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Exchange

ON HIV AND AIDS, SEXUALITY AND GENDER

Youth-friendly sexual and reproductive health services for young positives

By Petronella Mugoni

There is an urgent need for governments to adequately address the sexual and reproductive health needs of adolescents and young adults living with HIV. In the absence of strengthened measures to meet the needs of the group that accounts for a significant number of people living with HIV in the global south, governments, especially those in southern Africa, are unlikely to meet their Millennium Development Declaration and SADC Protocol on Gender and Development targets.

The SADC Protocol consolidates all the important SADC policies and programmes dealing with gender equity and the empowerment of women. It commits governments in the region to work towards ensuring the advancement and emancipation of women through policies, laws, programmes and projects, which all Member States have to implement in order to realise 28 targets by 2015.

Meeting Millennium Development Goals 4, 5 and 6 calls for specific focus on ensuring that relevant and targeted sexual and reproductive health policies and services that respond to the particular needs of young people, particularly those living with HIV, are in place. Goal 4 commits signatory states to reducing child mortality rates by two thirds. Governments also committed themselves to reducing the maternal mortality ratio by three quarters between 1990 and 2015 to meet Goal 5. Goal 6 is closely linked to Goals 4 and 5 and requires governments to halt or begin to reverse the spread of HIV and AIDS, malaria and other diseases by 2015.

After years of efforts to address the HIV epidemic, it is imperative that the issue of young people living with HIV, including those born with HIV, becomes a programming and advocacy priority. Not only are young people living with HIV trying to navigate life with HIV, but they are experiencing the same issues that other adolescents and young adults face. Young people living with HIV have unique health and psychosocial support needs that should be addressed.

The development of enabling national youth-friendly sexual and reproductive health (SRH) policies and services is a first step to ensuring that the particular psychological and biomedical needs of young positives are met. The need for youth-friendly SRH services is supported by concerns raised earlier this year at a high level consultation co-hosted by UNAIDS Executive Director Michel Sidibe, UN Women Executive

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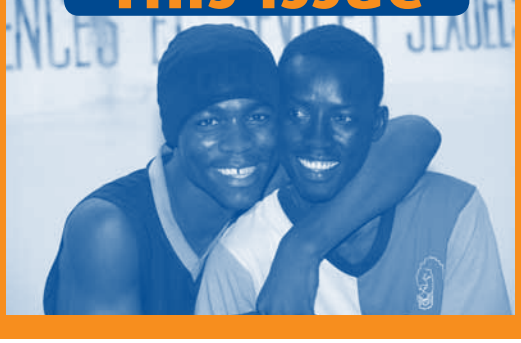

Editorial

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Dignified approaches to handling young positives

The sexual behaviour of HIV-positive young people, irrespective of how they got infected, is not much different from that of their uninfected peers. Because of highly active antiretroviral treatment (HAART), an increasing number of HIV-infected children are surviving into adolescence and are becoming sexually active. They therefore need sexual and reproductive health services.

In many countries, however, Young people living with HIV (YPLHIV) face confidentiality breaches and discriminatory attitudes when accessing healthcare and support services. Parental consent is required in many countries for accessing age-appropriate information and services for sexual and reproductive health, (including prevention, treatment, care and support services).

The Global Consultation on Strengthening the Health Sector Response to Care, Support, Treatment and Prevention for Young People Living with HIV, acknowledges that "lack of psychosocial support" is one of the eight priority challenges for YPLHIV to which the health sector should respond. The report from the consultation notes that the "...development of guidance to address the psychosocial needs of young people living with HIV is long overdue." Once this is developed, it can be adapted at country level as a training manual, in order to create or strengthen staff capacity to provide psychosocial support for young people through HIV care facilities.

Confidentiality is critical for young people living with HIV. To feel comfortable accessing services, they need to know that their HIV status will remain private, and may need support in deciding how to disclose their status to families and partners and the reassurance about their ability to become parents later in life. Actively engaging and supporting young people living with HIV in the global, regional and country HIV responses, is key to ensuring that we reverse the spread of the virus, realise human rights and achieve universal access targets.

Health-care providers and policymakers must respond to the unique needs of YPLHIV, needs that differ in various ways from those of children not infected with HIV or adults. Scale-up of youth-friendly and population-specific prevention, treatment and care interventions, including psychosocial support and sexuality counselling, should be delivered through a Positive, Dignity, Health and Prevention framework. This framework, developed by the Global Network of People Living with HIV (GNP+) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) is a rights-based approach that supports the health and wellbeing of and leadership of people living with HIV. There is consensus that much has been done to address the needs of young people living with HIV. Yet so much more effort is needed to tailor appropriate responses accordingly but this time through the lens of Positive Health, Dignity and Prevention. ■

Director Michelle Bachelet and UNFPA Executive Director Babatunde Osotimehin at the 55th Session on the Commission on the Status of Women.

> *After years of efforts to address the HIV epidemic, it is imperative that the issue of young people living with HIV, including those born with HIV, becomes a programming and advocacy priority.*

During this session, violations of the sexual and reproductive health rights of young women and girls living with HIV were reported. For instance, HIV positive women reported being advised not to engage in sexual relationships and reprimanded when they sought healthcare during pregnancy. Women who want to access prevention of mother-to-child transmission (PMTCT) and safe delivery services also faced obstacles. Such violations perpetuate stigma and discrimination directed at people living with HIV and discourage young positives from accessing services that are necessary for their survival. This is worrying because there are indications that in southern Africa, comprehensive knowledge about HIV and AIDS is generally low among the 15- to 24-year age group (World Health Organization, 2010).

Southern Africa is characterised by shortages of dedicated youth-friendly clinics where young people are encouraged to access and use contraceptives, including condoms, as well as screening for, and treatment of STIs. The exceptions are Malawi and South Africa. The two countries have done well in scaling up the number of dedicated clinics for the youth and in implementing strategies to enhance uptake of these services.

South African college girls during a Tshwane University of Technology sexual and reproductive health (SRH) activity in Pretoria. Individuals in this photo are not necessarily living with HIV. *[Photo by SAfAIDS].*

Shortages of dedicated youth-friendly clinics translate into low access to HIV prevention and treatment information; low adherence to antiretroviral therapy (ART); low use of contraceptives, including condoms among young unmarried positives and low uptake of PMTCT services. All these factors contribute to high rates of HIV transmission, greater incidences of treatment-resistant strains of HIV, unwanted pregnancy and higher incidence of perinatal transmission of HIV.

Young people's (and young positive's) ability to access sexual and reproductive health and rights is hampered by a variety of issues, which in turn challenge young people's ability to prevent (re)infection with HIV, and from transmitting HIV to their unborn babies, even when they know the risks involved. Among the issues that can be addressed by the development of national youth-friendly reproductive health policies and centres are:

1. Stigma and discrimination towards people living with HIV, which is still rife in southern African countries. While both men and women experience stigma and discrimination, such attitudes are stronger towards women and girls who are often seen as 'vectors' of the disease. These perceptions present great barriers to young women living with HIV disclosing their status to an intimate partner for fear of abandonment and violence. Lack of disclosure can lead to low and inconsistent use of condoms during sex.
2. Stigma and discrimination also lead to poor provision of services and has underpinned gross violations of the sexual and reproductive health rights of pregnant HIV positive women as seen in cases of forced sterilisation of pregnant women living with HIV in Namibia and South Africa. In 2009, 12 Namibian women sued their government after they were sterilised in public hospitals without their consent because they were HIV positive. Along with sterilisation, the women also faced related violations, including being denied health services, hostile attitudes from health staff, stigma from hospital staff and breaches of confidentiality.

Facts about young people living with HIV

- Each day, nearly 6,000 young people between the ages of 15 and 24 years become infected with HIV. Yet only a fraction of them know they are infected.
- Forty-five per cent of new transmissions take place among young people and there are currently an estimated 5.4 million young people living with HIV worldwide. Fifty-nine per cent are females and 41 per cent male.
- There are 3.2 million young people living with HIV in sub-Saharan Africa.
- There are two million children under 15 years living with HIV. Ninety per cent of them acquired HIV through vertical transmission, also known as mother-to-child transmission.
- Educating young people about HIV, and teaching them skills in negotiation, conflict resolution, critical thinking, decision-making and communication, improves their self-confidence and ability to make informed choices, such as postponing sex until they are mature enough to protect themselves from HIV, other STIs and unwanted pregnancies.
- In areas where the spread of HIV is subsiding or even declining, it is primarily because young men and women are being given the tools and the incentives to adopt safe behaviours.
- Young people living with HIV enter into relationships, have sex and bear children. They have unique sexual and reproductive health needs and hopes.
- Youth-friendly services offer treatment for STIs and access to condoms and help young people become responsible for their sexual and reproductive health.
- Safe environments for disclosure are the bedrock of an effective and expanded response. Laws that criminalise HIV transmission or require disclosure for school registration disempower young people.
- YPLHIV want to know and feel that essentially they are like any of their peers, who want to have productive lives, get a job, start a family as they desire and realise their dreams by maximising their skills and potential.
- HIV Young Leaders Fund (HYLF) is a community driven funding mechanism aimed at enabling new leadership in the HIV response among young people most affected by HIV.

Young college girls in an SRH information tent at Tshwane University of Technology activity in Pretoria. Individuals in this photo are not necessarily living with HIV. *[Photo by SAfAIDS].*

Cases of forced sterilisation in South Africa began to emerge in 2010 when news of the litigation in Namibia became more widespread. Here too, sterilisation was conducted in public hospitals, with women being compelled to sign consent forms when they were at their most vulnerable — during labour or shortly after a caesarean section. From a legal standpoint, forced sterilisation, or any procedure a woman undergoes without her informed consent, violates her right to control her own body and to make her own reproductive decisions. This is a basic human right, and a sexual and reproductive health right too.

3. The fact that HIV is predominantly transmitted via heterosexual sex in southern Africa contributes to assumptions that young positives must be sexually promiscuous to have contracted the virus. These assumptions, beliefs and perceptions may explain the negative attitudes of health workers towards young positives, which are played out in the way they are served. It may be necessary for governments to, among others, develop policies and programmes for training and sensitising health workers on the service needs of young positives.

   Zimbabwe is yet to establish separate youth-friendly SRH centres, and services for the youth are ostensibly provided by nursing staff in general hospitals and clinics. The nurses have been specifically trained to provide youth-friendly services. In the absence of separate and dedicated services, however, studies in the country have shown evidence of systematic denial of sexual and reproductive service and information to youth, particularly those in the 16- to 17-year age group, who, according to the law, are minors. Access is further hampered by unreceptive attitudes towards adolescents seeking such services, particularly those who are unmarried or living in rural areas (Centre for Reproductive Rights, 2002).

4. Young people themselves indicate that the most effective youth-friendly services are those which provide relevant, non-judgemental STI, pregnancy and HIV information and services, including contraceptives, which are well integrated into the activities and curriculum of educational institutions. Services, which should be available on weekends also, when clients are not in school or at work should incorporate other entertainment activities so as to be appealing and fun for young people. It is important to young people that services are easily accessible, and that they focus on prevention of HIV, sexually-transmitted infections and pregnancy, as opposed to mitigation. Services need to be confidential, with emphasis on non-disclosure to parents without consent, and should ideally be provided by individuals whom young people can consider as peers. This allows for more frank discussion, and building of trust and rapport between service providers and clients, with better health outcomes for young people.

   South Africa has made great strides in the development of youth-friendly health services. A good example is the Esselen Clinic which is part of the Hillbrow Health Precinct in Johannesburg's inner city. The clinic's main strategy is to have young people provide services in the clinic. Towards this end, the Esselen Clinic is manned by 10 peer educators (18-24 years old out of school youth), a young counsellor and a community liaison officer in the same age range. The clinic offers services to between 500 and 600 clients per month between the ages of 12 and 22 years old (523 clients in total were seen in May 2011). The most popular services requested in May 2011 were HIV counselling and testing (251), sexually transmitted infection screening and treatment (114) and family planning services (152). [2]

> *Malawi has put in place Youth Friendly Service Standards aimed at promoting the provision of SRH services to young people.*

The development of youth-friendly services with specifically-trained personnel is an area in which Malawi has done particularly well as a way of meeting the SRH needs of young positives. Malawi has put in place Youth Friendly Service Standards aimed at promoting the provision of SRH services to young people. In order to effectively implement the Standards, the country has expanded youth-friendly sexual and reproductive health services to 1,609 health facilities, an increase from eight per cent in 2004 to 85 per cent in 2010.

5. Cultural beliefs also hamper young people's ability to access sexual and reproductive health services, particularly in southern Africa where harmful cultural beliefs and practices have been identified as a factor underpinning the HIV prevalence in the region. This is particularly true when young women want to access contraceptives (including condoms) and screening and treatment of STIs. The attitude of many health workers (and among young women themselves) is that unmarried women should not be sexually-active, and therefore should not need sexual and reproductive health services. Zimbabwe recently introduced a highly contested proposal to begin providing condoms in secondary schools as a way of reducing HIV incidence among young people. Those against the proposal insist that it is 'un-cultural', and that providing condoms to young people promotes promiscuous behaviour and early sexual debut. These arguments are in spite of the fact that there are no legal restrictions on the provision of contraceptives to minors; adolescents from the age of 16 years can access contraceptives without parental consent.

South African college girls after participating in an SRH activity at Tshwane University of Technology in Pretoria. Individuals in this photo are not necessarily living with HIV. *[Photo by SAfAIDS].*

6. Inadequate emphasis on provision of appropriate psychosocial support specifically for young positives hampers the implementation of other HIV prevention and mitigation programmes aimed at the youth. For instance, plans by South Africa to provide HIV counselling and testing in schools as an entry-point to enabling young positives to access ART have been widely debated and are unpopular. South Africa's ART programme, the largest in the world, has the capacity to offer access to treatment for any learners who test positive for HIV. Concerns arose around the psychological impact on pupils following an HIV positive result, and the inadequate capacity in schools to provide follow-up support, and an environment where HIV positive learners would not be subjected to stigma and discrimination.

7. Age of Consent laws (for medical procedures) inhibit young people's access to SRH services where youth-friendly services are not available. Many countries require that young people be of specific age before they can consent to a medical procedure such as an HIV test without parental notification and/or consent. While these laws are meant to protect young people, they sometimes have the opposite effect, that of barring young people from accessing vital SRH services. In Seychelles for instance, contradictory laws mean that adolescent girls' access to contraceptives is often hampered. According to the law, girls aged 15 years and older can consent to sexual intercourse without sharing this information with their parents. However, providing contraceptives to a minor is illegal, and this leaves healthcare providers in a quandary as to whether to provide contraceptives to sexually-active minors or not.

> *"Inadequate emphasis on provision of appropriate psychosocial support specifically for young positives hampers the implementation of other HIV prevention and mitigation programmes aimed at the youth."*

Failure to meet the sexual and reproductive health needs of young positives has grave implications for the ability of young people to adhere to their treatment, to have safe sexual relationships, to protect themselves and others from contracting HIV and to access prevention of mother-to-child transmission guidelines and services.

Unless the needs of young positives are adequately addressed, the aim of achieving zero new infections and zero HIV-related deaths will remain a pipe dream. These services should ideally prioritise programmes providing ART to young positives, services to support their adherence to their life-saving treatment, and psychosocial support. There are good practices of programmes and interventions being implemented by organisations and institutions to address adolescent sexuality and the sexual and reproductive health needs of young positives profiled in this newsletter from which other countries and civil society organisations can learn.

A unique intervention that caters for the needs of adolescents and young people who were born with HIV and which has not been duplicated anywhere else in the world are the Teen Clubs run in Baylor Clinics. The Teen Clubs cater for children as young as eight years who have been fully informed of their condition and who have their parents' permission to participate. The clubs meet once a month and the children form informal and formal support groups.

An important focus of the Teen Clubs is on adolescents, due to an understanding that they are vulnerable to peer pressure that can lead them to engage in risky behaviour and to non-adherence to treatment. Teen Clubs are accessible to the youth utilising Baylor Clinics in Botswana, Lesotho and Swaziland (Save the Children Sweden, 2010). The clubs are an invaluable source of information about the sexual and reproductive health and HIV treatment adherence challenges faced by young people living with HIV. ■

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