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CHILDREN, HIV AND AIDS

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PROMOTING RIGHTS, ACTION & ACCOUNTABILITY



# **Blind spots *in the struggle against HIV and Aids?***

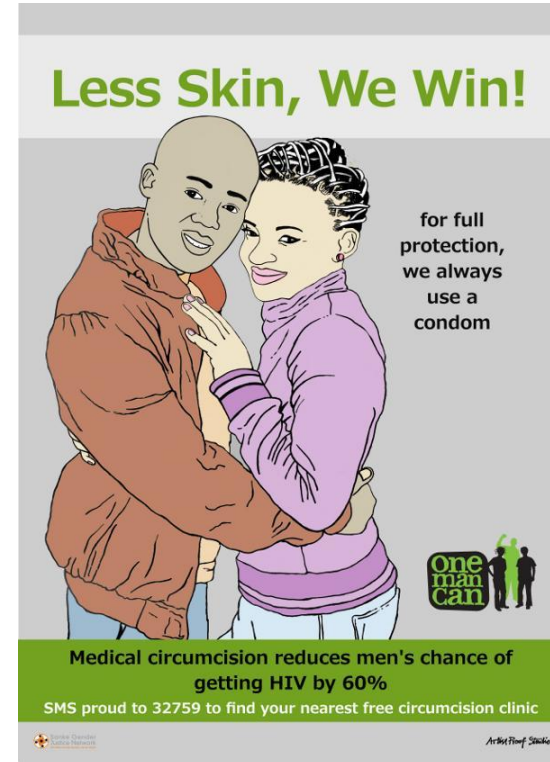
Angelica Pino, Programmes Director

PATA 2019 Summit

Johannesburg, 17 October 2019

# IN THIS PRESENTATION

- It takes two to tango: Where are the boys in the SRHR space?
- Men and HIV - To get to zero we must get to men
- Intersection between GBV and SRHR and HIV
- Some promising ideas/programmes



# DEMOGRAPHICS AND DATA: MISSING THE MARK ON AVAILABLE INFORMATION ON BOYS AND SRHR

- There are almost half a billion people living in Eastern and Southern Africa of which **23.8% are adolescent boys and young men aged between 10 and 34** – this equals 117 million people.
- **However, there is limited focus or information on boys and SRHR:** “Whilst a variety of data does exist that measures the various sexual and reproductive health and rights needs of adolescent boys and young people, most of this data is collected through population based surveys and is not routinely collected. Also, either due to a lack of disaggregation or a lack of reporting, **the data does not cover the full range of SRHR needs of adolescent boys and young people, especially when it comes to STIs, CSE, and prevention and treatment of sub-fertility and infertility, sexual function and satisfaction, and common risk factors**” (A *brief situational analysis of adolescents boys and young men’s SRHR in East and Southern Africa*’ by Jonathan Hopkins – Sonke/UNFPA research underway).

# WHERE DO WE FIND BOYS AND YOUNG MEN IN THE SRHR SPACE?

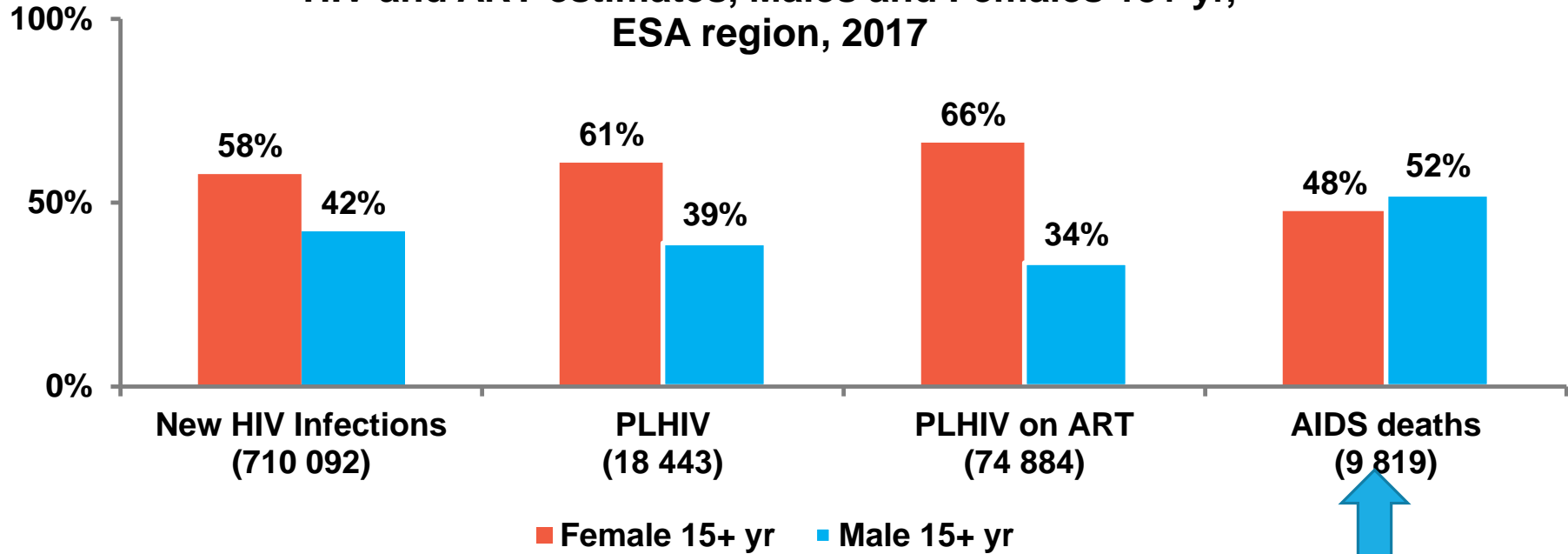
## Some presence

- Contraception
- Family planning
- Pre-natal care, safe delivery and post-natal care
- Reproductive tract infections, STIs
- **HIV (PrEP, condoms, VMMC, HTC, treatment)**
- Comprehensive sexuality education
- Male cancers
- Prevention and treatment of sub-fertility and infertility
- Sexual function and dysfunction

## Very little presence

- Supporting safe abortion and abortion care
- Harmful traditional practices (FGM, forced child marriage)

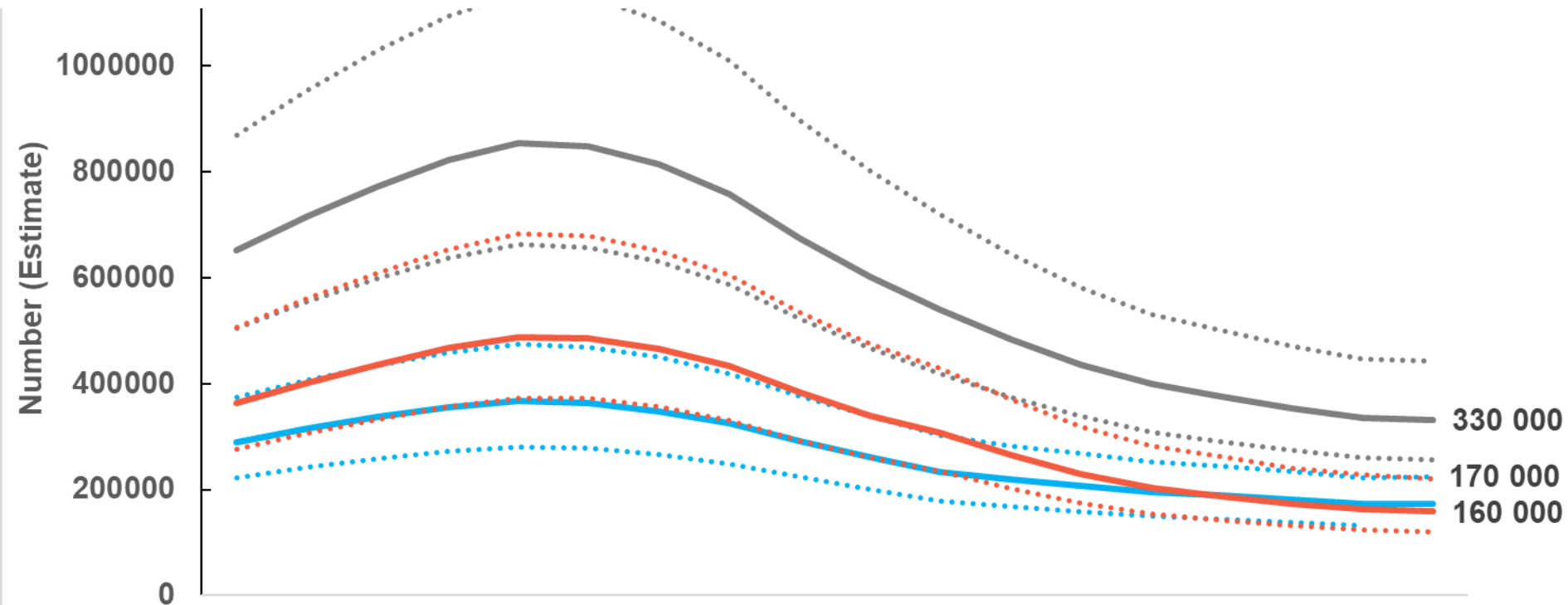
## HIV and ART estimates, Males and Females 15+ yr, ESA region, 2017



THERE ARE DIFFERENCES IN THE HIV EPIDEMICS AND ART COVERAGE  
AMONG MEN AND WOMEN IN THE ESA REGION OVERALL

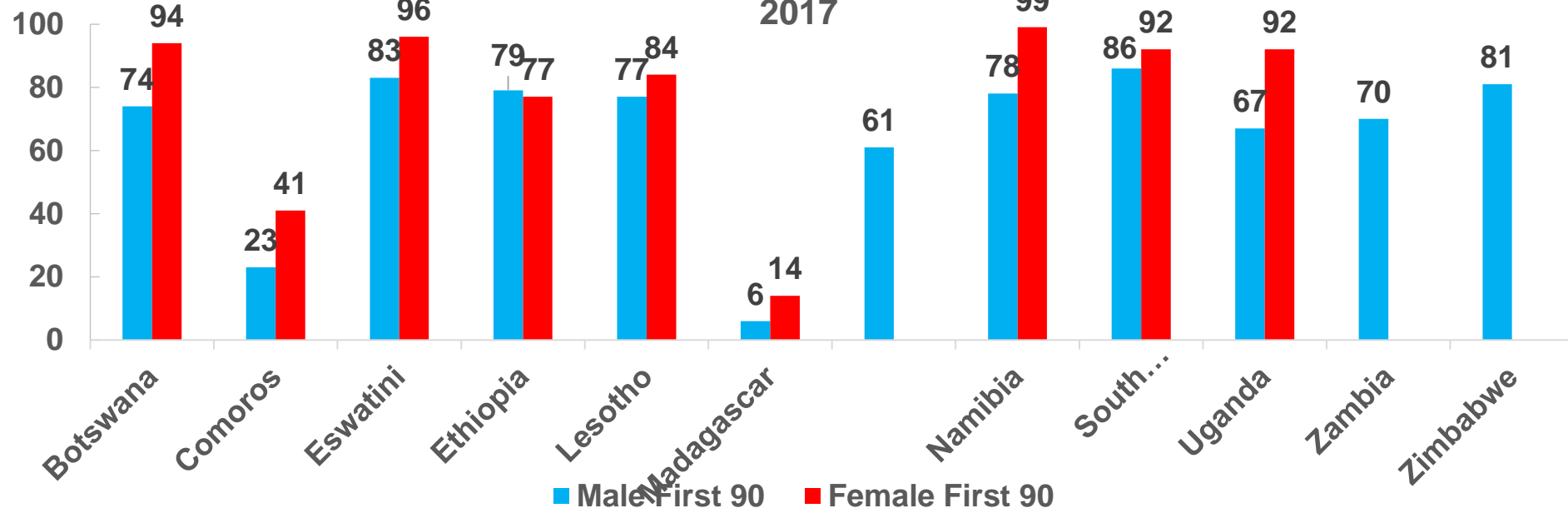
**TO GET TO ZERO  
WE MUST GET TO  
MEN**



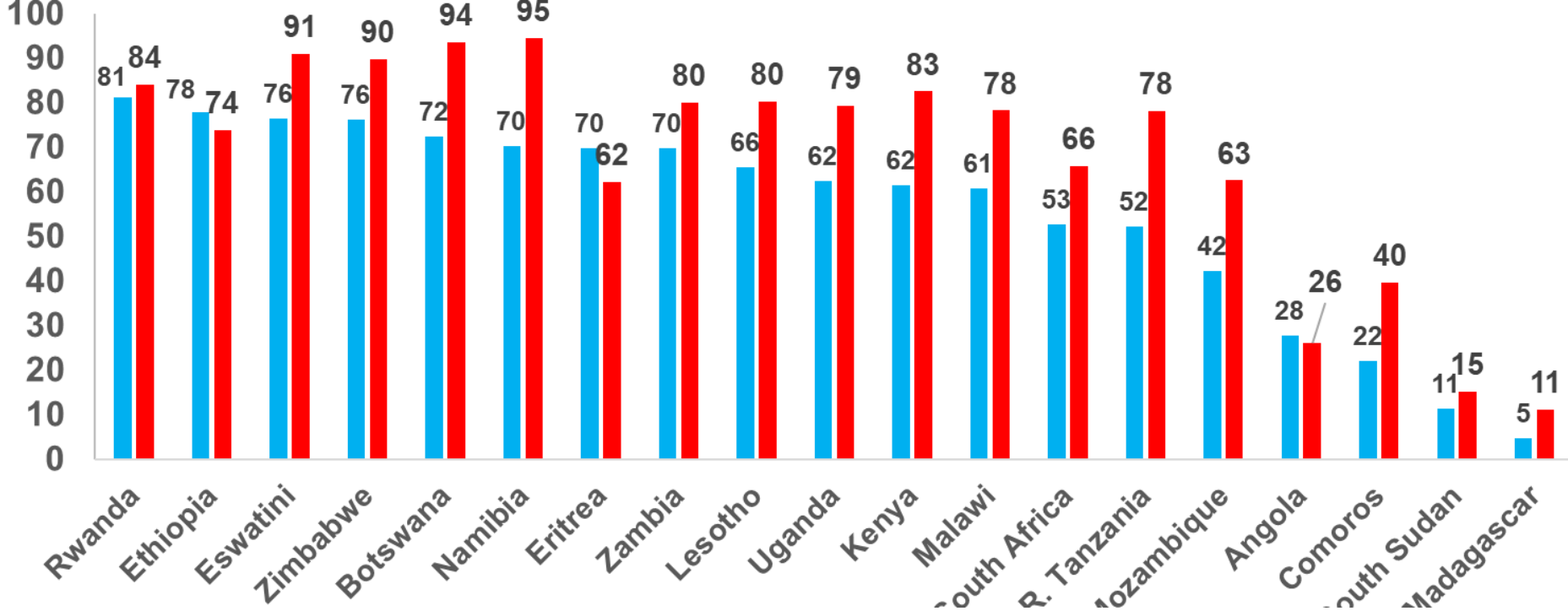


**MORE FEMALES ARE GETTING INFECTED... BUT 110 000 MORE MALES DIED AIDS-RELATED DEATHS THAN FEMALES**  
 AIDS-RELATED DEATHS DECLINED MORE RAPIDLY AMONG GIRLS AND WOMEN (48%) THAN AMONG BOYS AND MEN (26%) BETWEEN 2010 AND 2017, SO THAT NOW THE **MAJORITY (52%) OF ALL ADULT DEATHS WERE AMONG MALES 15+ IN 2017**

# Males and Females who are aware of their HIV status, Countries in ESA, 2017

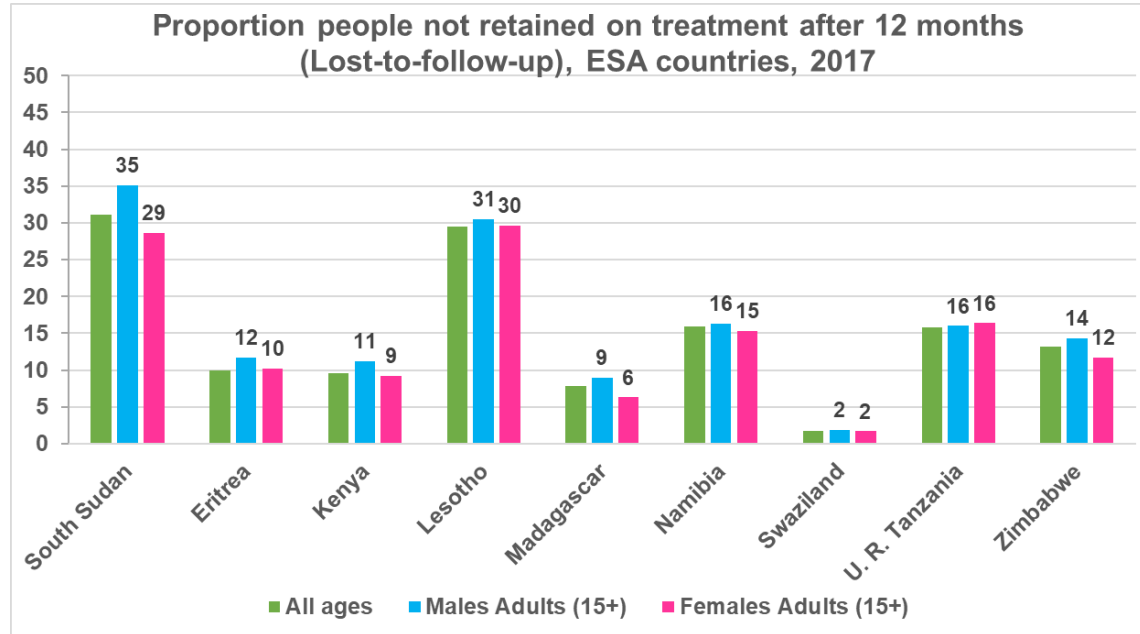


THE 1<sup>ST</sup> 90% IN ESA COUNTRIES: A **HIGHER PROPORTION OF WOMEN** THAN MEN ARE BEING TESTED AND ARE AWARE OF THEIR STATUS IN MOST COUNTRIES WITH AVAILABLE DATA

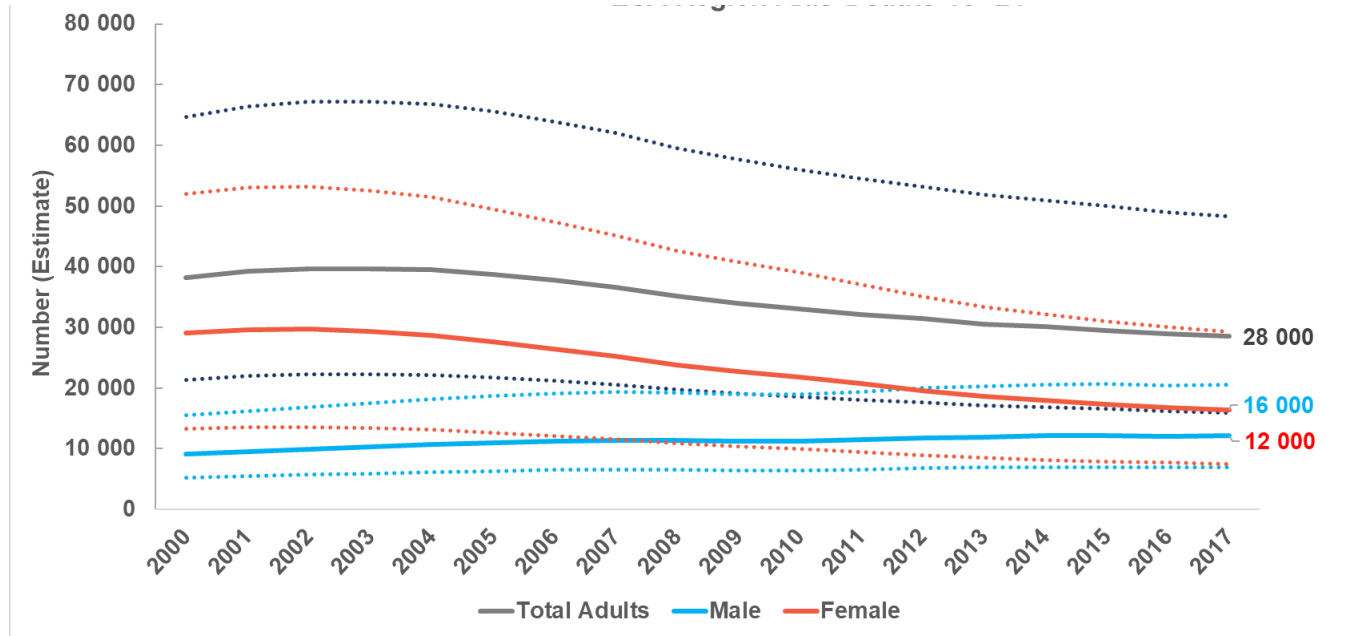


THE 2<sup>ND</sup> 81% IN ESA COUNTRIES: SIGNIFICANT DIFFERENCES EXIST IN ART COVERAGE AMONG WOMEN AND MEN. **MORE WOMEN THAN MEN ARE RECEIVING ANTIRETROVIRALS** IN MOST COUNTRIES ACROSS THE REGION (AVERAGES OF 68% AND 56%, RESPECTIVELY)

GENERALLY **MORE MEN ARE LOST TO TREATMENT FOLLOW UP** THAN WOMEN IN COUNTRIES IN ESA WITH AVAILABLE DATA



**AIDS-RELATED DEATHS AMONG YOUNG PEOPLE: THEY DECLINED FROM 2010 TO 2017 AMONG ADOLESCENT GIRLS AND YOUNG WOMEN (15-24 YEARS) WHILE THEY **INCREASED** AMONG ADOLESCENT BOYS AND YOUNG MEN**



# GENDER MATTERS IN THE HIV RESPONSE!

- Men are less likely to get tested than women
- Low male testing and treatment rates increase HIV transmission to female partners
- Men are not accessing antiretroviral treatment as much as women
- Men have a lower CD4 when they start treatment
- Men are more likely to interrupt treatment or be lost to follow-up
- Consequently, men are less likely to achieve viral load suppression – so that the preventive effect of treatment is not being realized
- Young people have low knowledge and significant risk behavior

# ANOTHER BLIND SPOT? INTERSECTION BETWEEN GBV AND HIV

The links between GBV and HIV are now well documented:

- Common risk factor for GBV and HIV – gender inequality being central
  - Women exposed to violence in childhood or who make early sexual debut (often coerced) - high risk of IPV or HIV
  - Men who have experienced or witnessed violence in childhood – harmful use of alcohol, concurrent partnerships and perpetration of VAW and increased risk of HIV infection
  - Condoning violence and social or gender norms and cultural practices legitimising male control over women – less access to health information

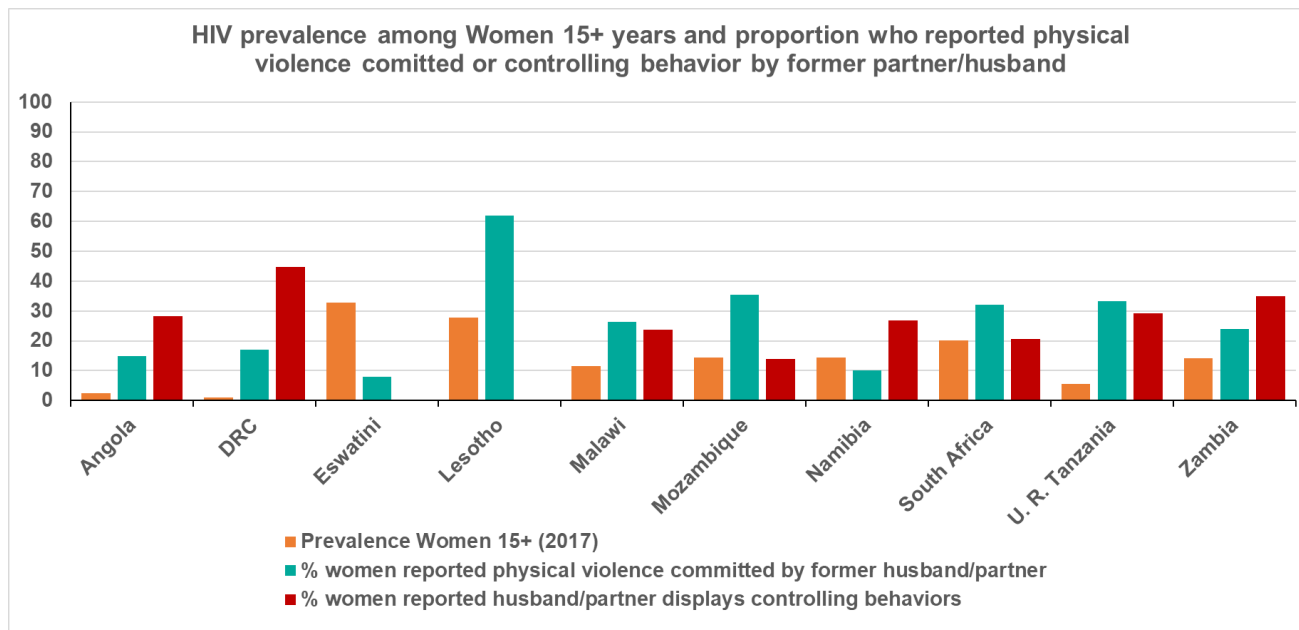
# ANOTHER BLIND SPOT? INTERSECTION BETWEEN GBV AND HIV

- VAW as an indirect factor for increased HIV and a barrier to uptake of HIV services
  - Women in abusive relationships are less likely to negotiate condom use and practice safe sex
  - Women victims of violence stigmatised – hence less likely to seek HIV services
  - Women living with HIV exposed to IPV – risk of no adherence to ART
- Sexual Violence as a direct risk factor for HIV - stranger rape; repeated rape in intimate partner relationship
- VAW as an outcome of HIV status – sterilisation; intimate partner violence



## GENDER NORMS AND INEQUALITY IN POWER RELATIONS EXACERBATE HIV TRANSMISSION: DESPITE 15/19 COUNTRIES IN ESA WITH DOMESTIC VIOLENCE AND SEXUAL OFFENCES LAWS, ON AVERAGE ABOUT A THIRD OF WOMEN REPORTED PHYSICAL VIOLENCE OR CONTROLLING BEHAVIOR FROM PARTNERS

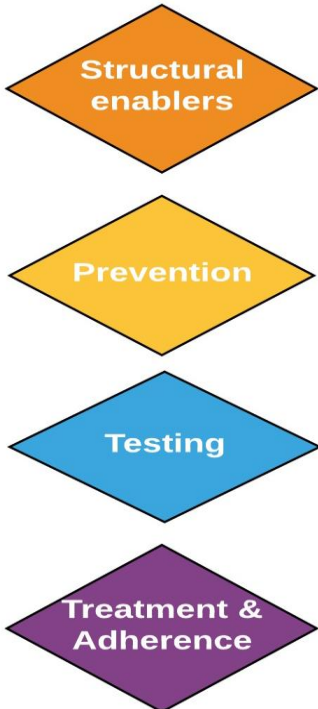
(SOURCE: PREPARED BY RST ESA SI HUB BASED ON GAM 2017, COUNTRY DHS AND WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN, 2005)



# WHAT CAN WE DO? MEN IN THE HIV RESPONSE

- Address the complex, multi-level factors contribute to men's low uptake for HIV-related services:
  - Some barriers are the product of prevailing gender norms – such as masculinity equating illness with weakness and men viewing clinical settings as female spaces – **focusing only on gender norms is an oversimplification.**
  - **Men lack the universal entry points to health systems** that women generally have which is compounded by a lack of extended opening hours and facility-based service delivery models which hinder access to men who work outside their communities during the day.
  - Health-system hindrances go beyond the service delivery level and a broader supportive enabling environment needs to be intentionally created, including laws, policies and health strategies.
  - In most countries, **men are largely missing from public health strategies** and there is therefore little mention of strategies or activities to improve their access to health and HIV services.
- Unaid, Promundo, Sonke and MenEngage Africa - Fast-Track Acceleration Plan provides the foundation for country-led movement towards ending new HIV infections & AIDS-related deaths among men. This plan builds on the UNAIDS Global Platform for Action on Men and HIV.

**Goal: By 2025 reduce new HIV infections & AIDS-related deaths among men & boys & decrease HIV vulnerability**

Strategies		Key components				
	Structural enablers	Improve access to health for men & boys and decrease vulnerability	Ensure required social, economic, legal and policy structures in place	Improve availability, accessibility & quality of health services for men & boys	Increase demand for, & utilisation of, health services among men & boys	Transform gender norms to improve gender equality and reduce GBV
	Prevention	Prevent HIV among men & boys	Provide combination prevention for men & boys	Strengthen national condom programmes	Promote VMMC uptake & use as entry point to other services	Offer PrEP to high-risk men & boys
	Testing	Diagnose more men & boys living with HIV	Expand targeted community based testing (e.g. mobile, work, home)	Implement guided HIV self-testing for high-risk men & boys	Apply routine partner counselling & testing (e.g. index testing & assisted partner notification)	
	Treatment & Adherence	Increase proportion of men & boys accessing & adhering to ART	Simplify linkage & access to treatment & care (e.g. extended hours, appointments, male corners, community distribution)	Utilise male-sensitive treatment & adherence messaging	Scale-up adherence and psychosocial support for men & boys (initial & ongoing)	

**Prevention**

90% men in high-prevalence settings access combination HIV prevention

90% men use condoms during sex with non-regular partner

90% of men aged 15–29 circumcised (in 14 high-priority countries)

# WHAT CAN WE DO? ADDRESSING THE LINKS BETWEEN GBV AND HIV

- Empowering women and girls through integrated multi-sectoral approaches (economic empowerment; cash transfers; property and inheritance laws)
- Transforming cultural and social norms related to gender (community education and mobilisation on norms change; communication campaigns, etc.) – Strong emphasis on gender transformation approaches targeting men and boys. Examples: Stepping Stones; SASA!; Sonke's One Man Can; Sonke's Tsimba  
<https://genderjustice.org.za/project/community-education-mobilisation/tsimba-treatment-as-prevention/>
- Integrating VAW and HIV services
- Promoting and implementing laws and policies to VAW, gender equality and HIV

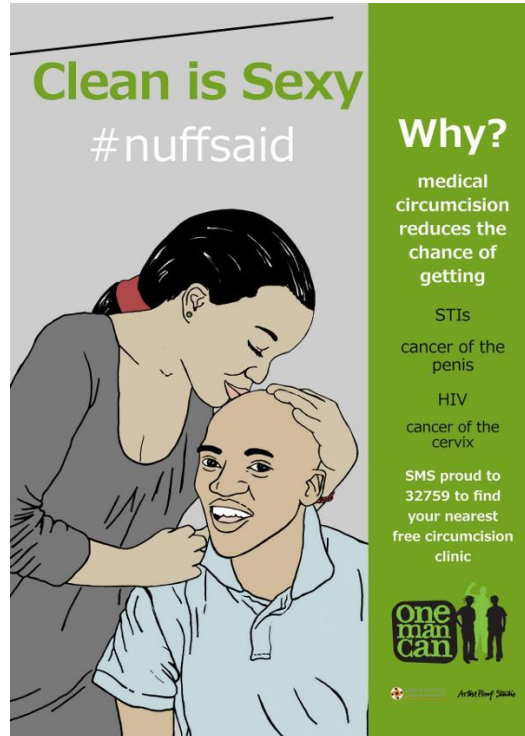
# INTEGRATING VAW AND HIV SERVICES

- Addressing violence in HIV-reduction counselling – at risk populations for instance
- Addressing violence in HIV testing and counselling, PMTCT, treatment and care services: identification of signs of violence; counselling; teaching partner communication skills, ensuring safety of victims, monitoring patients, etc.
- Providing comprehensive post-rape care including HIV PEP
- Addressing HIV in services for survivors of violence.

For more information: **WHO 16 Ideas for Addressing VAW in the context of the HIV epidemic – A programming tool**

[https://www.who.int/reproductivehealth/publications/violence/vaw\\_hiv\\_epidemic/en/](https://www.who.int/reproductivehealth/publications/violence/vaw_hiv_epidemic/en/)

# THANK YOU

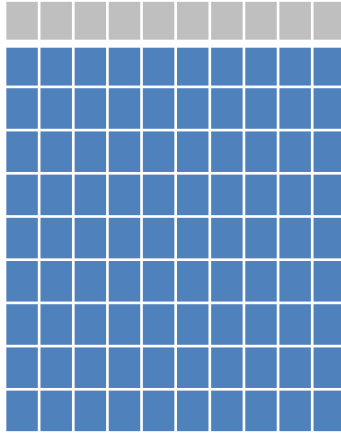


# **Delivering integrated SRHR services for marginalised youth in schools: Results from a Rural district in South Africa.**

Najma Shaikh, Ashraf Grimwood

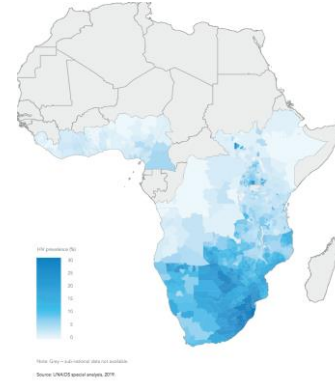


# What is the Problem



**90%** of  
2.8 million  
adolescent and  
children living  
with HIV globally  
reside in sub-  
Saharan Africa

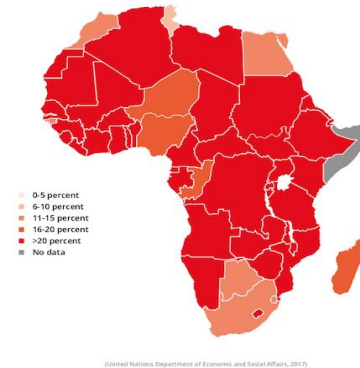
HIV prevalence



IN SUB-SAHARAN AFRICA,  
42% OF WOMEN LIVING IN  
URBAN AREAS AGED 15-24 HAD A  
PREGNANCY BEFORE THE AGE OF 18.

IN RURAL AREAS, MORE THAN 50%  
OF WOMEN AGED 15-24 HAD A  
PREGNANCY BEFORE THE AGE OF 18.

Unmet Contraceptive  
needs of YWG

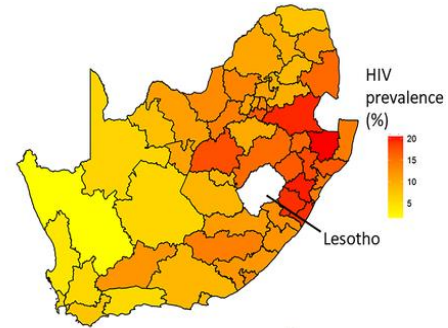




# South Africa



- SA is the epicenter of the global HIV pandemic and youth carry a disproportionate burden.
- 1200 young women acquire HIV per week
- Sexual Reproductive Health & Rights (SRH&R) services for adolescents have been identified as a key policy objective in South Africa.
- Whilst the Integrated School Health Policy(ISHP) is multi-sectoral and progressive in its approach, it is true to say that there remain implementation challenges.
- Needless to say it is exacerbated in the case of learners from multiple deprivation areas.
- We describe the outcomes of an innovative school-based SRHR service model that is closely linked to health, welfare and other services for a co-education high-school students in rural SA.



## Background & Demographics

iLembe, a rural district in South Africa, as the result of an IDP engagement

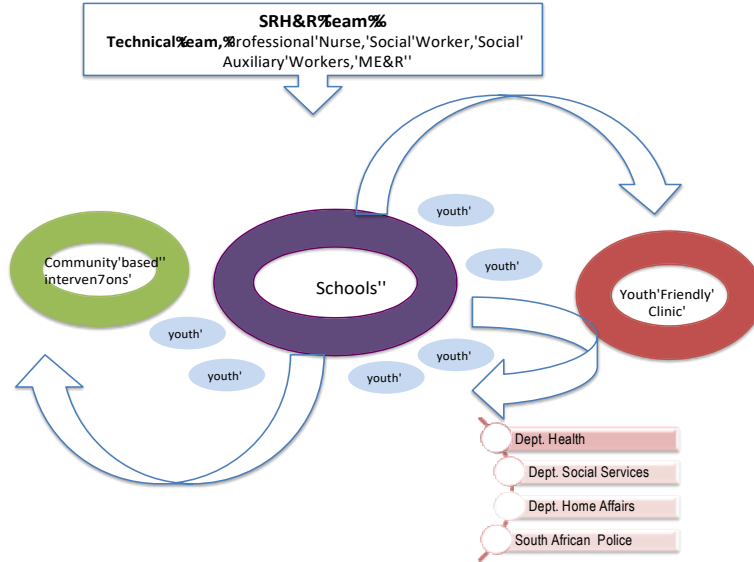
Population size	630464
HIV prevalence	38%
Teenage pregnancy	14%
Youth Unemployment	38%
Household Poverty Index	26%
Adolescent of total pop	42%
No Access to water	45%



# What we aimed to do

1. Prevention of new HIV, STI and unintended pregnancies through education, testing and referral.
2. Increase the uptake of health and welfare services by offering screening, referral for treatment, care & support.
3. Strengthen Community Support and inter-sectoral collaboration to improve referral pathways, the delivery of adolescent friendly SRHR & HIV health services.
4. Implement continuous improvement & sustainability measures to strengthen & mainstream the program





## Program Components

Structured SRHR

School-Based SRHR Prevention Services

Youth-friendly Health services

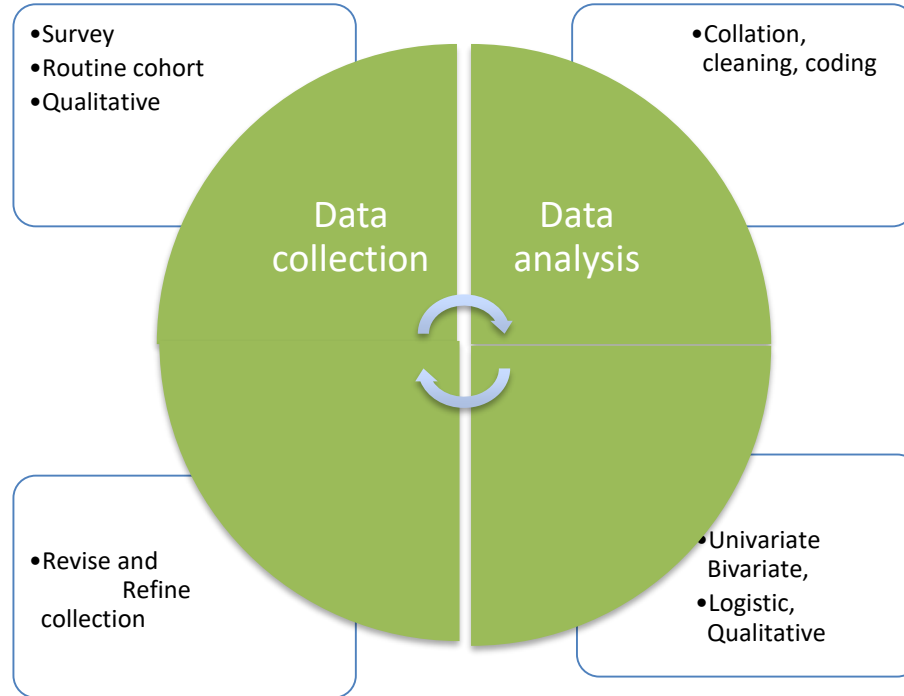
Referral pathways for Health & Social Protection

Holiday Programs, ART Adherence club

Community outreach and social mobilization



## How was this measured ?



## Context

Variable (n=1260)	Percentage(%), Mean
Female	48
Mean Age in years	16 yrs (Range 14-26)
Household Characteristics	
Grants: Pension	56
Child Support Grant	61
Other	20
Head of household : Female	70
Unemployment	40
Walk to school	53
Average Minutes To School (range)	46 min. (15-120)
Feel Unsafe Walking	28
Feel Tired Walking	42
No breakfast before school	60
Food insecure	33

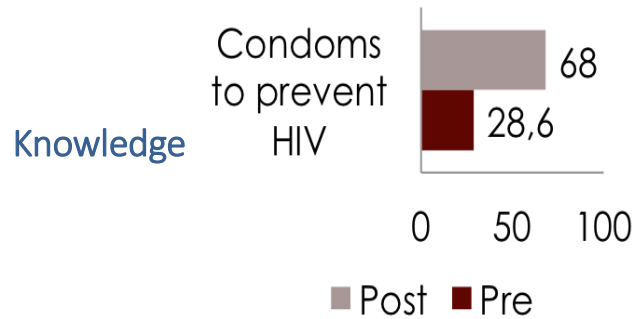


## Reported Sexual Behavior

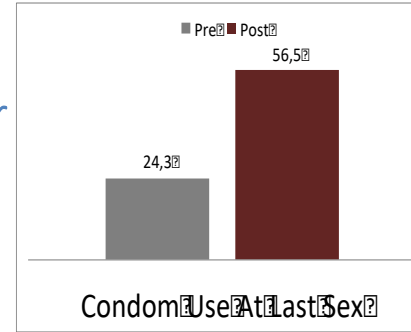
Indicator	Female n=604	Male n=655
Sexually active	35%	43% *
Mean Age of Sexual Debut in years	16.4 (95% CI: 16.1-16.8)	15.3 (95%CI: 14.9-15.6)*
First time I had sex, it was something I wanted	11.8%	36.8% *
Raped at first time I had sex	3.3%	1.7%*
Ever been pregnant	17%	-
Ever made Girl Pregnant	-	9.5%



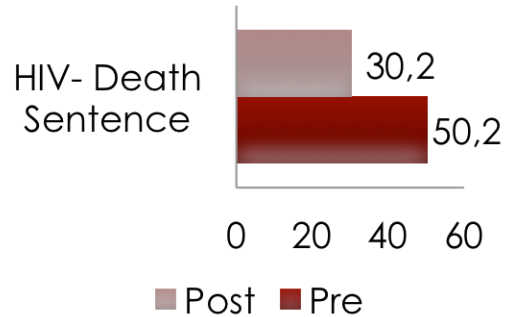
# Pre-& Post-Intervention Outcomes



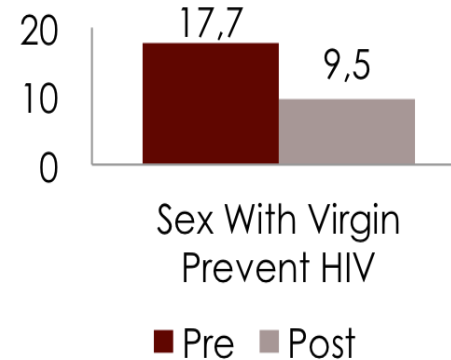
## Behavior



## Stigma



## Myths

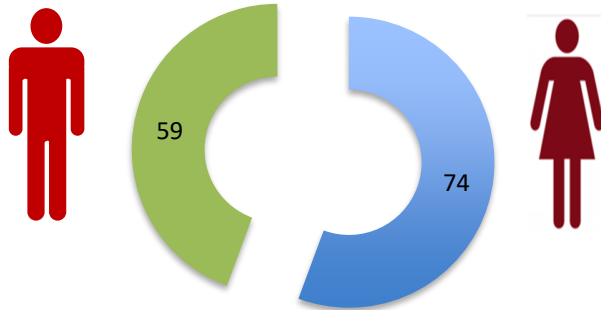


All with  $p < 0.005$

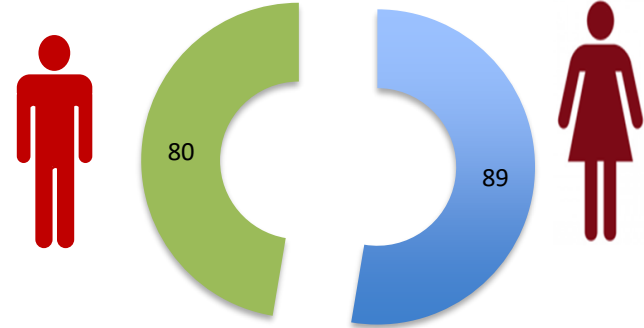


# Are you Willing to have an HIV test?

## Pre-Intervention

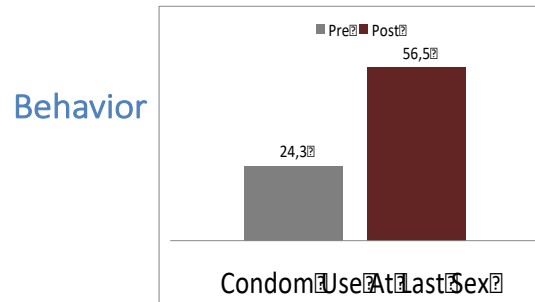
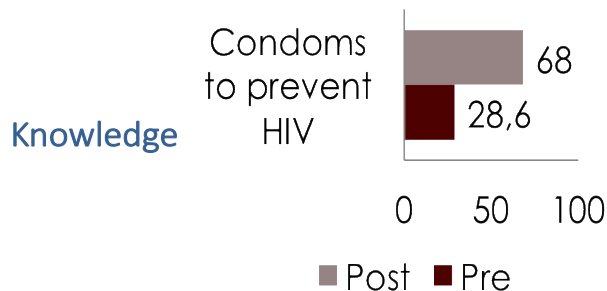


## Post-Intervention

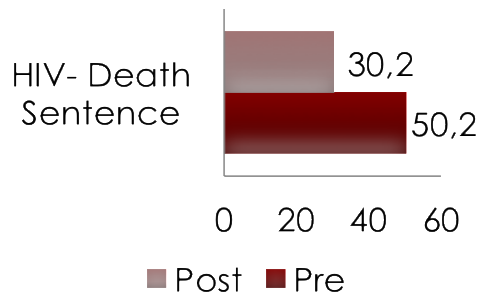


$p < 0.05$

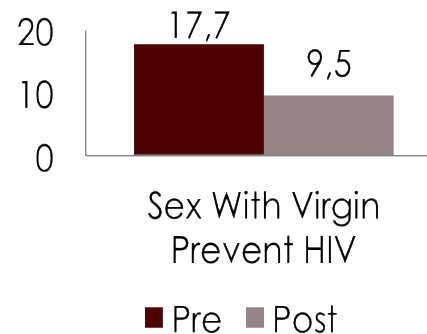
# Pre- & Post-Intervention Outcomes



## Stigma



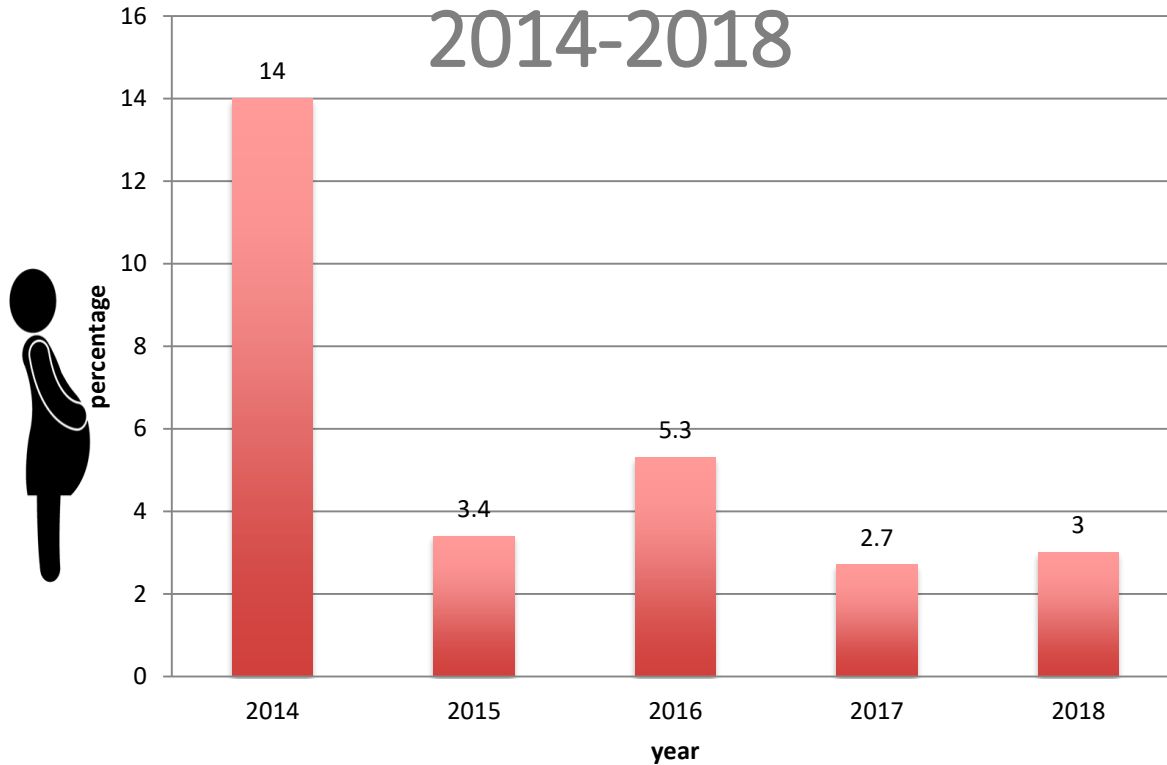
## Myths



All with  $p < 0.005$



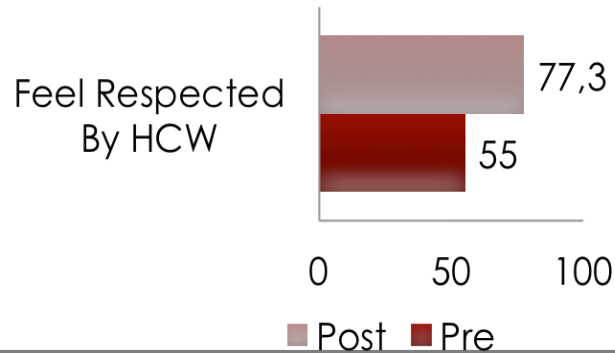
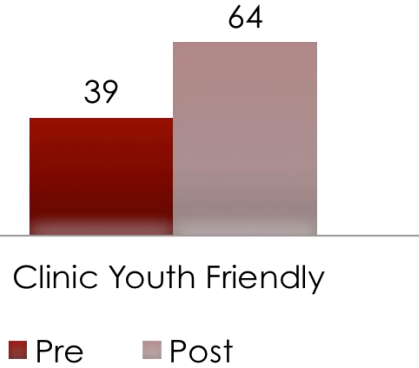
# Learner Pregnancy Rate- 2014-2018



# What are the factors that influence Condom use at last sexual Intercourse

Variable	Odds ratio	95% Confidence Interval	P value
Female	0.5	0.31- 0.99	0.05*
Age <15	0.44	0.24-0.80	0.01*
15-19	0.82	0.55-1.21	0.32
20+	Referent		—
Condoms a sure method to prevent HIV	0.44	0.08-2.22	0.32
Partner age No difference	Referent		
Younger	1.23	0.82-1.84	0.31
Older	0.66	0.47-0.99	0.05*
Attended clinic for Contraceptives	0.93	0.69-1.25	0.06
Reported Clinic was Youth Friendly	1.85	1.31-2.60	0.00*
One partner	Referent		
Multiple partners 2	1.08	0.74-1.57	0.69
3-5	0.58	0.32-1.05	0.07
>5	0.59	0.38-0.91	0.00*

# YFC Service Outcomes



All with  $p < 0.005$



"I can make wiser decisions"

"I have learnt that I can report if someone forced me to have sex."

"I'm able to protect myself and others."

"I have now tested for HIV."

"I am not afraid about HIV, adults make me so afraid."

"HIV is not a death sentence, I have hope."



# Interventions Leveraging off the School and Clinic as a Platform: Reaching Households

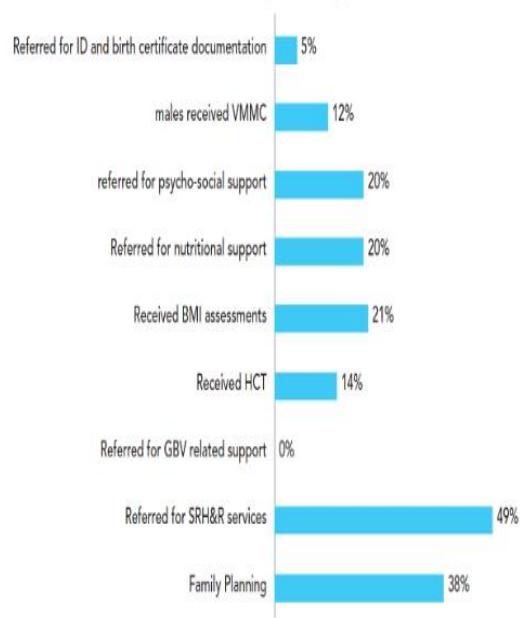
## Jamborees (WFP)

17- service providers enable access to services –private sector, state, CBOs and community structures

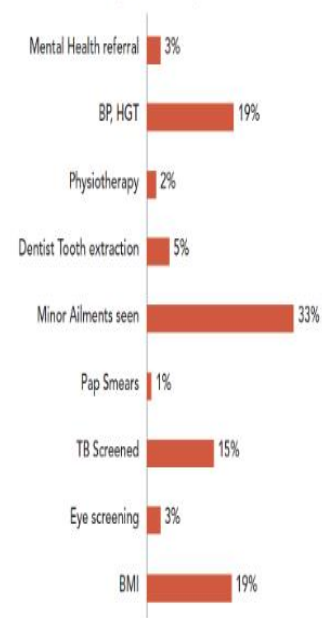
A cultural component of drama, debates is lead by learners on SRHR

14000 reached in recipients (0-97 years)

Adolescents by Service Uptake



Adults by Service Uptake





# Key Lessons

- Despite experiencing structural challenges such as nutritional, ses, service uptake increased, 95% self initiated- suggesting the unmet needs
- Sexual experience reported to occur in a context of sexual coercion for both male & females.
- Improvement in knowledge on HIV prevention, care and treatment although myths & stigma remain.
- Youth Friendly Services – important not only for service uptake but can play an important role in behavior change
- Leveraging off the program by strengthening inter-sectorial linkages community partnerships - improves, educates & enables service uptake by marginalized communities.
- Work within a National policy framework, co-create and co-deliver programs with the adolescent at the center of it.
- Engage with recipients in what they would like, how and where they would like the services



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Questions or feedback?  
Contact Rikke Le Kirkegaard ([rlkirkegaard@unicef.org](mailto:rlkirkegaard@unicef.org))



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