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Addressing the **vulnerability** of **young women & girls** to stop the HIV epidemic in southern Africa

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Addressing the vulnerability of young women and girls to stop the HIV epidemic in southern Africa

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The Problem:

The magnitude of the global AIDS epidemic is clearly influenced by the epidemic in southern Africa and the epidemic in southern Africa is sustained particularly by the relentless cycle of vulnerability affecting girls and young women. Young women and girls in the region grow and navigate their sexual health and relationships in a context of extremely high levels of HIV infection and throughout their life cycle, face disempowering social and cultural norms and attitudes governing their sexual relations. In this context, HIV prevention interventions that address technical needs are insufficient in reversing the epidemic.

Background

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The global epicentre

Southern Africa is the global epicentre of the AIDS epidemic, with recent data highlighting the continuing urgency of ensuring sustained and effective prevention and protection efforts particularly addressing the vulnerability of young women and girls. Southern Africa comprises nine countries with the highest HIV prevalence in the world. Over 12% of all adults aged 15 to 49 years are infected with HIV in each of these countries.[1] By the end of 2007, southern Africa alone was home to one of every three persons living with HIV worldwide. In 2007, 35% of all new HIV infections and 38% of all AIDS deaths occurred in southern Africa.

New infections in young women

The broader sub-Saharan Africa region is experiencing a generalized epidemic, with HIV transmitted largely through heterosexual intercourse and with high levels of new infections being found among young people, notably young women. Globally 45% of all new infections in 2007 occurred among young people aged 15 to 24 years.[1] In southern Africa, of all new adult infections aged 15 to 49 years, young people in the ten-year span from 15 to 24 years of age represented an estimated 42%, ranging from 37.9% in South Africa to 61.5% in Swaziland.[3] Almost two-thirds of all young people with HIV live in sub-Saharan Africa where about 75% of all infections among young people aged 15 to 24 years are among young women.[3] While similar disparities in HIV infection are seen between young women and men aged 15 to 24 years throughout sub-Saharan Africa (young women with prevalence three to four times higher than male counterparts) the level of infection is significantly higher among young people in southern Africa than it is in other parts of sub-Saharan Africa. HIV prevalence in young men aged 15 to 24 years in Rwanda and Uganda for example, was 0.5% and 1.5% between 2005 - 2007 while it was 2% and 4% in young women in these countries during the same period.[1] In contrast, in Malawi, South Africa, Swaziland and Zimbabwe, HIV prevalence in young men aged 15 to 24 years was 2%, 4%, 4% and 6% respectively between 2005 – 2007 whereas in young women of the same age, the prevalence in these countries was reported as 9%, 17%, 22% and 11%.[1]

[1]Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, Zimbabwe

2008 Epidemic Update
lives touched

Adults and children estimated to be living with HIV

TOTAL:
33.2 (30.6 - 36.1) million

Caribbean
230 000
(210 000 - 270 000)

Eastern Europe & Central Asia
1.6 million
(1.2 - 2.1 million)

East Asia
800 000
(620 000 - 960 000)

Western & Central Europe
760 000
(600 000 - 1.1 million)

Oceania
75 000
(53 000 - 120 000)

South & South East Asia
4.0 million
(3.3 - 5.1 million)

Middle East & North Africa
380 000
(270 000 - 500 000)

North America
1.3 million
(480 000 - 1.9 million)

Latin America
1.6 million
(1.4 - 1.9 million)

Sub-Saharan Africa
22.5 million
(20.9 - 24.3 million)

Continents and countries scaled according to prevalence of HIV.

Source: AIDS Epidemic Update, UNAIDS December 2007

Prevention efforts
HIV prevention efforts to reach young people, and in particular young women and girls, in southern Africa have focused on some general programmatic areas: awareness raising; HIV education and information dissemination; reduction of socio-economic vulnerability; service provision; and life skills development.

The 2005 Secretary General's Task Force on Women, Girls and HIV[4] attempted to specify priority actions further and raised awareness about the importance of prevention among young women and girls in southern Africa. However, since then increased attention to women and girls through advocacy and increased resource allocation for general HIV prevention measures have failed to make significant inroads to reduce the levels of infection and vulnerability across the region. While there is emerging evidence of encouraging declines in HIV prevalence among young pregnant women aged 15 to 19 years in countries such as Botswana and Zimbabwe,[1] HIV prevalence is high or even rising in most southern Africa countries among young women in their 20s and early 30s, indicating the continuing failure of HIV prevention efforts in this age group.

> *"Men and women have deeply unequal roles in Sub-Saharan Africa, deeply entrenched in language and in the way men and women are moulded within our society. Our African culture has to be preserved but cannot be left unquestioned especially in areas where it threatens life. We have to continue to be Africans but our children must be born to live, they cannot be born to die."*
>
> Graça Machel

Situation analysis

Persistent high levels of HIV infection reflect the fact that HIV prevention responses are not adequately tailored to address the principal drivers or causes of new infections with the scale, targeting and intensity required for success. National responses are also hampered by variable and sometimes inconsistent leadership, lack of state accountability for prevention, weak institutional capacities for implementation, stigma, denial, and sensitivity to addressing the social and cultural determinants of new infections. Responding to the evident need to understand these challenges and rise to them, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Reproductive Health and HIV Research Unit of the University of Witwatersrand in South Africa convened a technical meeting in June 2008 that brought together regional researchers; representatives of national AIDS councils, government departments and the Southern African Development Community; and members of the eastern and southern Africa United Nations Regional AIDS Team to reassess why young women and girls living in the HIV hyper-endemic countries of southern Africa are so vulnerable to HIV infection. Meeting participants were selected purposely to ensure strong representation of high level policy, social and scientific research and programming expertise related to women, girls and HIV, from all countries of southern Africa.

The background technical papers commissioned for the meeting were reviewed by global and regional peers in their respective subject areas. Some of the papers are presented here to provide a summary of the evidence, the research gaps, and the actions required to turn the epidemic around for girls and young women in southern Africa. The papers address the current status of the epidemic in southern Africa: age-disparate and intergenerational sex; biological vulnerability; economic empowerment; education and gender-based violence.

Key conclusions

The meeting concluded that to respond effectively to the exceptionally high levels of HIV infection among young women and girls in southern Africa and to achieve greater impact on preventing HIV transmission, an aggressive movement for social transformation is required. Such a movement must address the immediate practices that lead to HIV infection as well as the fundamental human rights violations, harmful social norms, weak community and leadership capacities and action to challenge these, and the disparities that underpin HIV risk for women and for men in southern Africa. The meeting agreed that in order to achieve reduced HIV incidence particularly in young women and girls, a set of proven effective interventions should be implemented to drive the outcomes required to make that fall in infections a reality. The outcomes of this combination prevention approach should be delayed sexual debut, increased knowledge of HIV sero-status, reduced numbers of sexual partners - particularly concurrent partners, reduced age disparate sex, increased condom use and male circumcision, and increased coverage and utilization of testing and counselling services by those at highest risk of HIV exposure. To achieve these goals, the meeting recommended the concurrent implementation of four key sets of action at community and country levels. In addition participants noted that sustained and effective implementation of these actions requires the full engagement and commitment of leadership that is able to mobilize and influence strategic use of resources based on an objective and robust understanding of the epidemic in each context. The four actions must themselves be grounded in a set of strategies and processes defined by countries to address their specific contexts and existing gaps in capacities at all levels: state, service provision, communities, families, and individuals.

1 THE FIRST KEY ACTION is **mobilisation of communities** for HIV prevention, with strong male involvement, to design relevant strategies and messages about the causes, consequences of and solutions to young women and girls' vulnerability. These must focus on reduction of concurrency of sexual partners, delaying early sexual debut, and increasing condom use, while raising awareness about and understandings of risk associated with age-disparate, intergenerational, transactional sex and concurrent partnerships. This mobilisation should encourage rejection of cultural practices that are harmful to women and girls and strengthen advocacy for "zero-tolerance" for gender-based violence and exploitation in any form.

2 THE SECOND KEY ACTION, as highlighted by the WHO in a series of global consultations and reviews on linkages between sexual and reproductive health services and HIV, is to **expand access to high quality, well-integrated essential sexual and reproductive health and prevention services**, while mobilising demand for and use of them.[5-7] This means bringing to scale improved public health interventions to result in:

a. Increased condom use based on improved access to male and female

condoms, age-appropriate information, and support on condom use for HIV prevention;
b. Effective STI treatment and improved STI awareness and treatment seeking-behaviour;
c. Prevention of teenage pregnancy through improved delivery of adolescent-friendly health services and high quality school-based HIV prevention programmes;
d. Prevention of mother-to-child transmission services that include systematic provider-initiated HIV testing and prevention counselling for all pregnant women, as well as HIV testing and counselling after delivery to counter any increased risk for HIV infection during pregnancy and lactation due to hormonal changes and reduced condom use;
e. Rapid scale up of adult and neonatal male circumcision services within comprehensive HIV prevention programmes; and
f. Delivery of services that address the sexual and reproductive health needs of people living with HIV and improved implementation of positive prevention within treatment services.

3 THE THIRD KEY ACTION is to develop and ensure adequate technical and financial resources for implementation of national strategies that **address the structural drivers of vulnerability**. These strategies must include:
a. Economic empowerment to reduce the effect of income disparities on women's choices and vulnerability;
b. Expansion of opportunities for secondary education and continued learning opportunities to extend the protection provided through formal education and training;
c. Prevention, enforcement of action and monitoring of action against gender-based violence.

4 THE FOURTH ACTION is to significantly strengthen **country capacities for epidemiological and behavioural surveillance, priority research, and monitoring coverage and impact of prevention responses – all of which can generate strategic information to improve decision-making for strategic planning**. This requires a stronger investment in data collection and information management systems.

Next Steps

There is no time to lose if HIV prevention is to make significant strides against the relentless HIV epidemic of southern Africa that is mortgaging the future of hundreds of thousands of young women and girls. The articles included in this supplement are being transformed into hard-hitting, issues briefs that will be used to influence policy makers and leaders across the region and at all levels through appropriate advocacy and communication. Nothing less than social transformation is needed now to turn this epidemic around. Every individual must see himself or herself as implicated in his or her personal and professional lives in either condoning the status quo or confronting it.

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Priority health sector interventions for reducing women's **biomedical vulnerability** to HIV infection in southern Africa:

An issues brief

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The Challenge

A disproportionate number of girls and women in southern Africa are infected with HIV, with levels of infection far exceeding that of men in the region and several orders of magnitude higher than that of women in other settings. The response to this requires a systematic analysis of the precise short- and long-range mechanisms that determine this vulnerability.

Such an analysis would assist in defining a coordinated HIV prevention response, with improved prevention programming and results.

A comprehensive response to HIV in women, where the health sector delivers a package of integrated HIV prevention interventions, is critical for reducing new infections, and thus consequent HIV-related morbidity and mortality. This requires a wide array of activities, provided within communities and health facilities, and includes interventions aimed at changing individual-level behaviour, and community- and policy-level interventions which alter the more distal underpinning determinants of vulnerability to HIV.

Prevention approaches have thus far largely ignored social contexts, presuming a degree of individual control in decision making that is dissonant with the reality of life for girls and women in southern Africa. There are critical characteristics of the risk environment which condition and constrain the behavioural 'choices' available to girls and women in this setting. In essence, the biomedical vulnerability which most interventions seek to target is an outward manifestation of an underlying gendered social and economic vulnerability, which takes expression in behavioural risks.

This policy brief provides an overview of the biomedical factors underlying women's vulnerability to HIV infection and prioritises the interventions that are essential for reducing this vulnerability.

Summary of key biomedical factors underlying women's vulnerability

Biological risk for HIV depends on the efficiency of transmission during a specific sexual encounter and the number of exposures, if any. Different types of sexual activity have varying efficiency. Importantly, the odds of HIV acquisition during receptive anal intercourse are about 10 times that with vaginal sex.

Stage of HIV infection is a key determinant of infectivity. Extraordinarily-high viral loads in all fluids, including semen make the acute stage of HIV infection a critical period of infectivity. People with acute HIV infection thus make a marked contribution to HIV spread, though a large proportion of HIV transmissions still occur during the longer chronic asymptomatic phase of HIV infection. Concurrent partnerships create a most conducive environment for HIV transmission during acute infection. When one person in a network of concurrent partners acquires HIV, others in the network are at considerable risk.

Sexually-transmitted infections (STI) facilitate transfer of HIV, amplifying the baseline risk predicted by factors such as semen viral load. Prompt and appropriate treatment of STI reduces an individual's risk for HIV acquisition. Further, treatment of STI in people with HIV may help prevent HIV transmission to sexual partners.

Evidence indicates that **younger women** are more biologically susceptible to HIV infection. Delaying sexual debut among girls and avoiding exposure to HIV during this especially vulnerable period is a key HIV prevention strategy. Cervical ectopy, more common in young women has also been associated with increased susceptibility to HIV infection.

Some studies show risk for HIV acquisition is higher for **pregnant women** than lactating or non-pregnant women. This appears more likely due to physiological changes during gestation than to social and behavioural changes during pregnancy. An important implication of this is that measures to reduce unintended pregnancies could potentially lower risk for HIV infection in women, in addition to other inherent benefits. Also, for girls, reducing unintended pregnancies keeps them in school, reducing their economic vulnerability (a highly important intervention point for reducing HIV vulnerability in girls).

Vaginal practices are used by large numbers of women in southern Africa to tighten, dry, or clean their vagina. These practices and associated products could potentially undermine each component of innate biological defences against pathogens. In addition to potential biological mechanisms, perceptions of desired vaginal states and vaginal practices themselves can undermine condom use. Evidence whether intravaginal cleansing or insertion of substances increases risk for HIV acquisition is conflicting however.

Rapidly accruing evidence indicates that **alcohol independently affects sexual-decision making**, and condom negotiating skills and their correct use. Patterns of drinking, in particular the intermittent episodes of intoxication which characterise southern Africa, are a powerful mediator for acute problems such as interpersonal violence and high-risk sexual behaviour.

The causal pathway between acute intoxication, unsafe sex and HIV is progressively becoming delineated. Women with heavy episodic drinking patterns (defined as more than five drinks on one occasion) are more likely to use condoms inconsistently and incorrectly; to experience sexual violence; and to acquire a STI, including HIV. Moreover, a biological explanation exists for the relationship. Alcohol reduces anxiety about the consequences of one's actions with consequent reduction in cognitive restraint. It also causes disinhibition, decreasing awareness of social norms of acceptable behaviour. Causality is also supported by results of event-level condom use (reduction of condom use coinciding with heavy-drinking events).

Research may show that alcohol control reduces unprotected sex, incidence of sexual violence and HIV. Specifically, it is possible that women who are assisted to adopt safer patterns of alcohol use will have concomitant safer sexual behaviours and reduced STI burden. Brief counselling interventions for alcohol in primary care together with alcohol control measures like those used for tobacco control are required.

Aberrant immune activation, especially following infections with helminths, tuberculosis and malaria, may raise susceptibility to HIV infection. Strengthened health services, with improved control of such infections could also have important benefits for HIV prevention, aside from inherent gains from reducing the burden of these major pathogens.

Recommendations

Health services role in reducing women's vulnerability
Key health sector interventions for preventing sexual transmission of HIV include: male and female condom programming, prevention and control of STIs, outreach to most vulnerable populations, male circumcision, and the integration of HIV prevention within sexual and reproductive health services. Prevention interventions must be configured to promote gender equality, itself likely to reduce HIV transmission.

TABLE 1: Priority biomedical interventions for reducing HIV acquisition in women in southern Africa

- Promotion of male and female condoms for reducing HIV transmission and avoiding pregnancy.
- Promotion of male and female condoms for HIV-negative pregnant and breastfeeding women.
- Promotion of abstinence and fidelity, reducing concurrent partners.
- Delaying age at first sex.
- Health promotion programmes and counselling for modifying behaviour and risk perceptions.
- HIV testing and counselling, focusing both on those who test HIV-negative and positive.
- Couple counselling and HIV testing.
- Treatment of sexually-transmitted and other reproductive-tract infections, especially viral STI.
- Treatment and prevention of harmful patterns of alcohol use.
- Promotion of contraception and reduction in unintended pregnancies, to potentially diminish risk for sexual transmission of HIV to women during pregnancy, keep girls in school and reduce women's economic vulnerability.
- Reduction in barriers to uptake of HIV prevention services, including addressing health worker's stigmatising attitudes.
- Antiretroviral drugs for non-occupational post-exposure prophylaxis, especially following sexual violence.
- Male circumcision.[1]

1 Evidence is not available about effects of this intervention on risk for HIV among women

Sexual counselling and condom promotion

Safe sex, the practices which limit contact between bodily fluids of sexual partners, remains a central element of HIV prevention. Large gaps, however, occur in consistent condom use with long-term partners and to a lesser extent with casual partners. Programming for male and female condoms is an integral and essential part of comprehensive prevention and care. Prevention programmes need to ensure that high-quality condoms are accessible to those who need them, when they need them, and that people have the knowledge and skills to use them correctly. Condoms must be readily available universally, either free or at low cost, and promoted in ways that help overcome social and personal obstacles to their use. The female condom remains an under-exploited prevention option, especially the newer FC2 condom.

Each clinical encounter serves as an opportunity for providing information and counselling. For pregnant women who test negative, particular efforts are needed to provide tailored counselling and to promote male and female condoms at this time. Women living within southern Africa require contextualised counselling, which encompasses:

- frank discussion of the dangers of having more than one long term sexual partner at a time;
- talking through locally appropriate strategies that women can use to avoid transactional sex, because in this cultural milieu the receipt of gifts often signals sexual acquiescence, mostly without a condom;
- female and male condom promotion, advice about their correct use and the dual benefits condoms offer for women who do not wish to become pregnant;
- informing women, including those who are married, that they should consider themselves at risk of acquiring HIV; and counselling women during pregnancy and lactation about the potential increased risk of HIV at this time and that the need for safe sex remains important.

Such messages must be piloted, evaluated and continuously improved.

Increasing knowledge of HIV serostatus

HIV testing is a key intervention for directly confronting the HIV epidemic and a prerequisite for provision of serostatus-specific prevention. Once diagnosed with HIV, the majority of men adopt safer behaviours, reducing risk for their uninfected partners. A diversified approach can increase knowledge of serostatus. This must draw on a range of testing and counselling models including client- and provider-initiated testing, and occur within health facilities and community-based settings. Universal access to provider-initiated testing and counselling (PITC) is required in all SRH services and during interface between patients and providers in southern Africa. More intensive client-centered counselling modalities for changing sexual behaviour in those who test negative can alter sexual behaviour and reduce incidence of STI.

Detection and treatment of sexually-transmitted infections

Though STI treatment in low-level or concentrated HIV epidemics has a larger impact on HIV transmission at a population level, in hyper endemic settings the population impact of STI treatment is nevertheless important. With improved knowledge and support, increasing numbers of women and men who suspect an STI would promptly seek and access STI care, reducing their individual risk for HIV infection.

Priorities must be set to target those pathogens that contribute most to expansion of the HIV epidemic in southern Africa. There has been an absolute increase in the incidence of herpes simplex virus type 2 (HSV-2) which has become the predominant cause of genital ulcer disease. Of all genital ulcer diseases, HSV-2 interacts most strongly with HIV. Bacterial vaginosis and Trichomonas vaginalis have also been more recently associated with HIV transmission. As these conditions are common, even a small increase in risk at an individual level may have a marked impact on overall HIV levels in the population.

Male circumcision

Male circumcision is an additional important health sector intervention to reduce the risk of heterosexually acquired HIV infection in men. This intervention should be scaled up as part of comprehensive HIV prevention, informed by social and cultural contexts. Broad community engagement is required to introduce male circumcision services, also for communicating accurate information about the intervention, to both men and women. Messaging here is critical, notably that male circumcision provides only partial protection. Also vital is the message that men who resume sexual activity before wound healing may be at higher risk of HIV infection, or if HIV-positive, at higher risk of infecting their sexual partners. PITC is recommended as part of the standard of care for men seeking circumcision as an HIV prevention intervention. Also, careful monitoring is needed of male circumcision service delivery for possible untoward effects such as increases in unsafe sex.

With male circumcision programmes, over time women would gain protection from HIV as male prevalence decreases (via ‘herd immunity’). However, circumcision has a long and complex traditional and cultural history; and considerable efforts together with appropriate cultural leadership may be required for implementing these programmes at scale.

Conclusion

Understanding principles of HIV infectivity and factors which modify vulnerability provides an opportunity to identify local strategies to reduce transmission. Far-reaching measures, like control of alcohol use, create conditions necessary for achieving sustained prevention results. These efforts will also have marked health and wellbeing benefits beyond a reduction in HIV.

More distal factors such as economic vulnerability, societal norms, and gender-based inequality and violence are inseparable from women's sexual behaviour and, at least in part, determine women's sexuality and wellbeing. For example, fidelity is undermined by occupational policies, like those of mining companies which involve single-sex hostels, or subsidised alcohol supplies. Keeping girls in schools is also critical. Moreover, there are underutilised opportunities for addressing biological determinants of HIV infection during interface between health workers and patients. Making better use of encounters with women bringing their children for immunization is one such example.

Thus far, the vigorous cultural and political leadership that would be required to alter gender norms or to implement programmes like male circumcision has been absent in southern Africa. It thus remains that the vulnerability of women due to biomedical factors is exacerbated by a deep-rooted lack of social capital, income equality, and social and gender justice, in themselves highly important predictors of HIV. With adequate political and cultural leadership, fundamental society-wide changes in sexual and gender norms have taken place in parts of Africa and other areas affected by HIV. With strong, bold and more informed leadership such changes could occur in southern Africa.

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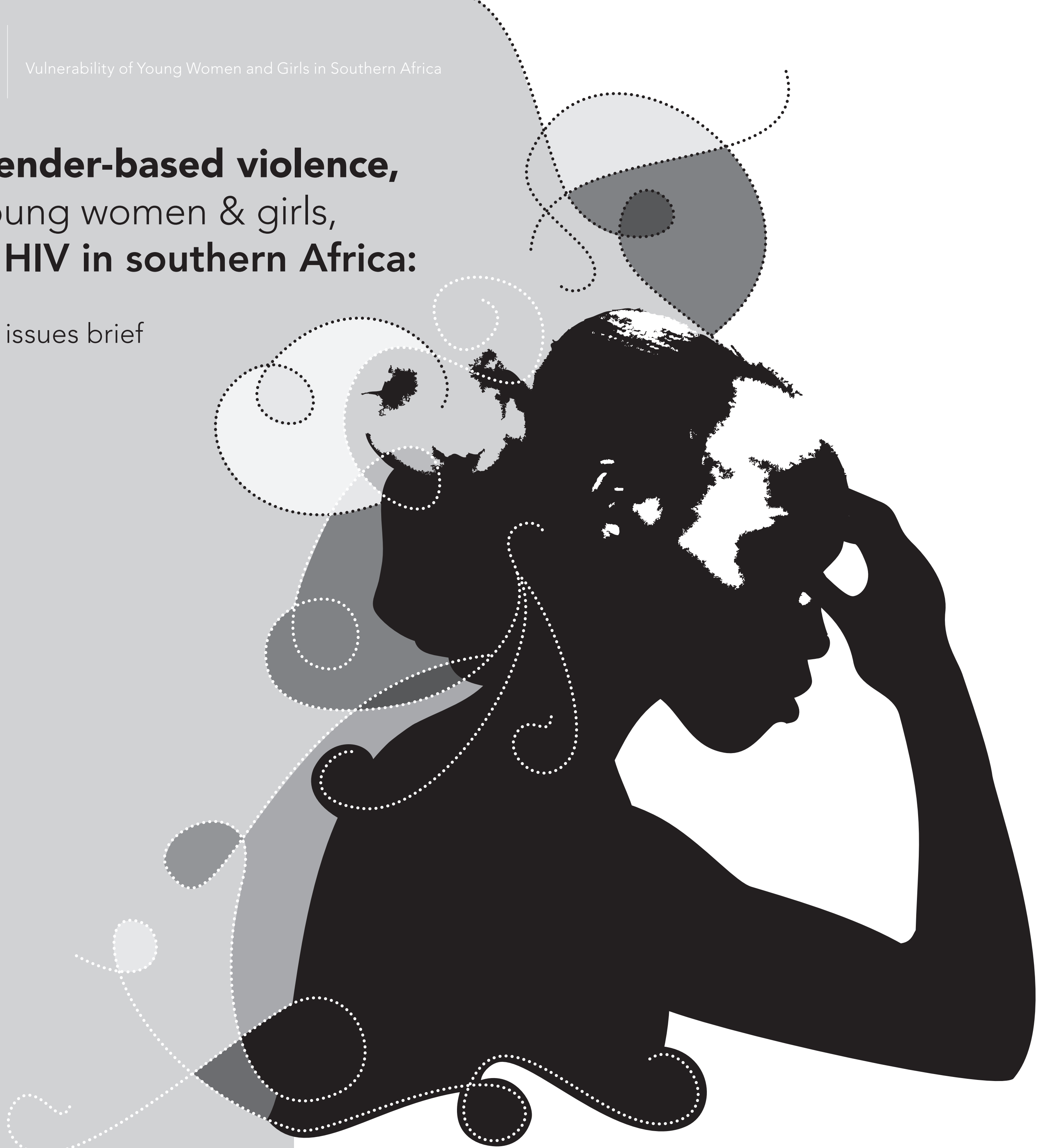
Gender-based violence, young women & girls, **& HIV in southern Africa:**

An issues brief



The challenge

We use the term gender-based violence (GBV) to go beyond the physical trauma of rape, childhood sexual abuse and forced sex, to include sexual coercion of any kind, non-sexual physical violence and related forms of abuse based on gender. GBV is common in the HIV hyper-endemic countries of southern Africa.
Some GBV survivors are at directly increased risk of HIV infection, as traumatic abrasions and lack of lubrication increase the risk of transmission. GBV also increases HIV risk indirectly by increasing the likelihood of high risk behaviours. Revictimisation compounds the risk.

GBV perpetrators are at especially high risk of HIV infection. They are more likely to force unprotected sex with people who have been victimised before, and who are more likely to be infected. Combining GBV perpetrators and victims, around one third of people in southern African are currently in a self-perpetuating cycle of GBV and HIV.

The challenge is to break this cycle.

Neil Andersson and Anne Cockcroft

CIET - Community Information, Empowerment and Transparency

Evidence of the problem and interventions that work

There is evidence of higher HIV risks among people with a history of gender based violence and higher rates of GBV among those who are HIV positive. Mostly cross-sectional designs, these studies do not tell us what comes first, GBV or HIV. There is evidence, however, in favour of GBV as a potentially actionable cause – direct or indirect – of HIV infection.

A. Prospective (follow-up) studies show GBV causing HIV infection directly: previously HIV-negative victims of rape become HIV positive.

B. Many studies report coerced first sex and childhood sexual abuse associated with HIV risk in later life. In these cases, GBV clearly precedes HIV infection.

C. In cohort studies of HIV discordant partners (one HIV-positive and other negative), there was a marked increased risk of infection among partners who reported GBV.

D. At least one author reported a gradient between HIV risk and intimate partner violence (IPV), with HIV risk highest among women reporting more violence.

Indirect effect of GBV on HIV risk
GBV can lead to HIV infection directly through trauma, or it can do so indirectly. Mechanisms include choice disability in relation to prevention or adoption of high risk attitudes and behaviours.

A **ATTITUDES:** People with a history of sexual assault are more likely to endorse hostile attitudes towards women and are more likely to accept violence against women.

B **MULTIPLE PARTNERS:** GBV survivors are more likely to report having multiple partners.

C **TRANSACTIONAL SEX:** childhood sexual abuse is strongly associated with “sex trading”. Power differentials in these settings increase the likelihood of unsafe sex.

D **CONDOM USE:** GBV is related to inconsistent use of condoms. Fear of GBV is a well recognised reason for accepting unprotected sex.

E **REDUCED TESTING OR DISCLOSURE OF STATUS:** Fear of violence also reduces disclosure of HIV status and HIV testing.

F **SEXUALLY TRANSMITTED INFECTIONS INDICATE HIGH RISK SEX;** the damaged mucosa also facilitates of HIV transmission. GBV victims have higher rate of STIs.

G **RECEPTION OF AWARENESS PROGRAMMES AND EDUCATION:** A history of GBV reduces likelihood of partner participation in programmes of PMTCT; and survivors of GBV may interpret awareness programmes differently to other people.

H **INTENTION TO SPREAD HIV:** Some young people say they would deliberately spread HIV if infected; this is more common among youth who have suffered forced sex.

I **PERPETRATORS OF GBV:** Abusers have frequently been abused themselves. They tend to pick on people who have already been abused, putting themselves at special risk of HIV infection. Their distain for the rights of other people rapidly converts their acquired infections into risks for future victims.

The context of vulnerability: Intergenerational sex and transactional sex are contexts of often unequal power relations. GBV-related choice disability regarding high risk practices may be compounded by food insecurity, minority or migrant status, substance abuse or a mixture of these factors. Other contexts that enable the GBV-HIV cycle include pervasive myths, for example, that sex with a virgin can cure HIV/AIDS, and legal systems that generate little disincentive for GBV or spreading HIV. Short-sighted AIDS prevention programmes fail to think through and test fully their effects on other aspects of prevention. For example, fear-based messages increase the stigma of HIV/AIDS, with negative consequences for voluntary HIV testing, disclosure and GBV.

Evidence of impact of interventions

Primary prevention (stopping the risk of GBV before it occurs): Several studies show reduction of violence through school-based interventions. A South African trial shows reduction of GBV and HIV risk behaviours among women with income enhancement and gender training. This advantage for the women receiving the intervention did not result, in the two years of the study, in a measurable decrease in HIV across the whole community. Another trial of an intervention to reduce GBV reported a non-significant reduction in HIV incidence. At least three other primary prevention trials are in progress in southern Africa.

Secondary prevention (for those with the risk factors, to stop this leading to HIV): Successful interventions focus on recovery from GBV, negotiating skills to increase protective practices, and condom uptake with regular partners. Male circumcision could be considered long term secondary prevention, as this could protect perpetrators from infection by their victims, and thus reduce the cycle of infection.

Tertiary prevention (reducing the consequences for those infected with HIV) focuses on coping reinforcement for those who become HIV-positive and, for those who go on to AIDS, uptake and adherence of antiretroviral therapy (ART).

Future research

Scope and types of research needed
Subgroup analysis: Since there are already a number of well designed trials of HIV prevention interventions currently ongoing; it makes sense to do GBV subgroup analysis of these trials. This can provide useful information with very little investment.

Complex interventions: Most AIDS prevention research focuses on the impact of single interventions rather than a calculated mix of synergistic actions. Southern African countries implement complex interventions to combat AIDS and the question to answer is the added value of each intervention, or its impact in the face of all else that is going on.

Economic analysis: Economic analysis should accompany these studies. This is relevant not only in relation to implementation costs, but because economic empowerment is a major aspect of prevention.

Research focus: Few current HIV prevention programmes address the needs of the choice-disabled, those who by reason of GBV are unable to make or to implement their prevention choices. This could be tagged onto other research – asking, for example, how to increase the relevance of condom promotion or male circumcision for the choice disabled. Another promising focus would be with HIV discordant couples, where these cohorts are available. The interaction between prevention initiatives is also important as is research on perpetrators. It is possible that perpetrators understanding better their own HIV risks could help to motivate a reduction in sexual violence.

Building African skills in GBV-HIV prevention
There is an urgent need for African skill development in high level research. Existing initiatives need full government, regional and international commitment.

Policy and political: appreciation of the value of and the way to use local high quality evidence related to GBV and its role in the epidemic can be transferred in brief executive retreats, which could be regional or national.

Short courses can transfer the skills needed for detailed interaction on AIDS prevention research, with a special focus on GBV. A national or regional consensus team could standardise instruments and define and refine structured outcomes; this will build local skills and optimise research to national needs.

Hands-on training in GBV prevention implementation research: a combination of in-service internships, degree courses and fully funded research posts could help to bring this to pass. A permanent university research chair in GBV-HIV in each one of the eight priority countries should be a priority.

Community capacity is crucial for AIDS prevention. Current HIV prevention research focuses on individuals and largely ignores the powerful influence of communities and networks. As communities engage in collective and cluster interventions, they can acquire the confidence and skills to lead their own HIV prevention initiatives.

Media sensitisation and training: Much has been done across the region to use mass media for edutainment and awareness programmes. There is also room for general awareness among journalists of the GBV dimensions of HIV and AIDS.

Recommendations

Policy and policy discourse
Policies must recognise that GBV increases HIV risk both directly and indirectly through increasing high risk practices. Both GBV survivors and perpetrators are at high risk. GBV is actionable – the policy paradigm must address primary prevention (stopping the risk by reducing GBV), secondary prevention (stopping GBV leading to HIV) and tertiary prevention (reducing the consequences of HIV).

1. LEGAL REVIEW: Policies should ensure that laws in the high risk countries cover GBV, rape, CSA and failure to disclose HIV status.

2. POLICY REVIEW: the HIV and AIDS prevention policies of each country should be reviewed to clarify their position on GBV-HIV. Key questions include: does the policy recognise the role of GBV on the HIV risk of victims; does it recognise the special HIV risk and subsequent role of GBV perpetrators; does it deal adequately with issues of primary prevention of GBV and HIV. Prevention of GBV should be promoted as a national and regional HIV prevention issue.

3. HIGH LEVEL COORDINATION AND COOPERATION: GBV and HIV prevention bodies in the UN and in national governments are usually quite separate at present. These "silos" are unhelpful and partly to blame for the low position of GBV-HIV on policy agendas. Concerting of these forces could have a positive effect on prevention of both GBV and HIV.

4. INTEGRATION OF GENDER AND GBV IN LARGE GRANT MECHANISMS: At present, much AIDS prevention in southern Africa is driven by international donors. GBV reduction and the amelioration of its indirect effects on the epidemic are not manageable as a vertical programme, although vertical programmes are attractive to some local and donor decision makers. It is necessary to engage with these external drivers of prevention to increase their understanding of GBV and its role in the epidemic. Asking policy questions about the relevance of campaigns or prevention programmes for the choice disabled can reduce the current trend of donors to invest mainly in prevention exclusively for the choice-enabled, those who can implement their prevention decisions.

Programmes
Each country should commit resources to socialising (communicating) the available information on GBV and HIV among prevention stakeholders. The exact cultural underpinning of the GBV-HIV dynamic may be different in different parts of the region, and there is an urgent need for country specific information on what it takes to tackle GBV or to reduce its effects on HIV. Effective GBV prevention is likely to include a structural component like access to credit or earnings, and a GBV awareness component covering GBV survivors, potential GBV victims and GBV perpetrators.

Legal reform: Countries where the legal framework is out of step with what is needed for GBV prevention and dealing with cases of GBV will need to promulgate new laws, to provide training for service providers (including police and health workers), and to implement knowledge translation programmes to involve the public in the legal reform.

Primary prevention programmes are needed, to focus on reducing risk factors for GBV. Programmes should be implemented in collaboration with bodies already working on GBV prevention. They should include structural and awareness/education elements, programmes in schools, a focus on men (as perpetrators and as victims of CSA), emphasis on resilience; and positive role models.

Secondary prevention programmes hinge on recovery from GBV – interventions can increase resilience of people who suffered GBV but who are not yet HIV positive. Psycho-educational interventions can also improve negotiating skills of those at risk of GBV. Longer term prevention strategies for reduction of HIV infection independent of any reduction of GBV, like male circumcision, could play a role.

Tertiary prevention of GBV includes making it easier to report abuse, to get support once abused and to increase deterrents for perpetrators. Given the sad reality that only one in five cases might be reported, one in four of those go to court, and of those only a minority of perpetrators are convicted, judicial processes are unlikely to play a role in decreasing overall GBV. Some advocate zero tolerance for CSA in schools, with suspension of teachers accused of CSA and sacking of those convicted; but the potential for false accusations needs fuller consideration.

Programmes focused on perpetrators could increase their awareness of their own safety and, perhaps in time, reduce the distain for the safety of others that is often part of GBV and transactional sex.

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Economic Empowerment & HIV Prevention:

An issues brief

The Challenge

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Global evidence suggests that the relationship between poverty and HIV risk is complex, and that poverty on its own cannot be viewed simplistically as a driver of the HIV epidemic. Rather, its' role appears to be multi-dimensional, and to interact with a range of other factors - such as mobility, social and economic inequalities, and social capital - which converge in a particularly potent way for young women living in southern Africa. To date, there have been few interventions that have explicitly attempted to combine economic empowerment with the goal of HIV prevention, and even fewer which have been rigorously evaluated. However, early lessons are emerging from circumscribed interventions that have attempted to link economic empowerment with HIV prevention. By providing a detailed exploration of how vehicles such as microfinance or livelihoods initiatives might impact on a range of HIV-related outcomes, such research is useful for drawing out broader lessons, and providing a metaphor for what might be possible in promoting women's economic empowerment on a wider scale.

However, there are clearly limitations to what individual intervention programs can achieve, and unless women's economic empowerment is supported by broader country-level policies that bridge a range of intersecting levels, impacts are likely to be limited. Thus, the challenge to policy makers is to begin using the lessons generated from such programmatic experiences to generate effective, cross-sectoral responses to HIV/AIDS that are relevant to their own context. Intervention programs targeting women's economic empowerment need to be supported by country-level policies that carry the potential for far more sustained and systemic changes in women's status and health.

Recommendations

The following recommendations highlight important entry points for strengthening HIV prevention efforts by deliberately addressing women's economic vulnerability.

1 **Policies and programs that promote the economic empowerment of women and girls should be included as core components of national HIV prevention strategies:** Research suggests that addressing women's basic economic needs through programs such as microfinance, youth livelihoods and life skills training, and initiatives to protect women's food security and property and inheritance rights not only targets women's economic vulnerability directly, but can also offer a strategic opportunity for attracting sustained group-based participation in HIV prevention activities among the poor. Experience with combined economic empowerment and HIV interventions suggest that it is feasible to address structural factors such as poverty, gender inequalities and gender-based violence as part of HIV prevention programs, and these goals should be explicitly included within national HIV/AIDS strategies. Adequate resources, technical expertise, and monitoring and evaluation mechanisms relating to these goals need to be included to support effective implementation.

2 **Increase financial support to community organizations that promote economic empowerment of women, and ensure that these organizations are represented on National AIDS Councils, Country Coordinating Mechanisms (CCMs), and in other relevant national and local decision-making and consultative bodies:** Currently, most national and local bodies focusing on HIV/AIDS tend to reflect the participation of stakeholders and advisors representing primarily clinical and public health expertise. Given the need to encourage greater cross-sectoral collaboration, these should be expanded to include a more diverse range of expertise, including groups working on poverty alleviation, food security, gender-based violence, and women's rights.

3 **Support the development of cross-sectoral partnership models and encourage programmatic innovation to develop combined economic empowerment and HIV prevention interventions:** While there have been increasing calls for a "cross-sectoral response" to the HIV pandemic, there are few concrete examples of programs that work – particularly in high-prevalence African settings. Emerging evidence suggests that adding a Gender and HIV training component to economic interventions such as microfinance can expand their health and social impacts. However, without specific funding to support the development of combined economic and health interventions, it is likely that further innovation will remain limited. Technical and financial support to develop cross-sectoral intervention programs, and the sharing of expertise required to initiate and sustain these, should be encouraged.

4 **Support scale up of promising cross-sectoral intervention models:** Where promising interventions combining economic empowerment and HIV prevention have been developed, they should be supported to scale-up where appropriate. Further research would help to identify how such programs might be replicated or adapted in different contexts. Many programs currently include an HIV training component, and best practice guidelines should be developed in relation to the content, delivery, and intensity of such training. Technical support may be required for including newer elements such as content relating to gender norms, gender-based violence or community mobilization activities. Such support should also consider what kind of capacity-building might be required for program implementers themselves, and what kind of institutional structures need to be developed in order to support and manage expanded activities and mandates. Where there are pockets of innovation, lessons should be shared regionally, through the development of learning centers and exchange programs.

5 Explore a broad range of economic empowerment strategies for women and adolescent girls as a platform for reducing vulnerability to HIV infection: To date, most experience with combining interventions aimed at women's economic empowerment and HIV prevention has arisen within the microfinance sector. There is a need to further explore other economic empowerment strategies which carry important opportunities for cross-sectoral interventions. Programs such as vocational training, literacy programs, or other livelihoods strategies may present relative advantages or disadvantages for different target groups and settings. Initiatives aimed at improving women's food security and safeguarding their property and inheritance rights have yet to develop strategic linkages with HIV training or service organizations. Lessons and partnership models from the microfinance sector should be further elaborated and expanded to include these other areas.

6 Evaluate interventions using realistic and relevant indicators, methods, and timeframes: There is a need for further research in order to guide programme and policy development for linking economic empowerment strategies and HIV/AIDS interventions in a range of settings. Few economic empowerment strategies – with or without an additional HIV-related component – have been well evaluated and it is rarely feasible to implement a randomized controlled trial. However, experience suggests that strong and informative evaluations are possible. To date, economic programs have tended to focus on measuring conventional financial indicators, such as poverty targets, or financial sustainability measures. Broader impacts on dimensions such as women's empowerment, gender-based violence, sexual behaviour, and other HIV-related outcomes should be more systematically evaluated, and consideration given to the longer timeframes that may be required in order to observe change. In some areas, there is a need to address information gaps, for example, by developing sex-disaggregated national- and local-level indicators that can measure progress toward women's equality in land and property inheritance rights. More research on such outcomes within different intervention models is needed, as well as operational research that evaluates the most effective institutional strategies for creating partnerships between economic empowerment and HIV prevention programs.

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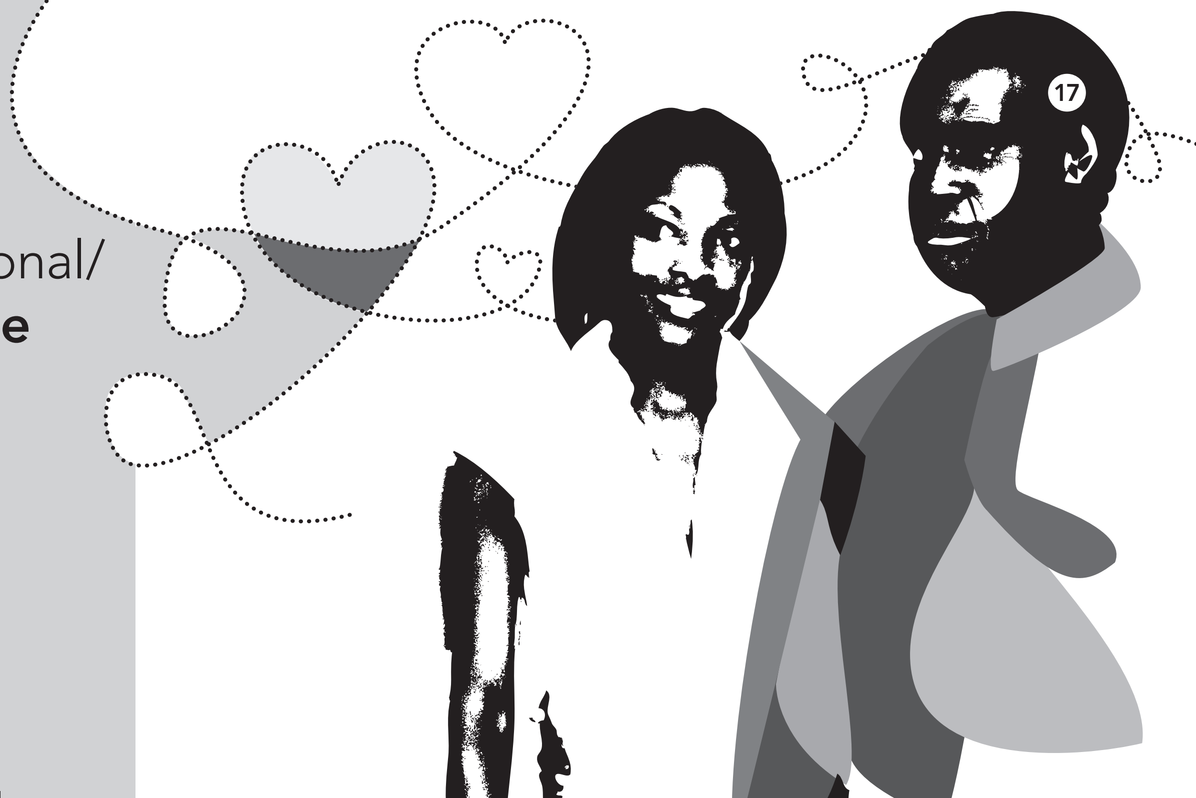
7 Ensure that broader country-level policies support and sustain the impact of individual programs. There are clearly limitations to what individual intervention programs can achieve. Often, the impact of scaling-up or replicating locally successful models is constrained by a lack of realistic engagement with broader policies and structures that can curtail or expand their scope. Therefore, in order to be effective, intervention programs need to be supported by country-level policies that carry the potential for far more sustained and systemic changes in women's status and health. Therefore, in addition to supporting programs that strengthen combined approaches to economic empowerment and HIV prevention, countries should ensure that domestic legislation is consistent with international human rights norms, and that it is effective in protecting women's rights within marriage, securing their right to own and inherit property, ensuring equality in the workplace, and strengthening laws against domestic violence and sexual violence.

8 Ensure that economic development plans (whether involving the development of productive sectors or the provision of social safety nets) pass an "AIDS impact assessment": Given the range of factors known to interact with poverty and increase vulnerability to HIV infection, economic development plans should be viewed with an "HIV lens" in order to determine whether they may inadvertently increase population risk of infection, and if so, whether deliberate measures can be taken to reduce this risk. Just as governments currently require private and public sector development projects to include an "environmental impact assessment", such projects should also be required to pass an "AIDS impact assessment". Relevant criteria might include: whether hiring practices critically examine the demographic profile of the work force and strive to reduce dependency on migrant labour; industry standards that seek to provide alternatives to congregate, single-sex dwellings at work sites; transportation alternatives to long distance truck routes; inclusion of workplace AIDS policies and policies promoting gender equity; and programs that provide educational or economic alternatives to sex work for women living in communities surrounding high-risk areas. As with environmental impact assessments, good practices can be encouraged through preferential consideration for contracts, as well as tax and other financial incentives where programs can demonstrate that such HIV-related considerations have been taken into account. Such structural-level interventions have the potential to make important contributions to addressing the broader contextual factors which may be beyond the reach of individual economic empowerment programs.

Intergenerational/
age-disparate sex:

An issues brief



The Problem

Young women in southern Africa between the ages of 15 and 24 are on average three to six times more likely to be infected with HIV than their male cohorts (UNAIDS 2004). In South Africa a high HIV infection rate of 29.5% was found among girls 15-19 in sexual partnerships with an age disparity of 5 or more years (Shisana et al., 2005), and a recent study in Botswana by Langeni (2007) found that for every year's increase in the age difference between partners there was a 28% increase in the odds of having unprotected sex. Studies indicate that relationships between young women and older men that are common in the region and largely premised upon material gain, are also associated with unsafe sexual behaviours and increased HIV risk (Glynn et al 2001, Gregson et al 2002, Leclerc-Madlala 2002a, Luke, 2003, Bagnol & Chamo 2004, Longfield et al, 2004, and Nkosana & Rosenthal 2007a).

Several factors have been identified within age-disparate relationships which increase risk of HIV. Older men often have infection rates higher than adolescent boys or young men, and age and economic disparity between partners has been shown to compromise young women's ability to negotiate safe sex. Risk perception in these relationships is often low. Men perceive young partners to be more likely to be free from STIs and HIV, while young women often view older men as less risk-taking, more stable, and hence 'safer' partners. In addition young women are often more concerned about the risk of becoming pregnant or of being 'found out' in their relationships with older men, than of STIs or HIV (Jones, 2006; Nkosana & Rosenthal, 2007).

While studies have tended to focus on poverty as the major factor prompting young women's involvement in sexual relationships with older men, closer grained research has demonstrated that this understanding is far too simplistic. While many young women do find themselves in age-disparate relationships because of poverty or coercion, studies also reveal that many play active roles in seeking and exploiting relationships with older men and do not perceive themselves as victims (Silberschmidt & Rasch, 2000; Wojciki 2002, Leclerc-Madlala, 2003; Nkosana, 2006).
Young women may be powerless as regards safer sex negotiations, but they often have a high degree of control over partnership formation and choosing the number and types of partners with whom they become involved.
This often gives them a false sense of being in charge (Bagnol & Chamo 2004).
Emerging evidence reveals that young women hold contradictory norms and values in relation to these relationships.
While positive perceptions and attitudes towards age-disparate relationships have been reported, young women are often simultaneously aware of dangers that include dependency and the common occurrence of unsafe sex that can result in pregnancy, STIs and HIV (Wight et al, 2006; Karlyn, 2005).

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Discussion

As economic gain emerges as the predominant motivation for young women's involvement with older men, insisting on safer sex practices such as condom use is often avoided so as not to jeopardise the women's economic goals in the relationship (Machel, 2001; Leclerc-Madlala, 2003; Dunkle et al, 2004; Hallman, 2004; Poulin, 2007). Young women perceive a range of potential benefits to be derived from these relationships that include opportunities for finding love, companionship, a husband, sexual fulfillment, impressing peers, boosting self-esteem, finding employment, acquiring social status or simply having fun in ways that suggest a modern lifestyle. Against such considerable potential benefits any perceived risk of HIV is pushed aside in an effort to enhance and add meaning to life. Few studies have explored age-disparate relationships from the perspective of the men involved.
The desire for entertainment, variety and relief from domestic and workplace stress as well as a desire for 'clean' partners have been reported as motivations (Weinrab, 2002; Kimuna & Djamba, 2005). Long-standing cultural allowances and pervasive myths in the region sometimes encourage intergenerational sex, such as notions that an aging man is entitled to seek a young woman for sexual rejuvenation to 'make his blood move again' (Nkosana, 2006), or that sex with a virgin can 'clean his blood' and thus rid his body of HIV (Leclerc-Madlala, 2002b). Studies indicate that men often view these relationships as transactional and are not willing to use condoms when they have given their young partners a valuable gift or service. Men commonly blame young women for seducing them because they are after money. Nkosana (2006) reports that Botswanan men see nothing wrong with using their socioeconomic power to entice young women into sex.

Recommendations

Age disparate relationships are one form of relationship within the wider sexual networking system of multiple concurrent partnering in southern Africa. Policies and actions to address this practice should form part of those that address multiple concurrent partnerships more generally while emphasising the special risks associated with age disparate relationships.

1 Rapidly and greatly increase programmes that work directly with men to alert them to and engage them on the factors that sanction engagement in age-disparate sex.
Across the region dominant ideas of masculinity are problematic for those men and women who wish to practice less-risky sexual behaviours. Male peer pressure for multiple and concurrent partnering is often intense and demonstrating an ability to attract young partners confirms manhood and raises social status among peers. There remains a need to cultivate positive peer norms and new culturally-recognised markers of manhood among both boys and men as well as a need for local champions of HIV prevention who are members of communities most at risk. Adult, heterosexual African male role models who mirror desired behaviours and represent a masculinity that protects self and others from HIV need to be identified, encouraged, mentored, and supported to be maximally visible, vocal, and prominent at local, national, and regional levels. HIV prevention programming that engages directly with men of all ages need to be brought to a mass scale for creating a social environment that supports rather than undermines safer sex messages. For intergenerational relationships the onus should be on adult men to stop engaging in potentially exploitative relationships and to recognise that relationships of wide age disparities represent an abuse of power and status. Older men need to be made aware of the very high HIV prevalence among young women as a way to militate against pervasive ideas that they are 'clean' partners.

2 Rapidly and greatly increase programmes aimed at empowering young women and raising their risk-perception regarding involvement in age-disparate relationships. Financial dependence on men remains a key factor in women's vulnerability to HIV generally, and economic stress makes young women's susceptibility to involvement in intergenerational relationships. Ensuring access to education remains as a major route out of women's ongoing poverty and dependency, and programmes aimed at keeping girls in school and economically empowering young women must be linked and expanded. Peers who have successfully resisted involvement in these relationships should be identified and supported to be local-level peer educators who assist with raising young women's awareness of risks in age-disparate relationships. Young women need to visualise the possibility of a future that is achievable through their own efforts and to contemplate relationships in which men are not expected to provide economically.

3 Work with cultural idioms and socio-moral frames that distinguish between normative, acceptable relationships and non-normative, unacceptable relationships such as prostitution.
While it may be acceptable for a young unmarried woman to have a number of pre-marital relationships through

Age-disparate sexual relationships as a strategy gain viability and meaning within the context of existing structural conditions and prevailing gender and power relations. Such relationships are nested within a common system of sociosexual networking that includes the normative elements of multiple and concurrent partnerships and the semiotics of sex-money transfers. While poorer women are more vulnerable to the coercion and material enticements of older men, all young women, whether rich or poor, rural or urban, living in a context where culture assigns an ethical obligation for men to reciprocate a woman's 'giving' of sex with a gift symbolic of love or appreciation (Swidler & Watkins, 2007), are mindful of how relationships with older men can be advantageous. Most economies in the region are expanding along with young women's expectations of a modern lifestyle, gender equality and relationships that simulate globalised images of prosperity and romance. Relationships with older men provide a readily available and largely socially accepted way to meet a growing list of needs and wants that range from bread and school fees to designer handbags and glamorous outings. Growing aspirations in societies where the gap between rich and poor is widening and women perceive few options for obtaining financial independence, coupled with cultural allowances for age-disparate relationships and exchange expectations in sex, make young women of southern Africa exceptionally vulnerable to HIV infection.

which she accumulates various forms of capital, prostitution (perceived as strictly transactional and devoid of emotion), is considered socially unacceptable. Studies reveal that relationships where there are wide age disparities are widely viewed as essentially and primarily transactional, resulting in ambivalence and covertness. When given a public face such relationships are often labeled as prostitution. Questioning and challenging the covert nature of intergenerational sex may be one way to stimulate social sanctioning against this practice.

4 **Intensify engagement of the faith-based and traditional leadership sectors.**
Throughout southern Africa the response of the faith based sector to HIV prevention remains limited in comparison to their response to AIDS treatment and care. Traditional leaders have yet to be effectively engaged and could play important roles in influencing changes in men's attitudes and behaviours, especially in rural areas. As moral authorities these two sectors are well placed to discourage age-disparate relationships.

5 **5. Compel the media to become real partners in HIV prevention.**
Throughout southern Africa media and advertising is playing an increasingly important role in shaping young people's expectations in relationships. Studies indicate that young women's aspirations and motivations for seeking older men as sexual partners are highly influenced by media images and messages. Ways need to be found for making this sector a more accountable partner in the creation of the type of environment required for sustainable, long-term protection against HIV/AIDS. Thus far the power and influence of these important role-players has been underutilized in the fight against HIV/AIDS. Media should be compelled to promote consideration for sexual safety and the sexual rights of others, and should not be allowed to proceed with business as usual in hyper-affected HIV/AIDS countries.

6 **Ensure that supportive legislation that protects against the sexual exploitation of girls is in place and strengthen efforts to enforce those laws.** While in most countries in the region it is a crime to engage in sex with a girl below the age of 16, the law is often applied selectively or ineffectively. Where a girl is underage men need to be prosecuted and prosecutions need to be made public and visible.

7 **Community driven, multiple responses to the social drivers of HIV need to be developed, supported and intensified.** HIV prevention needs to be understood as a process of social transformation. Changes in local norms and values associated with age-disparate sexual relationships are required to ensure effective responses to this practice. Social networks can play an important role in sanctioning against age-disparate sex by fostering local ownership of responses that are relevant and meaningful. Initiatives intended to discourage age-disparate sexual relationships should be integrated into responses that address poverty and the lack of opportunity experienced by young women.

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Education, HIV/AIDS, & **vulnerability:**

An issues brief

The Challenge

Both general schooling and HIV/AIDS-related education have a role to play in protecting girls from infection [1]. There is growing evidence [2] that keeping girls in school reduces the frequency of unprotected sex. The relationship between educational attainment and HIV has changed over time with educational attainment now more likely to be associated with lower risk of HIV infection than earlier in the epidemic [3]. However, educational attainment cannot be confidently isolated from other socioeconomic factors as the cause of HIV risk reduction.

Evidence of ineffective HIV prevention education in schools underlines the need for careful evidence-based program design. Despite the challenges, recent provisional evidence shows that short, highly-targeted programs promoting reasonable alternatives may lead to safer sexual behavior. Targeted education programs have also been successful in changing students' attitudes to people living with HIV and AIDS, which is associated with testing and treatment decisions. This reduction in stigma may be crucial in encouraging the uptake of voluntary counseling and testing, a central strategy in the control of the epidemic. Expansions of carefully designed and evaluated school-based HIV prevention programs can help to reduce stigma and have the potential to promote safe sexual behavior

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Policies on access to education

As it has become increasingly clear that keeping girls in school is protective against HIV, achieving Education for All (EFA) would be a critical contribution to HIV prevention. Achieving universal access is not just about meeting national goals, but about focusing on regions within countries that are falling behind. Further, it is necessary to develop an equivalent of EFA-FTI for secondary education, as achieving secondary education for all would be disproportionately advantageous for HIV prevention. While it is unrealistic to expect these countries to provide EFA and secondary education for all immediately, increasing population education levels is not an all-or-nothing proposition. Keeping girls in school a year longer is beneficial for HIV prevention even if they do not complete secondary school. Girls are less likely to engage in unprotected sex while they are attending school.

Focusing EFA efforts on the poor, who are the least likely to attend school, will have particular benefits in the fight against HIV. Poverty and HIV are intertwined issues in southern Africa. When faced with financial constraints, it may be impossible for HIV- and AIDS-affected families to pay school fees and indirect costs of education such as uniforms and books. Programs need to explicitly address this factor and make schooling affordable for the poorest segment of the population.

Action points

• Strengthen country actions to achieve universal access to basic education, addressing equity and equality in gender and geography.

• Develop a new focus on promoting participation in secondary education, especially for girls.

Policies on curriculum responses to HIV/AIDS

While increasing levels of general education can be effective, tailored HIV prevention curriculum also has a role to play. There are at least three successive levels at which a curriculum response can be effective. At the most basic level, even relatively simple interventions in resource-poor environments can usefully address stigma and discrimination, as discussed above. At a slightly higher level of complexity it is clear that strategic information or actionable knowledge can have important impacts while requiring relatively manageable intervention by the education sector. Provision of information that is useful, targeted, and relevant to students is one factor that influences parent and student perceptions of school quality. At the highest level of complexity, there is a clear and sound theoretical argument for providing an educational package that aims to develop knowledge, attitudes and skills specifically aimed at HIV prevention, promoting behaviors such as condom use and partner reduction [4]. However, it is not easy to implement these programs well, especially at large scale, and poorly-implemented programs are unlikely to show an effect. A particular challenge is that programs are not fully or faithfully implemented in some schools. Guidance on how to develop skill-building programs is vague and there is a great deal of confusion, resulting in enormous variation in program content and quality. Program design should be based on recent evidence-based recommendations [e.g. 5]. However, the recommendations to date are not based exclusively on rigorous trials and further evidence is needed.

Action points

• Ensure immediately that curricula at all levels address stigma and discrimination.

• Develop a renewed emphasis on actionable knowledge, starting with implementing approaches of known effectiveness, while simultaneously identifying and testing new approaches.

• Launch a systematic, sub-regional approach to implementing high-quality HIV prevention programs which incorporate impact evaluation as an intrinsic component of program design.

• Promote sustainability of the HIV response by packaging within existing frameworks, especially school health and nutrition programs.

Building a community of practice and sharing knowledge

The challenges that HIV presents to the education sectors of southern Africa are unique to the region. Lessons learned elsewhere may be important and useful, but lessons learned locally will be even more so. Yet, in the education sector there is a lack of a systematic mechanism for sharing knowledge and experiences of HIV, and in particular experiences that involve both the health and education sectors. Networks involving HIV focal points from Ministries of Education as well as representatives of National AIDS Authorities have proven very effective mechanisms for facilitating the sharing of information both elsewhere in Africa and in the rest of the world [6]. Establishing such a mechanism within the subregion might provide an important platform for sharing information and optimizing the investment in evaluations while avoiding duplication.

Key policy action

• Create an enabling network for the region, promoting information sharing and joint action by the education sector.

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