3 Global and regional initiatives to prevent HIV among adolescents and youth

Fulfilling the promise in
Eastern and Southern Africa

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Introduction

Over the course of the past decade, the global health community has shown an increasing interest in reducing HIV infections among youth, with a particular focus on adolescent girls and young women (AGYW) living in sub-Saharan Africa (SSA). Among the many reasons for their heightened concern is emerging data showing stagnating progress in curbing youth HIV infection and mortality rates, much higher infection rates among females than males in this age group, a set of root causes requiring greater attention, and a conducive political environment. As global health institutions seek to end the AIDS epidemic by 2030, more intensive strategies are needed to reduce new infections in this population, going beyond biomedical interventions to tackle the variety of societal, cultural, economic, and political drivers of HIV infection within this group.

Attention to HIV prevention among AGYW has been visible among a broad range of global health actors with significant political and financial resources at their disposal. Global health partners have created several new initiatives, frameworks, and funding streams, complemented by highly ambitious global prevention targets for AGYW. Continental and regional bodies in Eastern and Southern Africa (ESA) have also increased both their public discourse and initiatives on HIV prevention.

Such support is noteworthy: it has been maintained over a sustained period of time, backed by new funding streams, and coalesced around a distinct set of policy issues and recommendations. This chapter will provide an overview of these funding streams on adolescent HIV prevention and the common policy themes they have evoked. The chapter will also briefly examine national-level developments in ESA and provide recommendations on how to ensure the theoretical benefits of these initiatives actually change the reality on the ground.

Figure 3.1 Estimated distribution of new HIV infections among adolescents aged 15–19, by gender, 2017

Source: UNAIDS, 2018 estimates (UNICEF, 2018c).

HIV and adolescent girls and young women – re-stating the major issues

Global interest specifically on HIV prevention among AGYW materialized largely after 2010, when reports began to highlight significant age and gender disparities in progress against the HIV epidemic on both prevention and treatment. Data from 2012 to 2015 indicates that AIDS-related diseases were the leading cause of death among adolescents in SSA and the second-most leading cause worldwide (UNAIDS and UNICEF, 2015; UNICEF, 2018a) (see Chapter 1 for more recent data).

While the rates of new HIV infections have decreased among all age groups since the late 1990s, progress among adolescents has stagnated since around 2013 (UNAIDS, 2013; UNICEF, 2017a). The absolute number of new infections is expected to rise steadily over the next decade, with projections of both growing numbers of youth in SSA (referred to as a “youth bulge”) (UN DSA, 2015) and steady infection rates. Unless major changes in programs and policies occur, the number of new HIV infections among adolescents in SSA will rise 13% annually until 2030 (UNICEF, 2017a, 2017b).

Earlier chapters in this book have noted that in ESA, HIV prevalence is over twice as high among girls and young women as compared to men, and the countries with the highest levels of prevalence and highest absolute numbers of new infections among young women (15–24 years) are almost all found in ESA (Table 3.1) (Dehne et al., 2016). At the same time,

Table 3.1 HIV among adolescents and youth – global and ESA

	<i>Adolescents living with HIV (10–19) global</i>	<i>Adolescents living with HIV (10–19) ESA</i>	<i>New infections (15–19) Global</i>	<i>New infections (15–19) ESA</i>	<i>Young women (15–24) prevalence global</i>	<i>Young men (15–24) prevalence Global</i>	<i>Young women (15–24) prevalence ESA</i>	<i>Young men (15–24) prevalence ESA</i>
2011	1,600,000	1,200,000	320,000	155,757	0.4	0.3	4.1	1.8
2012	2,100,000	1,300,000	300,000	160,000	0.4	0.3	3.9	1.8
2013	2,100,000	1,400,000	250,000	130,000	0.4	0.3	3.8	1.7
2014	2,000,000	1,200,000	220,000	100,000	0.4	0.3	3.7	1.7
2015	1,800,000	1,100,000	250,000	130,000	0.4	0.3	3.5	1.7
2016	2,100,000	1,300,000	260,000	130,000	0.4	0.3	3.4	1.6
2017	1,800,000	1,100,000	250,000	122,000	–	–	–	–

Source: UNICEF stocktaking reports and statistical updates.

several countries in ESA have made progress in lowering new infections between 2010 and 2017 (UNICEF, 2018c), perhaps due to new programs implemented in this time period.

This marked gender disparity is linked to many socio-economic factors, including legal and societal inequalities and harmful gender norms. AGYW still experience “alarmingly high” levels of intimate partner violence (IPV) (UNAIDS and UNICEF, 2015) and child marriage, both of which raise the risk of HIV infection (Jewkes et al., 2010). Reported rates of IPV among ever-married women in SSA range between 20% and 50% in 18 high-prevalence states (UNAIDS and UNICEF, 2015). Child marriage rates in ESA were 35% in 2016, including around 9% who married before age 15 (UNICEF, 2018b) (refer to Chapter 7).

High rates of school dropout after primary or lower secondary school; discriminatory attitudes, practices, and laws; and other factors limiting girls’ economic independence can also drive them to age-disparate sexual relationships and transactional sex. In such cases, the relationships are usually between young girls and older men who have already had several sexual partners and, in many contexts, a relatively high risk of HIV infection. These relationships are also associated with higher levels of IPV and an unequal power balance that can prevent girls from exercising decisions about using protection as well as seeking HIV testing or treatment (Piot et al., 2015, p. 7). An early end to girls’ education is associated with a higher risk of HIV and a lower likelihood of seeking help in cases of gender violence (UNICEF, n.d.).

There also remain persistently low levels of access to sexual and reproductive health (SRH) education and HIV services among both genders in this age group (UNAIDS and UNICEF, 2016). For example, in 2016, only 15% of adolescent girls (15–19 years) in SSA had been tested for HIV in

Table 3.2 Drivers of HIV infection among AGYW and common proposed responses

<i>Driver</i>	<i>Policy/program responses</i>
Relationships with older partners or transactional sex	Social protection, such as cash transfers; empowerment and engagement of AGYW; PrEP for AGYW in high-incidence areas; voluntary male circumcision
High rates of school dropout (after primary or lower secondary school)	Cash plus care; free primary and secondary school; reintegration of teen mothers in schools; separate sanitary facilities and commodities for girls
IPV	Community mobilization and sensitization; post-violence care; economic empowerment and education
Child marriage	Raise legal and customary age for marriage; provide economic empowerment and education
Stigma and discrimination	Social engagement, political mobilization of youth
Lack of access to comprehensive sexuality education, including on HIV	Comprehensive sexuality education, inside and out of schools
Low levels of testing	Demand creation for adolescents; legal barriers to HIV services, such as age of consent laws; youth-friendly services; HIV self-testing
Low use of condoms	Condom promotion and provision

the past 12 months, and only 27% had comprehensive knowledge of HIV/AIDS (UNICEF, 2018c). Certain laws, policies, and societal stigma and discrimination, especially among healthcare workers, also create barriers to access to prevention services among AGYW (Eba, and Lim, 2017). Table 3.1 provides a summary of these factors, as well as the most common policy and programmatic responses put forward by global and regional policy-makers.

In global and regional fora, these data fueled a belief that the HIV epidemic could not be ended without a sharp decline in infections among AGYW. In new global HIV strategies, policies, and funding streams, AGYW began to receive greater attention than in the past, and a plethora of initiatives was developed to create an “AIDS-free generation,” most of them centering around the policy initiatives (see Table 3.2).

Global policy and funding initiatives

As the central HIV advocacy platform with global, regional, and national convening power, UNAIDS has played a leading role in calling attention to the situation of adolescents and youth. Its 2016–2021 strategy seeks to ensure that “young people, particularly young women and adolescent

girls, access combination prevention services and are empowered to protect themselves from HIV” through raising levels of secondary schooling, providing social protection to avoid transactional sex, reducing sexual and intimate partner violence, and ending harmful gender norms and practices (UNAIDS, 2010). These themes have been subsequently addressed in many UNAIDS progress reports, biannual governance meetings, guidance documents, HIV-focused panels with the Human Rights Council, and prevention reports and initiatives (UNAIDS, 2015). For example, the UNAIDS and UNFPA-led Global HIV Prevention Coalition endorsed a HIV Prevention 2020 Roadmap in October 2017 with a strong focus on AGYW combination prevention, and the UNAIDS-based secretariat is working with countries to set country-level targets and 100-day action plans (UNAIDS, 2018).

UNAIDS, supported by civil society and many governments, helped develop a strong AGYW orientation for the United Nations General Assembly’s 2016 High Level Meeting on HIV (HLM). The HLM Political Declaration adopted by UN member states included a target of reducing new HIV infections among AGYW (15–24 years) to under 100,000 by 2020 (an ambitious 75% reduction from 2010 levels). The Declaration also contains an entire section of political commitments related to eliminating gender-based violence and empowering women and girls.

In 2016, with the end of the largely successful Global Plan (UNAIDS, 2011) to end vertical HIV transmission, UNAIDS and PEPFAR created a successor framework called Start Free, Stay Free, AIDS Free, which emphasized the Plan’s less visible prongs,¹ including primary prevention among young women. The framework, led by PEPFAR, UNAIDS, UNICEF, the World Health Organization (WHO) and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), created “super fast track” targets including the HLM’s target of sharply reducing new infections among AGYW. These “Three Frees” have suffered, however, from a lack of enabling institutional support at the global, regional, and national levels.

UNICEF and UNAIDS launched the All In Fast Track for Adolescents framework in February 2015, a “collaboration platform” intended to drive national awareness and responsiveness to youth in 25 countries that contribute to 86% of all new infections in adolescents. It promotes leadership and advocacy skills among youth and strengthens national programming through better data collection and use and the adoption of innovative services. It set forth ambitious targets, including a 75% reduction in new HIV infections among adolescents by 2020 (UNAIDS and UNICEF, 2015). Together, the PEPFAR Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe program (DREAMS), discussed in more detail later, and All In have been credited with sharply increasing the attention given to HIV prevention among AGYW and prompting others to follow suit, with All In raising the profile of the issue and DREAMS providing the funding for effective interventions (Dehne et al., 2016).

With its role co-leading All In, as co-chair of the Start Free, Stay Free, AIDS Free Framework working group, and through the promotion of other policies and initiatives, UNICEF has played a central role in calling attention to AGYW HIV prevention. Since 2005 it has also issued regular stocktaking reports on the state of the HIV epidemic among children, which pointed to the need for better data disaggregation and other policy changes (Idele et al., 2014). The reports have increasingly focused on the lack of progress for adolescent HIV prevention, with its 2016 report saying the matter was “dire,” particularly for adolescent girls ((UNICEF, 2016). UNICEF’s 2018–2021 HIV strategy decried the slow progress on HIV prevention among adolescents and designated “scaling up targeted HIV prevention for adolescents” as one of three core objectives.²

As the principal international health institution, WHO’s increasing attention to adolescent health carries much weight, and it has used its role in setting the global health agenda, issuing normative guidelines and creating developing implementation tools to promote change at the national level.³ For example, its Global Accelerated Action for the Health of Adolescents (AA-HA!) and guidance on country implementation emphasized the need for better data disaggregation by sex and five-year age bands for the first 25 years of life (WHO, 2017a). WHO HIV self-testing (HIVST) guidance included adolescents and young people among those high-risk groups particularly suited for self-testing, noting age of consent policies may need to specifically address HIVST to be accessible to adolescents (WHO, 2016). The 2016 HIV treatment guidelines recommended PrEP for people considered at substantial risk of acquiring HIV, noting that in ESA such populations include AGYW (WHO, 2017b). WHO guidelines can have a significant impact at the national level, as many countries eventually adopt them and are reluctant to make policy changes before WHO recommends them.

PEPFAR (U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), 2017) was among the original stakeholders to raise the issue of empowering adolescent girls and young women backed by a dedicated funding stream. In December 2014, PEPFAR created the DREAMS partnership, spending \$761 million over four years to support packages of core prevention interventions in ten ESA countries,⁴ with a focus on community-based, innovative activities in high-incidence districts (PEPFAR, 2018). In addition to keeping girls free of HIV, DREAMS aimed to keep girls in school, prevent early pregnancies, prevent sexual violence, and provide post-violence care (see Table 3.2). DREAMS investments were determined in coordination with national authorities based on the country context and priorities, epidemiological data, partners’ capacity, and local leadership (see Table 3.3).

DREAMS also set out ambitious prevention targets, which sent a strong political message about the urgency of taking action, and guided implementing partners’ activities over that period (PEPFAR, 2015). By the end of the DREAMS partnership (December 2017), PEPFAR reported it had reached over 1 million AGYW and contributed to a reduction of 25%–40%

Table 3.3 DREAMS interventions and countries

<i>Interventions</i>	<i>Kenya</i>	<i>Lesotho</i>	<i>Malawi</i>	<i>Mozambique</i>	<i>South Africa</i>	<i>Eswatini</i>	<i>Tanzania</i>	<i>Uganda</i>	<i>Zambia</i>	<i>Zimbabwe</i>
Cash transfers	X				X		X		X	X
Characterization of male partners		X			X					
Combination socio-economic approaches	X	X	X	X	X	X	X	X	X	X
Community mobilization and norms change	X	X	X	X	X	X	X	X	X	X
Condom promotion and provision	X	X	X	X	X	X	X	X	X	X
Educational subsidies	X		X	X	X	X	X	X	X	X
HIV testing and counselling	X	X	X	X	X	X	X	X	X	X
Increase contraceptive method mix	X	X	X	X	X	X	X	X	X	X
Parenting/caregiver programs	X	X	X	X	X	X	X	X	X	X
Post-violence care	X	X	X	X	X	X	X	X	X	X
PrEP	X							X		X
School-based HIV and violence prevention	X	X	X	X	X	X	X		X	X
Social asset building	X	X	X	X	X	X	X		X	

Source: www.pepfar.gov/partnerships/ppp/dreams/c69041.htm (PEPFAR, 2017a).

in new HIV infections among AGYW (15–24 years) in 65% of high-burden communities and lower new infections across almost all DREAMS program districts (PEPFAR, 2017b). PEPFAR planned to continue support for DREAMS-related activities on a bilateral basis after 2017, adding five more countries in 2018.

In collaboration with PEPFAR to ensure complementarity, the Global Fund has also promoted greater support for AGYW programming through its technical briefs, 3-year grants, and special catalytic funds, which it allocates according to national priorities (Table 3.4). In its 2017–2022 global strategy and funding cycle, the Fund demonstrated marked commitment to supporting AGYW HIV prevention programs (GF, 2016). For example, it issued a technical brief on AGYW in high HIV burden settings to support programs strengthened through greater engagement with adolescents themselves (GF, 2017). The GF also created a special \$55 million catalytic fund for AGYW in its 2017–2019 funding cycle for 13 countries in ESA, as part of its funding for key and vulnerable populations (see Table 3.3). The fund supports a range of biological, behavioral, and structural interventions with potential to target the key drivers of HIV infection among AGYW (GF, 2018a).

Building on these efforts, the GF launched the HER Campaign in Davos in January 2018. The HER Campaign is a platform for a variety of public and private financial, in-kind, and technical contributions for programs that address AGYW HIV prevention in 13 ESA countries. Citing the risk of a “catastrophic resurgence of the epidemic” among AGYW, the campaign seeks to reduce new infections by 58% over five years in this population (GF, 2018b).

Table 3.4 GF and PEPFAR AGYW funding overview (in millions of US dollars)

<i>Country</i>	<i>PEPFAR DREAMS (F16–FY17 implementation)</i>	<i>GF Targeted AGYW Prevention Activities (2014–2016 Funding Cycle)</i>	<i>GF Matching Funds Targeted AGYW Activities (2017–2019 Funding Cycle)</i>
Botswana	–	6.0	1.0
Cameroon	–	1.8	1.9
Kenya	39.5 (4 districts)	3.5	5.0
Lesotho	14 (2 districts)	2.6	1.5
Malawi	14 (2 districts)	12.0	7.0
Mozambique	20.4 (5 districts)	4.5	6.0
Namibia	–	3.0	1.0
South Africa	66.7 (5 districts)	67.0	5.0
Eswatini	10 (19 districts)	5.0	1.5
Tanzania	16.3 (5 districts)	–	8.0
Uganda	31.4 (10 districts)	–	5.0
Zambia	16.3 (3 districts)	–	4.0
Zimbabwe	20.6 (6 districts)	–	8.0

These initiatives address all the key drivers of the HIV epidemic among AGYW in a variety of mutually reinforcing approaches. They are complemented by a set of regional policy frameworks described below, which also touch on the same themes. While the impact on national activities and new infection rates is not yet certain, it is clear that high levels of political will for this subgroup of the HIV epidemic have been created across all major stakeholders in the HIV community and are standing the test of time in a field of competing and fleeting priorities.

African continental and regional policy frameworks

Since around 2005, African intergovernmental bodies at the continental and sub-regional levels have elaborated a wide array of policy documents that address the health and well-being of adolescents and young people, many of them connected to HIV prevention (African Union, 2011). At the highest level, the African Union (AU) Agenda 2063 (African Union, 2015) lays out Africa's aspirational development goals, including creating an enabling, people-driven environment to empower women, children, and youth to reach their full potential. Implementation of the Agenda would contribute to reducing the risk of HIV infection in adolescents and young people. In addition, the Africa Health Strategy (AHS) (AU DSA, 2016), the 2006 AU Continental Policy Framework on Sexual Reproductive Health and Rights, the 2013 Addis Ababa Declaration on Population and Development in Africa beyond 2014 (UNECA, AUC, and UNFPA, 2013), the Catalytic Framework to end AIDS, TB, and Malaria in Africa (African Union, 2016), and the revised AU Maputo Plan of Action 2016–2030 that operationalizes the SRHR framework all address issues at the core of HIV prevention among adolescents and young people.

The 2001 AU Abuja Declaration on HIV/AIDS, TB, and Other Related Infectious Diseases (African Union, 2001), renewed in 2006 and 2013, urges countries to invest 15% of their annual budgets in health. The 2013 Abuja Declaration encouraged countries to especially focus on increasing access to prevention programmes targeting youth, especially young women, to ensure an AIDS-free generation (African Union, 2013). These AU commitments demonstrate that there is continental endorsement of strategic approaches to addressing HIV and other health challenges for youth, and they are reinforced by AIDS Watch Africa's⁵ Strategic Framework (2017–2030), which highlights the disproportionate impact of HIV on young people.

Regionally, the East African Community (EAC), Southern African Development Community (SADC), and the Common Market for Eastern and Southern Africa (COMESA) have promoted collaboration and accountability on ending AIDS among AGYW through various frameworks, policy documents, and model legislation. For example, the 2012 EAC HIV and AIDS Prevention and Management Act promotes a framework to address

common priorities in the region and minimize gaps and discrepancies in national HIV laws. An assessment of the application of this legislation cannot yet be conducted, however, since Uganda is the only member state that has reviewed its HIV legislation since its passage. Moreover, the Uganda legislation has been criticized (Hanibal, 2017) as it criminalizes transmission of HIV and requires pregnant women to undergo mandatory HIV testing.

The 2008 SADC model HIV/AIDS legislation was developed to inspire countries to undertake legislative reforms in line with international human rights law and to promote the implementation of effective prevention, treatment, care, and research strategies and programmes on HIV. According to AIDS and Rights Alliance for Southern Africa (ARASA, 2016, p. 26), between 2009 and 2016, several countries in EAS (Angola, DRC, Kenya, Madagascar, Tanzania, and Uganda) disregarded the model law by introducing specific legislation or continuing to use existing legal provisions to criminalize HIV transmission, exposure and/or non-disclosure. In the same period, only Malawi, DRC, and Mozambique had made some progress in reviewing criminalization provisions in their laws. Only two countries in SSA (Comoros and Mauritius) have HIV-specific laws that do not criminalize HIV transmission.

The 2013 Ministerial Commitment on Comprehensive Sexuality Education and SRH Services for Adolescents and Young People in ESA (ESA Commitment) (Young People Today, 2013) was developed in response to the continuing lack of access to such information and services among young people in the region. Twenty-one ESA countries committed to taking bold actions to ensure quality comprehensive sexuality education and youth-friendly SRH services. To date, however, the implementation of the ESA Commitment has been mixed, with several countries not having taken any steps to develop a coordination mechanism or work plan or mobilize any resources, which are critical to driving its implementation (UNESCO, UNFPA and UNAIDS, 2016, p. 26).

Several other continental and regional initiatives have been created over the years to promote progress for AGYW. For instance, the theme of the Organization of African First Ladies against HIV/AIDS (OAFLA) for 2018 is “Transforming Africa through Prioritizing Children, Adolescents and Mothers in the Fights against HIV and AIDS,” focusing political attention on children and adolescents living with and at risk for HIV (African Union, 2018). Other initiatives such as the joint AU/OAFLA Free to Shine Campaign (2018) and the AU Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA) all add to the continental push to ensure that AGYW have access to comprehensive SRH and HIV prevention services. When resources are available to drive the initiatives at the country level, there has been significant traction and greater likelihood of national impact. In the case of CARMMA, continental political support, a system for integrating the initiative at the country level, and an accountability mechanism are associated with progress on the ground (CARMMA, 2012).

National impact in ESA countries

Global and regional mobilization on AGYW appears to have prompted rising national political awareness and commitment to the issue in ESA, steering policy, guideline, and program development and orienting government and civil society activities towards evidence-based solutions. This connection is most visible when initiatives have been accompanied by funding, which strengthens the hand of the institution seeking national changes while enabling the country to pay for new or expanded programs. National buy-in to global goals and regular interaction between the global/regional bodies and the national authorities also stimulates greater national-level activities. Civil society involvement, both at the community and national levels, supports stronger connections between the aspirations of the initiative and the needs of affected populations.

For example, under the All In framework, UNICEF supported country-by-country assessments and investment cases in 25 countries in a process that included ministries, UN agencies, and young people (UNAIDS and UNICEF, 2016). It also led countries like Kenya, where a national high-profile meeting was held on All In, to give visibility and political attention to the AGYW issue. The Global HIV Prevention Coalition's push for national targets and action plans, backed by a global secretariat and national prevention coalitions, has also prompted several policy revisions and programmatic innovations (UNAIDS, 2018). The establishment of an accountability mechanism, including progress reports with individual country scorecards and community-based monitoring tools, has already appeared to encourage national activities, though civil society shadow reports decry insufficient community involvement in program planning and implementation (International HIV/AIDS Alliance, 2018).

Arguably, the clearest connection between global and local efforts has been due to DREAMS, where PEPFAR partnered with ministries of health (MoH) at the national level and emphasized the generation of evidence to steer programming. PEPFAR-backed largely community-driven intervention packages in a limited number of regions, closely monitoring implementation and data produced by the initiative. As of mid-2018, PEPFAR was still assessing why more progress was made in some districts than others, an analysis that will help shape its planned continuing support for DREAMS in a broader set of countries. It also began a process of consultation with adolescent girls on their priorities, with early feedback centering on enhancing financial opportunities.

As a public-private partnership, DREAMS acted as a catalyst to engage private sector partners and to work in coordination with the development community. DREAMS also created a ripple effect, such as South Africa's creation of *She Conquers*, a national campaign to take DREAMS beyond the four PEPFAR-supported districts. The Global Fund's 2017–2019 allocations and catalytic investment for AGYW will also build upon DREAMS, with

dedicated funding set to arrive in 13 ESA countries in 2018. For example, Eswatini is joining forces with the Global Fund and the National Emergency Response Council on HIV/AIDS, resulting in close to national coverage for adolescent girls and young women (UNAIDS and UNICEF, 2016, p. 18).

Reflecting initiatives at the global and regional levels, most countries in ESA are in the process of reviewing or revising their HIV prevention policies and guidelines for adolescents, and some countries' policies include foci such as gender-based violence and HIV that had not been prioritized in the past (see Box 3.1). In Lesotho, in line with global and regional support for such activities, more policies and guidelines were updated or generated in 2017 than in the past decade combined. In June 2017, Uganda, with HIV prevalence almost four times higher among females aged 15–24 than males, launched the Presidential Fast-Track Initiative for Ending HIV/AIDS as a public health threat in Uganda by 2030, with a focus on girls and young women and their male partners.

Box 3.1 Examples of recent guideline and policy adoption/amendments in ESA

Kenya

- Building a situation room platform to better monitor prevention progress, including on AGYW
- Indicators for cash transfers for adolescents and retention in secondary school to be included in district health management system.

Lesotho

- Adolescent and Young People's Health and Development Strategy revised in 2015
- Comprehensive Sexuality Education Guidelines for Secondary Schools created in 2017, supported by UNESCO and PEPFAR
- 2002 Gender-Based Violence (GBV) Guidelines updated in 2017
- Guidelines for the roll out of pre-exposure prophylaxis (PrEP) developed in 2017; determines eligibility by risk rather than age alone, and includes PrEP for priority populations with high HIV incidence, such as AGYW
- National policy on testing and treatment, including HIV self-testing, revised in 2017; age of consent to increase from 12 to 16 years for testing at facilities

- Essential service packages for AGYW to be reviewed in 2018 and included in 2018–2023 national strategic plan.

Malawi

- National prevention strategy was being developed in 2018, including results framework and targets for AGYW
- A national strategy on condom programming was launched
- An AGYW empowerment/HIV prevention strategy was being developed in 2017–2018.

Mozambique

- Establishment of a national prevention coalition with high-level MoH leadership for the prevention agenda
- High-priority locations for AGYW HIV prevention were defined in 2017.

South Africa

- South African National AIDS Council has re-established a prevention technical task team and technical working groups, including one for AGYW
- National prevention targets are being revised in line with the 2016 HLM targets.

Eswatini

- A national HIV Prevention Road Map was launched, backed by a high-level oversight committee
- The 2017–2019 Global Fund request included increased funding for prevention.

Uganda

- Adolescent Health Policy Guidelines and Service Standards (2011)
- Presidential Initiative for AIDS Strategy on Communication to the Youth
- Investment Case for Reproductive, Maternal, Newborn, Child, and Adolescent Health Sharpened Plan for Uganda, 2016
- National HIV Testing Services (HTS) Policy and Implementation Guidelines – revised 2016; streamlines testing for minors, lowers

the age of consent for HTC to 12 years, and increases the number of young testing providers

- National sexuality education framework approved in 2018.

Tanzania

- A national condom strategy was launched in 2018 with focus on young people's access to condoms
- Plans in 2018 to establish program targets related to AGYW HIV prevention.

Zambia

- Legal and policy barriers to HIV prevention among adolescent girls identified; work ongoing with parliament on age of consent for HIV services
- National technical guidelines on HIV prevention among adolescents developed.

Zimbabwe

- Strengthened coordination on prevention among AGYW
- In 2018 public health bill review, proposals to address policy and legal barriers for adolescents to access health services.

Sources: EGPAF programs; UNAIDS (2018).

On the other hand, where global targets such as those in the Three Frees and the HLM have received less national or global advocacy, it is harder to observe a direct impact of the initiative. Since the creation of the Three Frees, progress has been made, including a 19% decline in the number of adolescent girls and young women acquiring HIV and 85% ART coverage for pregnant women globally. Despite these advances, however, most of the Start Free Stay Free AIDS Free targets will not be met (UNAIDS, 2020). In addition, ESA countries have been slow to implement global guidelines, such as those on PrEP and HIVST for older adolescents, and improving data collection techniques and age disaggregation. Many regional initiatives provide states with suggested packages of services, standards, and legal changes that may have inspired national revisions to laws and policies, but a separate analysis would be needed to review their country-by-country implementation. An analysis of adoption of the 2008 SADC model legislation, for example, shows no significant impact to date (UNAIDS and UNICEF,

2016), nor does the 2012 ESA model legislation appear to have had an impact. And despite the ESA Commitment referred to earlier, a large proportion of schools in SSA still promote abstinence only and teach “life skills” rather than meaningful HIV education or comprehensive sexuality education (CSE) (UNFPA, 2015).

Finally, global and regional initiatives do not appear to have promoted the development of much-needed inter-ministerial collaboration in such areas as education, social protection, and IPV. For example, most schools do not facilitate HIV testing or treatment access, which could be addressed through better coordination between ministries of health and education. Better integration has been seen, however, when global and regional actors underscore the importance of such integration, such as PEPFAR’s push for an inter-ministerial strategy in Malawi and its support for sexual violence strategies in Mozambique and Tanzania. But such collaboration, as with all systematic change, requires national commitment for real effectiveness and sustainability.

Conclusion and recommendations

This overview of policy and funding initiatives does not represent the totality of global and regional efforts to cut new HIV infections among AGYW, but it does clearly demonstrate the degree to which global, regional, and national stakeholders have embraced the need to reduce infections among this group as key to ending the HIV epidemic. In boardrooms, conference halls, policy decisions, guidelines, and donor budgets related to HIV, there is firm and consistent support for tackling the root causes of HIV infection among adolescents and young women. Amassing such a level of political will is particularly notable in the face of historically weak backing for the broader prevention agenda (Dehne et al., 2016). The consensus around which policies and programmatic initiatives should be prioritized is also remarkable, with more options on what could work for different cultural contexts and epidemics than ever before.

As policy commitments have been matched with significant donor funds, ambitious global targets, new guidelines, and a consistent set of policy and programmatic recommendations, there would seem to be an extraordinary opportunity for real change for young people in ESA. But while supra-national support appears to be impacting policies and programs at the national and sub-national levels, at this relatively early stage the causative effect is unclear. Measuring the impact of each initiative in reducing HIV infections is also complex given the number of interventions being implemented in various combinations (Krishnaratne et al., 2016). Actors are also learning while doing, regularly refining solutions as new data becomes available.

At this point, some shortcomings related to the development and implementation of top-down initiatives are already apparent. For example, there seems to be insufficient emphasis on building national ownership of global

and regional targets, as well as consultation with community-based groups and the affected youth. In addition, global and regional initiatives often lack mechanisms to assign responsibilities, monitor implementation, and hold actors accountable. The following recommendations would support better national-level outcomes:

- Global and regional organizations should work more closely with national authorities to ensure greater national ownership and alignment of national plans with global targets, initiatives, and policies.
- Global and regional organizations should work with civil society, including community-based organizations and young people, to ensure their initiatives respond to the true needs of the people they seek to support.
- Global and regional organizations should establish in-country focal points for their initiatives to maximize communication and promote comprehensive implementation.
- Global and regional initiatives should be backed by funding streams (from donors and/or national budgets) to promote maximum impact and sustainability.
- Global and regional initiatives should include accountability mechanisms with clear assignment of roles and responsibilities, establishment of SMART milestones, and a system of monitoring and evaluation.
- Countries should improve multi-sectoral collaboration between the ministries of health and education and ministries concerned with gender, social protection, and related areas to address multi-layered prevention needs in a coordinated way.
- National authorities should expand youth involvement in advocacy and program design, implementation, and evaluation.
- All stakeholders should support better capacity for disaggregated data collection so progress can be measured separately for younger adolescents, older adolescents, and young men and women.
- All stakeholders should continuously assess programs and policies against evidence and revise them accordingly when necessary.

The types of economic, societal, cultural, and policy changes needed to reduce significantly HIV infection among AGYW will require long-term political commitment and financial support for the types of programmatic interventions described throughout this book. Global and regional efforts are an essential first step to raise the profile and available resources for such activities. But global and regional actors must continue their support over the long term while working with national authorities to build political and financial support. The greatest changes will come only when national governments take full ownership of the issue, leading calls for change, providing adequate financial and human resources, and working closely with communities and youth to ensure effective laws, policies, and programs are implemented.

Notes

- 1 The four prongs of the Global Plan were primary HIV prevention, family planning for women living with HIV, HIV testing and treatment for women living with HIV, and HIV care and treatment for children and their families.
- 2 Available at: <www.unicef.org/aids/files/Unicef-HIV_Vision_Summary_Final_May2017.pdf> [Accessed 15 February 2018].
- 3 One visible signal of WHO's interest in adolescent health was in the addition of "adolescents" to its 15-year maternal, newborn, and child health strategy: the Global Strategy for Women's, Children's, and Adolescents' Health 2016–2030, which emphasizes a number of socio-economic issues for HIV prevention among AGYW.
- 4 The ten focus countries are Kenya, Lesotho, Malawi, Mozambique, South Africa, Eswatini, Tanzania, Uganda, Zambia, and Zimbabwe.
- 5 AIDS Watch Africa is an advocacy platform of African heads of state and government within the AU.

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