomes.

In the words of Archbishop Desmond Tutu: “If we are to see any real development in the world, then our best investment is women.” This holds true for the AIDS response, which needs greater attention, reaffirmed commitment and resourced action to ensure the health, rights and well-being of adolescent girls and young women throughout their life-cycle. The solutions engage all sectors of society and must embrace innovation.

The key message of advancing women’s rights and gender equality in order to fast-track the end of the AIDS epidemic among adolescent girls and young women outlined in this report is an important contribution to the 2015 African Union theme “Year of women’s empowerment and development towards Africa’s agenda 2063”. This will guide our blueprint for future action.

As the African community and the global community stand at the dawn of a new era of sustainable development, let us reaffirm our commitment to empowering girls and young women. A firm foundation of social justice, human rights and gender equality will make the AIDS response formidable and the end of the AIDS epidemic possible.

**Michel Sidibé,**  
Executive Director, UNAIDS

**Nkosazana Dlamini-Zuma,**  
Chair, African Union Commission

## Three political commitments to Fast-Track the end of AIDS among young women and adolescent girls by 2030

Commitment to:

- 1 Stop new HIV infections among young women and adolescent girls and ensure AIDS is no longer the leading cause of death among adolescents, through reaffirming Africa's commitment to sexual and reproductive health and rights in the Maputo Protocol and Plan of Action and putting in place the conditions that ensure young women and adolescent girls can claim their rights, access services and live free of violence and discrimination,
- 2 Stop new HIV infections and empower young women and adolescent girls by committing to an Africa-wide ministerial commitment on comprehensive sexuality education, building on the 2013 Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health and Rights in Eastern and Southern Africa,
- 3 Stop new HIV infections among children and keep their mothers alive, by stopping early marriage and adolescent pregnancy, improving access to services that eliminate mother-to-child transmission of HIV, and doubling access to treatment.

## INTRODUCTION

With the platform provided by the post-2015 sustainable development goals, and leveraging the successes of the AIDS response so far, Africa has a historic opportunity to end the AIDS epidemic as a public health threat by 2030.

This requires adapting to the dynamism and opportunities of the continent and reaching people most vulnerable to HIV including young women and adolescent girls. It also requires taking action to target the root causes of vulnerability. The magnitude of young women's and adolescent girls' vulnerability to HIV cannot be explained by biology alone but lies in pervasive conditions of gender inequality and power imbalances as well as high levels of intimate partner violence.

Since the 1995 adoption of the Beijing Declaration and Platform for Action, the reality for most women and girls worldwide, including in Africa, is that the pace of change has been unacceptably slow. Women and girls are subject to multiple and intersecting forms of discrimination. These inequalities are even more acute for marginalized women, such as women with disabilities, migrant women, female sex workers and transgender women, who are also at heightened risk of discrimination and violence (1). There also remain other large disparities, such as fewer than one in three girls in sub-Saharan Africa being enrolled in secondary school, women having unequal access to economic opportunities, and women lacking decision-making power in the home and wider society (2, 3).

Within the context of HIV, this manifests in different ways. Young women and adolescent girls acquire HIV five to seven years earlier than young men, and in some countries HIV prevalence among young women and adolescent girls is as much as seven times that of their male counterparts (11, 54). Despite the availability of antiretroviral medicines, AIDS-related illnesses remain the leading cause of death among girls and women of reproductive age in Africa (4).

Many of these young women and girls are born and raised in communities where they are not treated as equal. Many cannot reduce their vulnerability to HIV because they are not permitted to make decisions on their own health care. They cannot reduce their vulnerability because they cannot choose at what age or who to marry, when to have sex, how to protect themselves or how many children to have.

The impacts of gender inequality are far-reaching. Gender equality matters intrinsically because the ability to make choices that affect a person's own life is a basic human right and should be equal for everyone, independent of whether person is male or female. But gender equality also matters instrumentally because it contributes to economies and key development outcomes (3).

To be effective, any health and development agenda needs to focus on the root causes of the gender gap, and the AIDS response is no different.

But there is also good news on which to build. In the past 20 years the gender gap has closed in many areas with the most noticeable progress made in primary school enrolment and completion, in almost all countries. In addition, life expectancy of women in low-income countries is now 20 years longer on average than in 1960, and over the past 30 years women's participation in paid work has risen in most parts of the developing world (3).

There is also significant political commitment from Africa to gender equality and women's empowerment, with specific goals and targets for the response to HIV and sexual and reproductive health and rights. African leaders have enshrined the priorities of gender equality and rights in (among others) the African Union Agenda 2063; the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Declaration 2003); the Solemn Declaration on Gender Equality in Africa (2004); the Sexual and Reproductive Health Strategy for the Southern African Development Community Region (2006–2015); the 2013 Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health and Rights in Eastern and Southern Africa; the Arab Strategic Framework on HIV and AIDS (2013-2015); and the Arab AIDS Initiative 2012; the Addis Ababa Declaration on Population and Development in Africa Beyond 2014; and the 2013 Declaration of the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria.

The depth and breadth of this political platform and the potential for action to transform the lives of young women and adolescent girls in Africa cannot be underestimated.

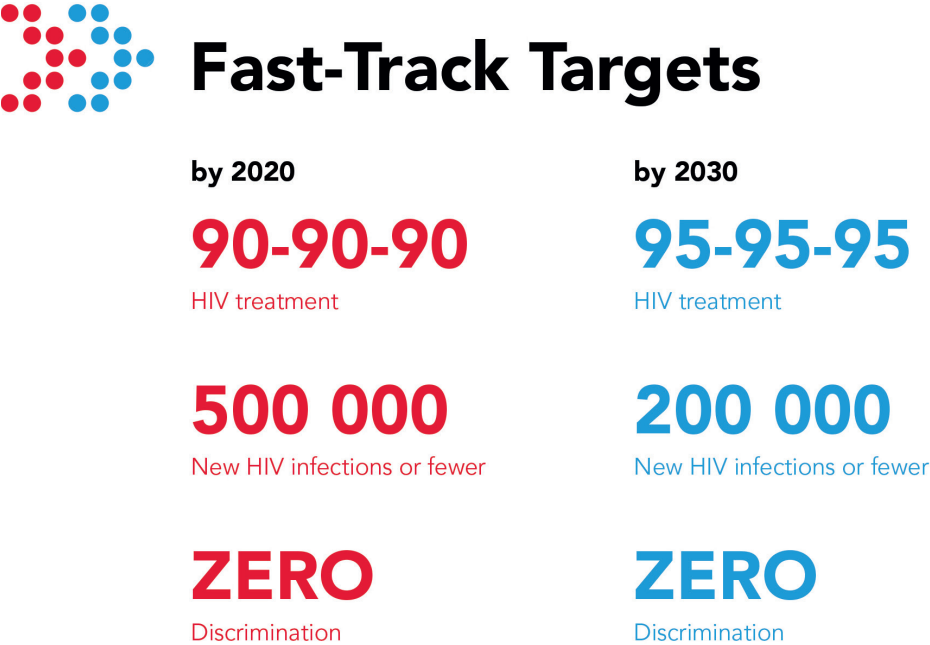
The purpose of this report is to guide regional and global advocacy and inform political dialogue over the coming year, including in the contexts of the African Union Agenda 2063 and the post-2015 sustainable development agenda. With this commitment we can reach the Fast-Track targets (Fig. 1) to end the AIDS epidemic as a public health threat by 2030.



The report outlines:

- the current progress, gaps and impact of HIV among young women and adolescent girls in Africa;
- how to adapt, given the dynamic context of the African continent, and what needs to be considered in the response;
- how to leverage the commitments of African leaders to end the AIDS epidemic and transform the lives of young women and adolescent girls on the continent.

Fig. 1



i.e. no more than 500 000 new infections by 2020 and 200 000 new infections by 2030.

**74%**

Percentage of new HIV infections among adolescents in Africa in 2013 that occurred in adolescent girls

**3x**

HIV prevalence among young women and adolescent girls in sub-Saharan Africa compared with their male counterparts

**HIV**

Leading cause of death among adolescents in Africa

**15%**

Percentage of young women aged 15 to 24 in sub-Saharan Africa who are aware of their HIV status

**THE AIDS RESPONSE IN AFRICA: YOUNG WOMEN AND ADOLESCENT GIRLS LEFT BEHIND**

Both globally and in Africa, there is good news. Our collective efforts to end the AIDS epidemic are paying off. Now more people living with HIV than ever before are accessing treatment, more people know their status, and AIDS-related deaths are declining. New HIV infections among young people aged 15–24 years are also declining (460 000 new infections in 2013 compared with almost 715 000 new infections a decade earlier) (55).

This progress, however, belies a dangerous reality: young African women and adolescent girls are especially vulnerable to HIV.

Globally in 2013, 15% of the approximately 16 million women aged 15 years and older living with HIV were young women of these over 80% live in sub-Saharan Africa (55).

Despite declining HIV infection rates, in 2013 globally, there were approximately 250 000 new HIV infections among adolescent boys and girls, 64% of which are among adolescent girls (Figs 2 and 3). In Africa, 74% of new infections among adolescents were among adolescent girls (55). In addition, AIDS-related illnesses are the leading cause of death among adolescent girls and women of reproductive age in Africa, despite the availability of treatment (4).

Fig. 2

HIV prevalence among young people aged 15-24 in Africa, 2001-2013

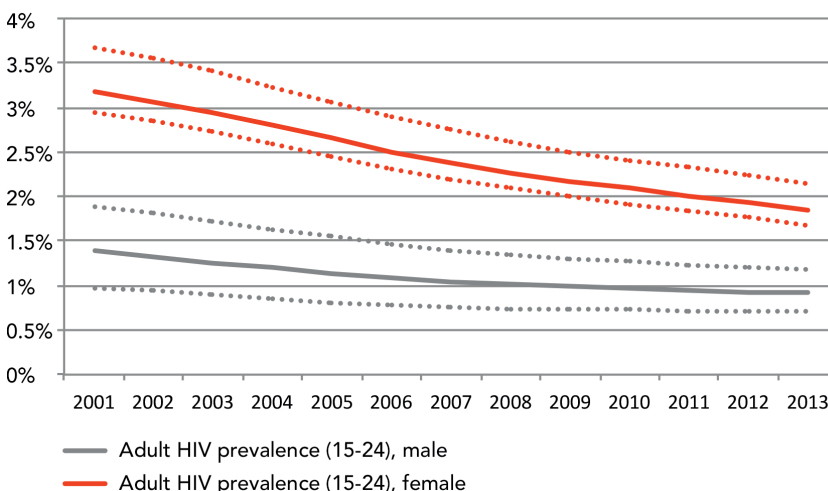
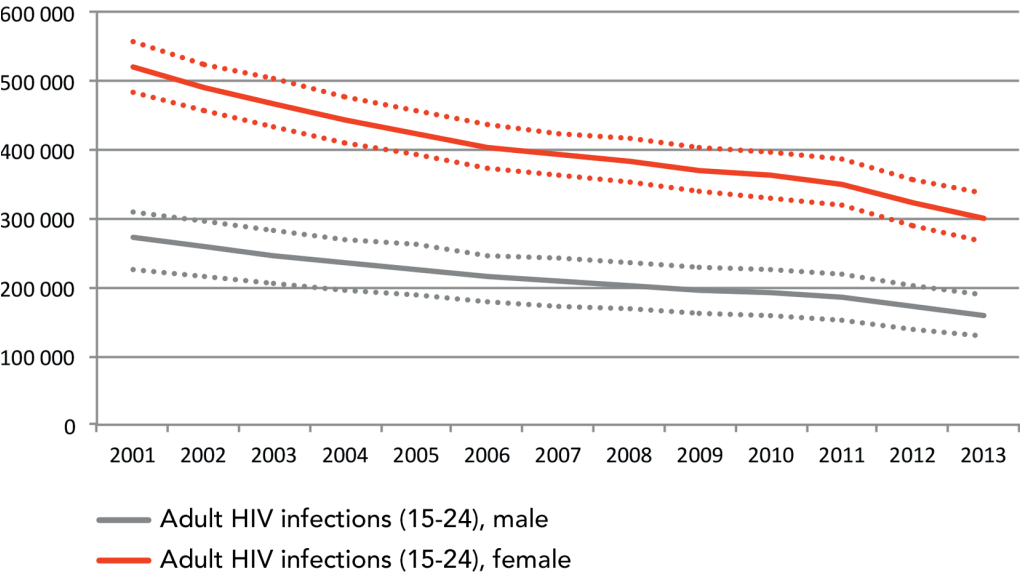


Fig. 3

New HIV infections among young people aged 15-24 in Africa, 2001-2013



Furthermore, young women and adolescent girls are missing out on the scale-up of antiretroviral treatment access for people living with HIV. Only 15% of young women and adolescent girls aged 15–24 years in sub-Saharan Africa know their HIV status (6). In the Middle East and North Africa, only one in five people living with HIV has access to treatment (55).

Young women and adolescent girls from socially marginalized groups are at increased risk of HIV because they face multiple challenges. Stigma, discrimination, punitive laws and a lack of social protection increase the risk of HIV, notably for young female sex workers, young transgender women, young migrants and young women who use drugs (7). In Kenya, HIV prevalence among female sex workers in Nairobi is 29% – approximately three times the HIV prevalence among other women in Nairobi (8).

**Eliminate mother-to-child transmission of HIV and keeping mothers alive**

Progress to eliminate new HIV infections among children and keeping their mothers alive has been one of the most impressive achievements of the AIDS response to date. In 2013, for the first time since the 1990s, the number of new HIV infections among children in the 21 Global Plan<sup>1</sup> priority countries in sub-Saharan Africa dropped to

1 The Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.

under 200 000. This represents a 43% decline in the number of new HIV infections among children in these countries since 2009 (58).

Despite successes, progress among young women and adolescent mothers has been slow with many challenges. The average adolescent birth rate in Africa is 115 per 1000 girls, more than double the global average of 49 per 1000 girls (6). In western and central Africa, 28% of women aged 20–24 years have reported a birth before the age of 18 years, the highest percentage among developing regions. In Chad, Guinea, Mali, Mozambique and Niger, 1 in 10 girls has a child before the age of 15 years (9). In sub-Saharan Africa, an estimated 36 000 women and girls die each year from unsafe abortions, and millions more suffer long-term illness or disability (9).

Many young women who marry or enter into partnerships early do not have the knowledge or the personal agency that enables them to protect themselves from HIV – for example, they cannot negotiate when to have sex or to use condoms.

A core strategy to eliminate mother-to-child transmission of HIV is to prevent pregnancy in young women and adolescent girls who do not want to have a child at that time. According to the United Nations Population Fund, 33 million women aged 15–24 years worldwide have an unmet need for contraception, with substantial regional variations. For married girls aged 15–19 years, the figures for an unmet need for contraception range from 8.6% in the Middle East and North Africa to 30.5% (one in three married girls) in western and central Africa (10). Among unmarried sexually active adolescent girls, the unmet need for contraception in sub-Saharan Africa is 46–49%; there are no data for North Africa (10).

According to 2013 data, in sub-Saharan Africa, only eight male condoms were available per year for each sexually active individual. Among young people, and particularly among young women, condom access and use remain low, despite offering dual protection against HIV and unwanted pregnancy (11). Sub-Saharan Africa accounts for 44% of all unsafe abortions among adolescent girls aged 15–19 years in low- and middle-income countries (excluding east Asia) (9).

Governments in Africa have already made important commitments in this area that can be leveraged. Among the strongest is the 2013 Ministerial Commitment for Comprehensive Sexuality Education and Sexual and

Reproductive Health and Rights in Eastern and Southern Africa. This commitment includes action to “reduce early and unintended pregnancies among young people by 75%”(12).

Providing access to comprehensive sexuality education, keeping girls in school and implementing social protection programmes such as cash transfer programmes have all proven effective in reducing new infections among young women and adolescent girls.

Stopping child marriage and early pregnancy is also central to success. Across Africa, 41% of girls in western and central Africa, 34% of girls in eastern and southern Africa and 12% of girls in the Arab states are married as children (13). Child marriage has been associated with higher exposure to intimate partner violence and commercial sexual exploitation (13). Child marriage is a form of violence.

### **Intimate partner violence and the association with HIV**

Over the past decade strong evidence has emerged on the relationship between intimate partner violence and HIV. There is equally strong evidence for and recognition of successful community strategies to prevent intimate partner violence and vulnerability to HIV (16, 29, 30, 57).

In high HIV prevalence settings, women who are exposed to intimate partner violence are 50% more likely to acquire HIV than those who are not exposed (16). Adolescent girls and young women also have the highest incidence of intimate partner violence (11). In Zimbabwe, for example, the prevalence of intimate partner violence among women aged 15–24 years is 35%, compared with 24% for women aged 25–49 years; and in Gabon, prevalence of intimate partner violence among young women is 42% compared with 28% for older women. In some settings, 45% of adolescent girls report that their first experience of sex was forced, another known risk factor for HIV (Fig. 4) (17). In addition, girls who marry before age 18 are more likely to experience violence within marriage than girls who marry later (14). According to the United Nations Children’s Fund (UNICEF), globally 120 million girls – 1 in 10 – are raped or sexually attacked by the age of 20 years (15).

**1.5**

Times more likely to acquire HIV - women exposed to intimate partner violence in high HIV prevalence settings

**45%**

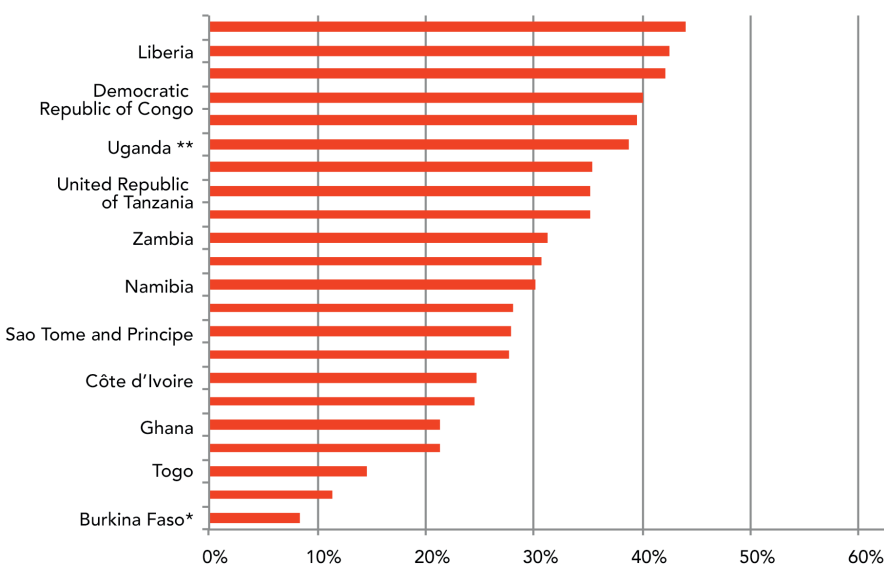
Percentage of girls in some settings who report that their first sexual experience was forced

**30**

Number of African countries where 30% or more of girls are married before the age of 18 years (14)

Fig. 4

Prevalence of intimate partner violence in the last 12 months among ever-married or partnered women ages 15-24



Source: most recent Demographic Health Survey

Women and girls also continue to experience unique risks and vulnerabilities to HIV during conflicts, emergencies and post-conflict periods. In conflict situations, rape can be used as a weapon of war, increasing the risk of HIV transmission because rates of HIV among military personnel typically exceed those of the general population (18). Adolescent girls are particularly vulnerable and, in some cases, are abducted and used for sexual purposes by armed groups (15). The 2011 United Nations (UN) Security Council Resolution 1983 recognizes that the impact of HIV is felt most acutely by women and girls in conflict and post-conflict settings due to both sexual violence and reduced or no access to services (19). As highlighted by the resolution, however, there is also potential for peacekeeping operations to protect civilian populations through prevention of conflict-related sexual violence.

**Core reasons why young women and adolescent girls are vulnerable to HIV**

Every hour, around 34 young African women are newly infected with HIV. The reasons for relatively high rates of infection and low scale-up of

services for young women in Africa are complex and interwoven. Changing the course of the epidemic requires addressing the root causes and understanding the core conditions that exacerbate vulnerability. Seven core conditions stand out:

- inadequate access to good-quality sexual and reproductive health information, commodities and services, in some measure due to age of consent to access services;
- low personal agency, meaning women are unable to make choices and take action on matters of their own health and well-being;
- harmful gender norms, including child, early and forced marriage, resulting in early pregnancy;
- transactional and unprotected age-disparate sex, often as a result of poverty, lack of opportunity or lack of material goods;
- lack of access to secondary education and comprehensive age-appropriate sexuality education;
- intimate partner violence, which impacts on risk and health-seeking behaviour;
- violence in conflict and post-conflict settings.

Individually or in combination, these factors severely inhibit the ability of young women and adolescent girls to protect themselves from HIV, violence and unintended or unwanted pregnancy. Gender inequality and lack of women's empowerment or agency are key themes that cut across these drivers.

Women's agency or empowerment is the ability to make choices and to transform them into desired actions and outcomes. Across all countries and cultures there are differences between men's and women's ability to make these choices. Women's empowerment influences their ability to build their human capital. Greater control over household resources by women leads to more investment in children's human capital, shaping the opportunities for the next generation (3). In sub-Saharan African countries, more than half of married adolescent girls and young women do not have the final say regarding their own health care and play a low decision-making role in the household (20).

Poverty is another overarching factor. Poverty can push girls into age-disparate relationships, a driver of HIV risk for young women and adolescent girls. For example, in South Africa, 34% of sexually active adolescent girls report being in a relationship with a man at least five years their senior. Such relationships expose young women and girls to unsafe sexual behaviours, low condom use and increased risk of sexually transmitted infections (57). The risk of trafficking and sexual exploitation is also higher for young women and adolescent girls living in poverty (21).

Poverty also increases the risk of child marriage, and girls in the poorest economic quintile are 2.5 times more likely to be married as children compared with girls in the richest quintile (21). In 2010, 67 million women aged 20–24 years had been married as girls, of which one-fifth were in Africa (14).

In May 2014, after numerous national and regional commitments to address child marriage (including the 2005 Maputo Protocol, Article 6c), the African Union Commission initiated a 2-year campaign, starting in 10 African countries<sup>2</sup>, to accelerate the end of child marriage on the continent by increasing awareness, influencing policy, advocating for the implementation of laws and ensuring accountability. Eliminating child marriage will decrease African girls' greater risk of experiencing domestic violence, premature pregnancies and related complications, and sexually transmitted diseases, including HIV.

There are promising solutions, but the solutions today are not the solutions of yesterday. Fast-tracking the response is about being flexible and taking account of the rapid transition taking place in Africa today, looking at the new risks but also at the new opportunities.

<sup>2</sup> Burkina Faso, Cameroon, Chad, Ethiopia, Malawi, Mauritania, Mozambique, Niger, Sierra Leone and Zambia.



## **AFRICA: A DYNAMIC RESPONSE FOR A CONTINENT IN RAPID TRANSITION**

Three central changes are taking place on the continent that have particular relevance for fast-tracking the end of AIDS among young women and girls.

### **Africa has a fast-growing economy**

Sub-Saharan Africa is among the world's fastest-growing economic zones. In 2015 the gross domestic product (GDP) is expected to increase by 4.5%, and by 2020 the continent's share of global GDP is predicted to rise to 4% compared with 1.4% in 2015 (22, 23). This economic growth can be a key engine for reducing poverty, particularly if fertility declines and yields a demographic dividend. This can be supported by generation of decent paid work and gender-responsive social protection and social services. The creation of decent work to ensure that women and their families have a route out of poverty is particularly important, as women are overrepresented in the informal labour market, including unpaid care work and low-paid employment. The consequences of preventing women from participating in and contributing to the formal economy are far-reaching and adverse, and yet 61% of sub-Saharan African economies and 93% of economies in the Middle East and North Africa have restrictions on the jobs women can do (24).

Yet, when women participate in the economy, poverty decreases and GDP grows. An increase of only 1% in girls' secondary education attendance adds 0.3% to a country's GDP (25), a clear illustration of an early and smart investment that pays off. The health benefits of women's and girls' participation in a nation's economy are huge, not only in terms of their own economic empowerment and health choices but also in terms of improving the health of their children and communities.

### **Africa's population is young and growing rapidly**

Africa's population is diverse and has an increasingly youthful population. Sourcing the power and potential of the region's young people will provide enormous opportunity for growth.

Over 30% of the African population is aged 10–24 years. In 15 sub-Saharan African countries, half the population is under the age of 18 years (10). In some countries, fertility is barely declining while the number of women of childbearing age is rising significantly .

Africa made good progress in expanding facility-based deliveries from 40% coverage in 1990 to 53% in 2014, but the number of pregnant women needing antenatal care and delivery facilities doubled between 1990 and 2014, from 9 million to 18 million.

Prevention of mother-to-child transmission services will need to increase significantly as the population of women of reproductive age is projected to increase by 65% by 2030, with the potential to outstrip services for young women and adolescent girls to prevent transmission of HIV to their children.

If current population growth trends continue, then by 2030 almost one in four adolescent girls will live in sub-Saharan Africa, where the total number of adolescent mothers aged under 18 years is projected to rise from 10.1 million in 2010 to 16.4 million in 2030 (9).

Africa's young population presents challenges in terms of access to sexual and reproductive health and HIV information commodities and services; yet, this burgeoning youth population is also the region's greatest asset. Reaching and engaging young women and adolescent girls, and empowering them to make their own health choices in safe and equitable environments, has the power to change the trajectory of the HIV epidemic.

### **Africa is urbanizing fast**

Most African countries are undergoing rapid urbanization, calling for innovative solutions that adapt to these changes. Africa is projected to be 56% more urban by 2050. In terms of service outreach, 52% of people living with HIV in sub-Saharan Africa will be living in urban areas by 2020 – and 62% of urban people living with HIV will be living in slums (26).

Increasing urbanization should improve proximity and access to services, but this is not always the case. Informal settlements or slums often do not have public services or have poor-quality private services.

This context, combined with other aspects of urban poverty, such as exposure to violence, increases the HIV risk for young women and adolescent girls. The intersection of violence, insecurity and transactional sex means young women living in slums are 23% more likely than other urban young women to be living with HIV. They are also 3.4 times more likely than young men of the same age to be living with HIV. Urban poverty and location appear to have a bigger impact on the vulnerability to HIV of young women compared with men and older women (26).

This rapidly changing environment calls for an AIDS response that accommodates change, including the integration of services for sexual

and reproductive health and rights, gender-based violence and HIV, to address vulnerabilities and the specific needs of girls and young women in increasingly urbanized and crowded settings.

In line with this, in 2014, UNAIDS launched the Fast-Track Cities initiative with world mayors to commit to fast-tracking the response in urban areas, demonstrating high level political commitment to address the HIV specific needs, that are arising out of a rapidly changing environment.

## **FIVE KEY RECOMMENDATIONS TO FAST-TRACK THE HIV RESPONSE AND END THE AIDS EPIDEMIC AMONG YOUNG WOMEN AND GIRLS**

The 2011 UN General Assembly High-Level Meeting Political Declaration on HIV/AIDS pledged to eliminate gender inequalities and gender-based abuse and violence, and to increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, but the scale-up of evidence-informed and resourced interventions has not been fast enough. Although the inclusion of gender equality in national HIV responses is a recognized game changer, a survey of 104 countries found that only 57% had an HIV strategy that included a specific budget for women in 2014 (27). Moreover, the underlying structural gender inequality drivers that exacerbate young women's and girls' physiological vulnerability to HIV are often ignored. Global commitment is needed for the five recommendations outlined below.

### **1. Women's agency, participation and leadership**

Women's collective agency is transformative for society. It shapes the institutions, markets and norms of a society. Empowering women as political and social actors can change policy choices and make institutions more representative of a range of voices (3). There has been progress in political participation. In Rwanda women make up 63% of all members of parliament, and in 11 other countries in the region women make up over 30% of lower house members (28).

The meaningful engagement and leadership of women living with and affected by HIV, in the HIV response, are critical elements to ensuring a response, which is effective and sustainable. Young women living with and affected by HIV must be involved and represented at all levels of policy and decision-making, including as members of parliament, as representatives in advisory groups for policy development, and in the implementation, monitoring and evaluation of HIV policies. Young women should be recognized and included as decision-makers and not considered only as victims or recipients of assistance. It is only through significant improvements in the representation and meaningful participation of young women in these processes that HIV policies and programmes will be truly human rights-based.

All over the continent, women's groups have mobilized in the AIDS response. In the Middle East and North Africa, MENA-Rosa, launched

in 2010, is the first regional group dedicated to women living with HIV. Members of MENA-Rosa were among the first women living with HIV in the region to speak out openly about their lived experiences. The organization provides women living with HIV with the opportunity and platform to mobilize and advocate around key issues related to sexual and reproductive health and rights, HIV and empowerment. In 2011, MENA-Rosa solicited the views of 200 women living with HIV in 10 countries across the Middle East and North Africa, with their stories and voices being narrated in the UNAIDS report, *Standing up, speaking out: women and HIV in the Middle East and North Africa*.

Women's participation in humanitarian situations is also important and feasible. Even though women are critical to reconciliation and reconstruction efforts, they have been underrepresented in peace processes and poorly involved in the establishment of post-conflict frameworks. Yet when women have been included in peace-building, such as in Sudan and Burundi, the specific needs and rights of women, including support for victims of sexual violence, services for widows, and education and health, were reflected in frameworks (2).

## **2. Strategies to reduce intimate partner violence and reduce vulnerability to HIV**

Strategies and action implemented at the community level to address intimate partner violence are critical to reducing young women's and adolescent girls' vulnerability to HIV. Two randomized controlled trials have shown positive outcomes.

The Raising Voices SASA!<sup>3</sup> kit was designed to inspire, enable and structure effective community mobilization to prevent violence against women and HIV (29). Community activists spearheaded a wide range of activities in their own neighbourhoods designed to decrease the social acceptability of violence by influencing knowledge, attitudes, skills and behaviours on gender, power and violence. When implemented in four communities in Kampala, Uganda, the SASA! kit was associated with significantly lower social acceptance of intimate partner violence among both men and women. It was also associated with lower incidence of intimate partner violence and more supportive community responses to women who experienced such violence (59). SASA! has been implemented by over 25 organizations in sub-Saharan Africa in diverse settings such as religious, rural, refugee, urban and pastoralist communities.

The Safe Homes and Respect for Everyone (SHARE) project in Rakai, Uganda aimed to reduce physical and sexual intimate partner violence and HIV incidence using two main approaches: community-based mobilization to change attitudes and social norms that

3 Sasa is a Kiswahili word that means now.

contribute to intimate partner violence and HIV risk, and a screening and brief intervention to reduce HIV disclosure-related violence and sexual risk in women seeking HIV counselling and testing. Evaluation of the project showed significant decreases in both intimate partner violence and HIV incidence. The SHARE model could inform other HIV programmes' efforts to address intimate partner violence and HIV and could be adopted, at least partly, as a standard of care for other HIV programmes in Africa (30).

In both approaches outlined above, engaging men and boys has been essential to tackle harmful masculinities and redress power imbalances in the private and public spheres. These interventions also contribute to the broader goal of challenging cultural and social norms that are harmful to women and girls and communities as a whole. For example, MenCare+, a community-based intervention in Rwanda and South Africa, engages young men and women together in group sessions on gender equality, sexual and reproductive health and rights, maternal and child health, fatherhood and care, and uses reflection groups with men who have used violence with their partners. The One Man Can campaign, launched by Sonke Gender Justice, is another example of engaging men in advocating the elimination of gender-based violence and gender equality, while at the same time responding to HIV.

### **3. Scaling up social protection and cash transfers to reduce poverty and girls' vulnerability to HIV**

Girls in families affected by HIV are more likely to drop out of school to care for sick parents or generate income for the family. As such, in the context of comprehensive social policies and programmes, households affected by HIV are an appropriate target for cash transfer programmes that aim to alleviate poverty.

Cash transfers such as the Zomba programme in Malawi are estimated to have reached over 1 billion people in low- and middle-income countries worldwide. The approach has been used across Africa, including in Kenya, Malawi, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe (31, 32). Cash transfers can achieve multiple simultaneous outcomes, including declines in early marriage and teenage pregnancy. Introducing a cash transfer programme with the primary target of HIV prevention among adolescent girls, or adding an HIV dimension to an existing cash transfer programme, can shift the emphasis of this social protection measure from being an expense and reframe it as a cost-effective investment in human development. Cash transfers targeted at

adolescent girls are one of the few HIV interventions that have proven to be a highly effective means of HIV prevention (61).

#### **4. Strategies to keep girls in school and comprehensive sexuality education**

Education confers higher knowledge about HIV and sexual and reproductive health and rights and leads to better health outcomes for young women and adolescent girls (32, 33). It lowers exposure to gender-based violence and increases women's and girls' chances of being financially secure and independent. Compared with girls who have at least six years of schooling, girls with no education are twice as likely to acquire HIV and do not seek help in cases of intimate partner violence, which can increase the risk of HIV infection by 50%, according to a South African study (60, 16).

The longer a girl stays in school, the greater the chances that she will use modern contraception if she does have sex and the lower her chances of giving birth as an adolescent (9).

Some of the most powerful structural interventions for HIV risk reduction among adolescent girls across Africa are those that aim to keep girls in school (34-37). These interventions include making education free of charge for girls (38), supporting orphans and other vulnerable children to stay in school (39, 40), and conditional cash transfers that reward parents for keeping their daughters in school (41).

When young women and adolescent girls have access to comprehensive age-appropriate sexuality education before becoming sexually active, they are more likely to make informed decisions about their sexuality and approach relationships with more self-confidence (42, 43, 44). Critically, school-based comprehensive age-appropriate sexuality education is also known to increase young girls' condom use, increase voluntary HIV testing among young women, and reduce adolescent pregnancy (45, 46, 47).

The 2013 Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health and Rights in Eastern and Southern Africa reaffirmed the commitment of Africa's leaders to ensure that all adolescents are equipped with "life skills-based HIV and sexuality education and youth-friendly sexual and reproductive health services", demonstrating a clear dedication to addressing the specific needs of young people and their right to their own agency, in the context of HIV and sexual and reproductive health.

## 5. Scaling up and integrating HIV with sexual and reproductive health services

A massive scale-up of comprehensive and youth-friendly sexual and reproductive health and HIV services for young women and adolescent girls should be planned and rolled out, taking into consideration rapid population growth. Looking at projections for urbanization, these services need to be focused increasingly on urban areas and in particular to reach poor urban women and girls. The type of service is important. Condom programming designed to reach young people, such as through schools, can increase accessibility and confidence among those who are sexually active (48, 49). In addition, removing barriers such as parental and spousal consent, which further institutionalizes sexual and reproductive rights violations, is critical for scaling services and ensuring access.

For young women living with HIV, access to youth-friendly sexual and reproductive health services, including screening for and treating reproductive cancers, preventing and addressing violence, and HIV prevention, treatment, care and support, has proven to be life-saving. Studies from southern Africa found that access to such services and peer support groups helped young people adhere to antiretroviral treatment (50, 51). Ensuring that young women and adolescents have access to good-quality contraceptive services and antenatal care is essential to reducing the number of unintended pregnancies and new infections among children. (52, 53)

### Conclusion

Fast-tracking the end of the AIDS epidemic by 2030 requires strong political leadership and commitment to stop new infections and deaths among young women and adolescent girls and eliminate mother to child transmission of HIV. This requires building on, and extending Africa's commitments on sexual and reproductive health and rights, expanding ministerial commitments on comprehensive sexuality education and stopping early marriage, adolescent pregnancy and expanding treatment service coverage.

The technical and programmatic solutions are within our reach. An effective and sustainable HIV response must call for scaling up poverty reduction and social protection programmes that keep girls in school and reduce vulnerability to HIV; community programs that engage men and boys and eliminate intimate partner and advance gender equality; ensuring that young women and girls can access good-quality youth friendly, comprehensive sexual and reproductive health information and services that respond to their specific needs.





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