The Next Frontier

Stop New HIV Infections in Adolescent Girls and Young Women

By Janet Fleischman and Katey Peck[1]

U.S. leadership through the President's Emergency Plan for AIDS[1] Relief (PEPFAR) has driven remarkable progress in curbing the global AIDS epidemic, raising the possibility of epidemic control[2] in 10 African countries by 2020. **BUT THIS SUCCESS MASKS AREAS OF URGENT UNFINISHED BUSINESS THAT COULD DERAIL THIS MOMENTUM, NOTABLY PREVENTING HIV INFECTIONS IN ADOLESCENT GIRLS AND YOUNG WOMEN AGES 15–24 IN EAST AND SOUTHERN AFRICA**. Addressing the acute risks that these young women face presents unique challenges, especially in the current U.S. budgetary environment, but continued progress against HIV requires that this be a consistent and sustained U.S. priority. The benefits are clear and compelling: empowering these young women and providing access to services to protect themselves from HIV enables them to be healthy and to thrive, which contributes to healthier, more stable and prosperous families, communities, and societies.

ADOLESCENT GIRLS AND YOUNG WOMEN FACE SIGNIFICANTLY HIGHER HIV RISK THAN MALES THEIR AGE. That, combined with a youth population that has doubled since the start of the epidemic, leads to an inescapable conclusion: if new HIV infections among girls and young women are not greatly reduced, PEPFAR's enormous investments to achieve an AIDS-free generation are at risk, as is the global response. Focusing on adolescent girls and young women, while also systematically engaging their male partners, provides a critical opportunity to interrupt the cycle of HIV transmission.[3]

In response to these stark realities, in late 2014 PEPFAR launched DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe), a public-private partnership to reduce HIV in adolescent girls and young women in 10 countries. DREAMS holds notable promise in confronting this critical next frontier in fighting HIV, but faces challenges in demonstrating short-term impact on social and economic realities that directly or indirectly contribute to HIV risk for these young women.

Fast Facts on HIV in Girls and Young Women[4]

NEARLY 7,500 ADOLESCENT GIRLS AND YOUNG WOMEN ARE INFECTED WITH HIV EVERY WEEK, representing almost 75 percent of infections among adolescents and 25 percent of all new infections in sub-Saharan Africa.

COMPARED TO YOUNG MEN, the rate of new HIV infections among young women is 5 times greater in Zimbabwe, 8 times greater in Malawi, and 14 times greater in Zambia. Men catch up in later years.

GIRLS WHO EXPERIENCE VIOLENCE ARE UP TO THREE TIMES MORE LIKELY TO BE INFECTED WITH HIV or with a sexually transmitted disease (STD), and surveys in 11 countries found on average that one in three young women reported that their first sexual experience was forced.

MORE THAN HALF OF MEN UNDER 35 DO NOT KNOW THEIR HIV STATUS and are not on treatment, which is fueling the epidemic in 15- to 24-year-old girls and young women.

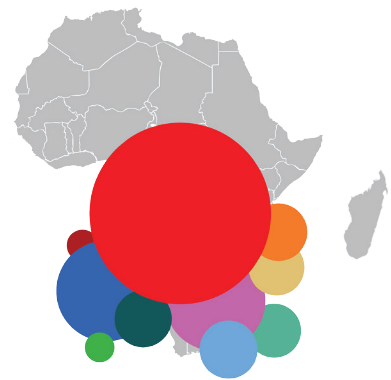
CSIS | CENTER FOR STRATEGIC & INTERNATIONAL STUDIES | GLOBAL HEALTH POLICY CENTER

CSIS Global Health Policy Center HIV Working Group

July 2017

High Burden of HIV in Young Women in Southern and Eastern Africa

- Young women
- Sex work
- People who inject drugs
- Gay men and other men who have sex with men
- Migrants
- Prisoners
- Displaced
- Pregnant women
- 50+
- Disabled



Source: UNAIDS, "The Gap Report," 2014, http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf.

Background: The Toll of HIV on Young Women

Data from east and southern Africa, where the world's HIV burden is greatest, **HIGHLIGHT THE UNRELENTING TOLL THAT THE EPIDEMIC CONTINUES TO TAKE ON YOUNG WOMEN: WITH SOME 7,500 NEW INFECTIONS EVERY WEEK**, adolescent girls and young women constitute 75 percent of HIV infections among adolescents in sub-Saharan Africa. This disproportionate impact stems from social, cultural, and economic factors that fuel discrimination and violence against girls and young women. Most new HIV infections in this population occur in geographic "hot spots" (areas with high rates of new infections) and are connected to gender-based violence and rape,[5] barriers to health services and education, poverty and lack of access to resources, and harmful cultural practices such as child marriage.[6]

Higher infection rates among young women are due to a pattern of transmission in which older men (23–35 years old) transmit the virus to adolescent girls and young women (16–23). Later, these young women infect their longer-term partners (young men 24–29) who are not yet living with HIV. Interrupting this cycle is essential to control the epidemic's trajectory.[7] These patterns increase risk of transmission, since half of the men under age 35 do not know their HIV status and are not on treatment, even though HIV treatment reduces transmission by decreasing the amount of virus in the body.[8] This underscores the need to reach these male partners with HIV testing and condom availability, linking men living with HIV to treatment and linking uninfected men to voluntary medical male circumcision (VMMC), a proven method of HIV prevention.[9]

The immediate challenge is to strategically address the needs of young women who have fallen through the cracks. Historical HIV prevention strategies such as A-B-C (abstinence, be faithful, use condoms) are too often not within a girl's power to control, and no single approach has proven effective in reducing their vulnerability to HIV. Ensuring that girls have the necessary tools and family and community support to protect themselves, access education, and be economically productive improves their chances of staying HIV free.

The Impact of Rising Youth Populations on the Epidemic: The Youth Bulge

Changing population dynamics contribute to the urgency of the HIV epidemic and necessitate a far greater focus on meeting the needs of young people. **THE YOUTH POPULATION AGES 15–24 HAS NEARLY DOUBLED IN SUB-SAHARAN AFRICA SINCE 1990 AND IS PREDICTED TO INCREASE BY AN ADDITIONAL 30 PERCENT BY 2030.**[10] This is due in large part to the success of U.S. leadership and investments in reducing early childhood deaths in sub-Saharan Africa, through HIV programs that have prevented mother-to-child transmission and increased treatment for pediatric HIV, as well as U.S. support for vaccinations and malaria programs. Another contributing factor to the youth budge involves high unmet need for family planning, which contributes to high fertility rates in many countries hard hit by the epidemic. With millions more young people entering adolescence and adulthood—a time of increased vulnerability for HIV—these demographic trends mean that there is a limited window to reduce new HIV infections before important gains, stemming from the success of PEPFAR and other global investments, are lost.

U.S. Leadership Generates Other Investments

U.S. leadership has been instrumental in the fight against HIV, backed by its unique ability to mobilize diplomatic, scientific, community, faith-based, and financial commitments. Still, the alarmingly high levels of infection in adolescent girls and young women prompted PEPFAR to launch DREAMS on World AIDS Day, December 1, 2014. DREAMS is a public-private partnership that includes the Bill & Melinda Gates Foundation, Girl Effect, Gilead Sciences, Johnson & Johnson, and ViiV Healthcare, and is active in 10 high-burden countries in east and southern Africa that represent half of new HIV infections.[11] Its ambitious goal is to reduce HIV infections among 15- to 24-year-olds in selected geographic "hot spots" by 40 percent by the end of 2017.

This $385 million effort[12] operates through a "core package" of evidence-based interventions with three main components: 1) empowering adolescent girls and young women to reduce risks and access services (HIV testing and counseling; post-violence care; relevant skills in finance management, health, social networks, and personal goal setting; condom availability; increased contraceptive method mix); 2) strengthening the family (parenting/caregiver programs, educational subsidies, socioeconomic approaches); and 3) mobilizing the community (school-based HIV and violence prevention; community mobilization and support for empowerment).

The program seeks to reach at-risk young girls and women ages 10–24, many of whom are out of school and married before the age of 18. At the community level, the DREAMS program is also engaging faith-based organizations and community-based groups. DREAMS includes an $85 million Innovation Challenge Fund that brings in additional private-sector resources and local partners to spur new approaches. In addition, PEPFAR is providing supplemental funding to reach the male partners and link them to HIV services through voluntary medical male circumcision, condoms, and HIV testing.

PEPFAR'S LEADERSHIP IN LAUNCHING DREAMS IS ALREADY GENERATING ENGAGEMENT BY OTHER DONORS, MULTILATERAL INSTITUTIONS, AND NATIONAL GOVERNMENTS, which are developing strategies and national programs that build on the DREAMS model. For example, the Global Fund to Fight AIDS, Tuberculosis and Malaria is providing $55 million over three years in 13 countries. The government of South Africa has launched SheConquers, which is expanding a DREAMS-like approach to meeting the needs of young women across the country, and other governments are developing new strategies and policies. UNAIDS and PEPFAR also lead a strategy called "Start Free. Stay Free. AIDS Free" that includes targets for reducing HIV infections in adolescent girls and young women by 2020.

Next Steps

The Trump administration and Congress should make HIV prevention among adolescent girls and young women a top priority in U.S. HIV strategy, which also requires reaching their male partners with HIV services. The approach developed by DREAMS to address the needs of this population is the most promising vehicle for moving this agenda forward and should remain a vibrant, well-funded, and politically supported initiative. To increase impact and effectiveness, certain areas will need to be addressed as the program moves forward, including:

1. **Strengthen measurement and documentation** of what works and systems to track progress, to ensure accountability.
2. **Generate greater leadership, capacity, and implementation of programs** by national governments, community engagement, and private-sector support to ensure scale and sustainability.
3. **Increase approaches to reach men and boys** with HIV testing, treatment, and VMMC services, and engage them in the broader efforts to empower adolescent girls and young women and reduce new infections in their communities.
4. **Build on existing U.S. investments in global health** and development and strategic partnerships with other bilateral and multilateral donors to accelerate an integrated approach to addressing the needs and unleashing the potential of adolescent girls and young women.

This is a moment of great opportunity as well as challenge; it requires continued focus on and pressure for results, combined with realism and patience about the timeline needed to achieve such ambitious and critical outcomes.

Notes

1. Janet Fleischman is a senior associate of the CSIS Global Health Policy Center; Katey Peck is a program manager and research associate at the CSIS Global Health Policy Center. This paper grew out of a CSIS Global Health Policy Center working group on HIV and adolescent girls/young women, whose members include the following individuals (organizations listed for identification purposes only): Isolde Birdthistle, London School of Hygiene & Tropical Medicine; Sara Bowsky, Palladium; Lisa Carty, UNAIDS; Gina Dallabetta, the Bill & Melinda Gates Foundation; Nina Hasen, Population Services International; Jen Kates, Kaiser Family Foundation; Pete McDermott, Fajara Associates; Julie Pulerwitz, Population Council; Anita Smith, Children's AIDS Fund International; Shepherd Smith, Institute for Youth Development.

2. According to PEPFAR, epidemic control refers to the point at which new HIV infections have decreased and fall below the number of AIDS-related deaths. See PEPFAR, "PEPFAR 3.0: Controlling the Epidemic and Delivering on an AIDS-free Generation," https://www.pepfar.gov/documents/organization/234744.pdf.

3. Recent U.S.-funded Population HIV/AIDS Impact Assessment (PHIA) data out of the first 3 of 13 PEPFAR-supported countries largely in sub-Saharan Africa show that this cohort is less likely to know their HIV status and thus be on life-saving treatment.

4. PEPFAR, *Preventing HIV in Adolescent Girls and Young Women: Guidance for PEPFAR Country Teams on the DREAMS Partnership* (Washington, DC: PEPFAR, February 2015); UNAIDS, *The Gap Report* (Geneva: UNAIDS, July 2014), http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf; PEPFAR, "Optimizing Results in PEPFAR Every Partner Every Site Driving Towards Increased Impact," PEPFAR 2017 Annual Report to Congress, March 29, 2017, 11–12, https://www.pepfar.gov/documents/organization/267809.pdf; Amb. Deborah Birx, "Ending the HIV Epidemic through data use and targeted interventions to reach adolescent girls and young women" (presentation at the Atlanta Summit on Global Health, May 8, 2017).

5. According to the Violence against Children Surveys (VACS) in several DREAMS countries, between 22 and 54 percent of young women ages 13–24 reported that their first sex was forced or coerced; between 8.5 and 49 percent of young women reported to have experienced sexual violence in the past 12 months. See Together for Girls, "Violence Against Children Surveys," various dates, http://www.togetherforgirls.org/knowledge-center/violence-against-children-surveys/.

6. Married adolescents have higher HIV rates than their unmarried, sexually active peers. See Girls Not Brides, "Four facts you need to know: child marriage and HIV," July 14, 2016, http://www.girlsnotbrides.org/child-marriage-and-hiv/.

7. Birx, "Ending the HIV Epidemic through data use and targeted interventions to reach adolescent girls and young women."

8. HIV treatment as prevention refers to the impact of antiretroviral therapy (ART) on someone living with HIV, since these medications reduce the amount of the virus in the body and keeps the immune system functioning. This reduces transmission through sex, needle sharing, and from mother-to-child during pregnancy and childbirth. See CDC, "HIV Treatment as Prevention," https://www.cdc.gov/hiv/risk/art/.

9. VMMC provides life-long, partial protection against HIV. WHO, "Voluntary medical male circumcision for HIV prevention: fact sheet," July 2012, http://www.who.int/hiv/topics/malecircumcision/fact_sheet/en/.

10. Birx, "Optimizing Results in PEPFAR Every Partner Every Site Driving Towards Increased Impact"; PEPFAR, *Preventing HIV in Adolescent Girls and Young Women.*

11. The 10 countries are Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe. In this next year, five additional PEPFAR countries will receive funding for "DREAMS-like" activities, with a focus on risk-avoidance in 10- to 14-year-old girls: Botswana, Côte D'Ivoire, Haiti, Namibia, and Rwanda.

12. This figure rises to $500 million when including voluntary medical male circumcision and other programs to reach the male partners.