
ISSUES BRIEF

Advancing young women's sexual and reproductive health and rights in the context of HIV



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Executive Summary

This issues brief is part of a series commissioned by the Global Coalition on Women and AIDS (GCWA). It is designed to bring to light critical issues pertaining to the sexual and reproductive health and rights (SRHR) of young women¹ living with, at risk of and affected by HIV, along with examples of good practice interventions and successful scale-up approaches. The brief is intended to guide global advocacy and inform negotiations in the context of the Post-2015 development framework, the International Conference on Population and Development (ICPD)¹ Beyond 2014 Review and the Beijing+20 Review.²

The brief opens by explaining why the fulfilment of young women's SRHR is critical for a gender transformative AIDS response. It then examines the multiple dimensions of inequality that create unique challenges for young women, and the subsequent impact on their health and rights. The brief then summarises evidence about promising practices that can effectively advance young women's SRHR in the context of HIV. These promising practices include strategies for:

- Scaling up effective HIV prevention and SRH interventions for young women, including comprehensive sexuality education, integrated youth-friendly HIV and SRH services, multi-sectoral programmes for young women, harm reduction services for young women, and safe spaces for girls and young women;
- Tackling all forms of violence against young women and harmful gender norms;
- Expanding the participation of young women in decision-making that affects their lives;
- Ensuring a protective legal environment for young women; and
- Tackling socio-economic inequalities and expanding social protection for young women.

The brief concludes with seven recommendations to advance young women's sexual and reproductive health and to uphold their rights in the context of HIV, within the post 2015 development framework, ICPD Beyond 2014 and Beijing+20 reviews:

1. Recognize all young women as autonomous rights holders and ensure a protective legal environment.
2. Ensure the meaningful participation of young women in decision-making processes.
3. Explicitly recognize young women's sexual and reproductive health and rights in the context of HIV.
4. Increase access to quality, rights-based integrated HIV and SRHR services and comprehensive sexuality education.
5. Advance gender equality with a focus on ending all forms of violence against young women.
6. Expand the availability and quality of strategic data on young women.
7. Place young women's social protection at the core of poverty eradication.

¹ In this issues brief, young women refer to girls and women between 15 and 24 years, in line with UNAIDS' HIV monitoring frameworks.

Introduction

This issues brief is part of a series commissioned by the GCWA. It is designed to bring to light critical issues pertaining to the SRHR of young women living with, at risk of and affected by HIV, along with examples of good practice interventions and successful scale-up approaches. It also examines how multiple dimensions of inequality create unique challenges for young women, and the subsequent impact on their health and rights. The brief is intended to guide global advocacy and inform negotiations in the context of the Post-2015 development framework. The brief concludes with seven recommendations to advance young women's sexual and reproductive health (SRH) and to uphold their rights in the context of HIV.

Why is the fulfilment of young women's sexual and reproductive health and rights critical for a gender transformative AIDS response?

Young women are recognized as powerful drivers for social change and as central to achieving global targets for health and development, including the millennium development goals (MDGs) and the future post-2015 goals. At the same time, young women, especially those living with and affected by HIV, continue to experience multiple layers of discrimination, which result in negative health and rights outcomes.

Worldwide, young women are twice as likely to be living with HIV than are their male peers.³ Every hour, 50 young women are newly infected with HIV⁴, predominantly through sexual transmission. In low- and middle-income countries, young women account for 24% of all new HIV infections among adults, which is 50% more than young men of the same age group.³ Globally, young women have less comprehensive and correct knowledge of

HIV than do young men, 28% and 36%, respectively.³ Throughout the world, HIV prevalence is substantially higher among women in key populationsⁱⁱ compared with the general population. For example, transgender women are 49 times more likely to be living with HIV than are women overall.⁵ Female sex workers (FSW) in low- and middle-income countries are 13.5 times more likely to be living with HIV compared with the general population of women.⁶ HIV prevalence is also 22 times higher among people who inject drugs than in the general population.⁷

At the same time, young women are disproportionately affected by violations of their sexual and reproductive rights, resulting in increased vulnerability to HIV and negative health outcomes.

- Adolescent girls are physiologically more prone to HIV infection and to pregnancy-related complications, including obstetric fistula, than are adult women.^{7,18}
- Access to and use of condoms among young women remains low in many countries, despite condoms offering dual protection against HIV and unintended pregnancy.²⁷
- Up to 45% of adolescent girlsⁱⁱⁱ around the world report that their first sexual experience was forced.⁸ Sexual violence is associated with increased risks of HIV infection and unintended pregnancies.⁹⁻¹²
- Young women living with HIV have reported cases of forced sterilization or coerced abortions in several countries.²³⁻²⁶
- Every year, there are approximately 16 million births among adolescent girls, accounting for 11% of all births worldwide.¹⁶ Yet, adolescent girls disproportionately experience 23% of the

ⁱⁱ UNAIDS defines "key populations" as communities that are most likely to be living with HIV or those disproportionately affected by HIV as compared to the general population. Key population groups vary from one setting to the next, depending on the specific epidemiological and social factors that characterise the setting. In general terms, the following groups of young women are often considered key populations: young women who inject drugs or who are sexual partners of people who inject drugs; female sex workers and young women under 18 years who sell sex; transgender young women.¹⁷¹

ⁱⁱⁱ In this issues brief, adolescent girls refer to girls between 10 and 19 yrs. (as defined by the WHO and UNICEF), unless stated otherwise for specific figures.

global burden of disease associated with pregnancy.¹⁷

- Pregnancy-related complications are the leading cause of death among young women 15 to 19 yrs.¹³ Approximately 10% of maternal deaths worldwide are associated with HIV, with adolescents disproportionately affected.^{14,15}
- Globally, 41% of unsafe abortions occur among women ages 15–24.¹⁹ Women living with HIV are more prone to septicaemia and other complications resulting from unsafe abortion.²⁰
- One of the most common sexually transmitted infections (STI) worldwide is Human Papilloma Virus (HPV), which disproportionately affects young women and results in half a million cases of cervical cancer annually with, 240,000 deaths, primarily in developing countries.²¹ Women living with HIV are more susceptible to HPV and are more prone to developing cervical cancer as a result of HPV.²²

While the HIV response has made notable gains in raising awareness on the link between gender inequality, gender-based violence and HIV, the above statistics reveal that more is needed to address the multi-faceted dimensions of gender inequality and discrimination that continue to impose detrimental consequences on young women's health, resilience, self-determination and agency. Indeed, numerous human rights treaties^{iv} affirm that all young women are entitled to sexual and reproductive rights and several international agreements have set out frameworks for the fulfilment of such rights.^v Yet, sexual and reproductive rights violations continue to be an

^{iv} Including: the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child (CRC), the Convention against Torture and other cruel, inhuman or degrading treatment or punishment (CAT) and the International Convention on protection of the rights of all Migrant Workers and members of their families (ICMRW)

^v Particularly the Programme of Action of the International Conference on Population and Development (para 7.3) and the Declaration and Platform for Action from the 4th World Conference on Women in Beijing (para 96). The 2002 WHO technical consultation on sexual health also produced an international definition of sexual rights.¹⁷²

underlying cause and consequence of HIV infection and negative SRH outcomes for young women.

Intensifying efforts to advance gender equality and the SRHR of young women is not only a human rights imperative but also essential to an effective and sustainable HIV response and as such, a cornerstone for sustainable development. By prioritising young women's SRHR and leveraging synergistic actions around MDGs 3, 4, 5, and 6, governments, civil society and the international community can dramatically reduce HIV infections, AIDS-related deaths and discrimination, while simultaneously improving SRH, expanding gender equality, and making strides to achieve universal access to health care.

Challenges to the fulfilment of young women's sexual and reproductive health and rights in the context of HIV

i. Lack of recognition under the law and protective legal environments

Worldwide, young women are not adequately recognized as rights-holders in laws and policies. Girls and young women who do not have identity papers, fail to claim their legal entitlements.⁴⁶ Mandatory parental or spousal consent regulations reflect the lack of legal recognition of young women's rights. Evidence shows that mandatory parental notification requirements deter young women from accessing important SRH and HIV services due to fear of disclosure or violence.^{17,50–52} Additionally, these laws have not been found to foster positive parental involvement in decision-making concerning young people's health.⁵³

Furthermore, discriminatory social and cultural norms, in particular when translated into laws, result in public denial and, at times, repression of young women's sexuality and autonomy. Approximately 40% of women of reproductive age live in countries with restrictive abortion

legislation.⁵⁶ In countries where abortion legislation is restrictive, incidences of unsafe abortion are generally high, contributing to increased rates of maternal mortality and morbidity.⁵⁷ Laws that criminalise the transmission of HIV, injecting drug use, sex work and homosexuality also have negative consequences on young women's SRHR, for example resulting in lack of access to contraceptives.^{46,54,55}

ii. Limited space for meaningful participation

Notable progress has been made in terms of recognizing young people's participation as a human right and as an essential element for an effective response to HIV. Nonetheless, young women, continue to be overlooked and under-represented in decision-making processes that affect their lives. Furthermore, when opportunities for youth participation exist, they are often limited to programmatic interventions, such as peer education, rather than inclusion in decision-making and design processes. As such, young women's participation is often limited to implementing policies and programmes rather than designing, monitoring or evaluating them.

Young women living with HIV and from key populations are often even not only challenged in accessing services but also in meaningfully participating in policy setting and programming, thus missing out on opportunities to shape health and social services they need. One example is the relatively limited space for young women who have sex with women (WSW) to participate in HIV and SRH programmes and policy-making. A widespread misconception exists that WSW are all at low risk of HIV infection, contracting STIs, and unintended pregnancies.⁸¹ The fact that WSW might also engage in sex with men, experience sexual violence perpetrated by men and/or use injection drugs is often overlooked. The meaningful participation of young WSW in decision-making processes could contribute to more effective programmes and services.

iii. Lack of access to quality integrated health services

There is growing recognition of the importance of adapting health services to the needs of young people. However, most countries lack adequate

youth-friendly SRH and HIV service delivery models that respond to the diverse realities of young women. In many settings, SRH services are designed primarily for married women with children, thereby excluding young unmarried women. For example, in Kenya, Rwanda and Senegal, over 70% of unmarried sexually active adolescent girls (15 to 19) have an unmet need for contraception.⁶⁸ A key challenge to adapting SRH services for young women is the scarce availability of health and demographic data about adolescent girls and young women. Population-wide data are often not disaggregated in such a way to collect information about young women in age cohorts between 10 and 24 years. Disaggregation of data by demographic characteristics, such as marital status and socio-economic status, of young women is also lacking.

In many countries, safe abortion services are only available for women under a limited number of circumstances, despite the fact that unsafe abortion is responsible for about 13% of all maternal deaths, with adolescents disproportionately affected.^{57,70} Lack of access to youth-friendly integrated SRH services is another reason young women are more likely than older women to delay seeking abortion services, if available, when confronted with an unwanted pregnancy.⁶⁹ Later-term abortions are associated with greater risk of mortality and morbidity compared with abortions performed at earlier stages of a pregnancy.

Many HIV treatment, support and care services are designed either for children or for adults. The lack of adapted health services for young people creates a specific barrier for young women living with HIV wishing to access antiretroviral therapy (ART). Recent studies from Southern Africa have demonstrated that ART attrition rates are significantly higher among young people than among children or adults, partly due to a lack of youth-friendly services.^{71,72}

Even when young women are able to access SRH services, stigma and discrimination exhibited by health providers and community members create additional barriers for young women. Health professionals' judgemental attitudes can result in a denial of important health services for young women or can lead to coerced services.⁷⁵⁻⁷⁷ Furthermore, health providers often lack adequate training and skills to deliver youth-friendly SRH and HIV services and often have unclear notions of

pertinent laws, including age of consent to access services, age of consent for sexual activity and abortion legislation.⁸⁰

Women living with HIV often experience interdependent and simultaneous barriers to accessing health services related to marginalized social identities and inequities such as HIV-related stigma, sexism, racism and homo/transphobia, as shown by a study in Canada and confirmed elsewhere.⁷³ For example, women living with HIV have reported forced sterilisation or coerced terminations of pregnancy in many countries in Africa, Asia and Latin America.^{23,25,26,78}

Social exclusion, including stigma and discrimination, of young women in key populations and limit their access to quality SRH and HIV information and services. For example, in many countries, health and social services for FSWs are only offered to women over the age of 18, thereby excluding adolescents who sell sex.⁷⁴ FSWs and young women who use drugs are usually less likely to access general youth-friendly services due to stigma and prejudice among health care staff. Limited access to services has also been documented in Eastern Europe and Central Asia with people who use drugs.⁷⁹ In some cases, particularly adolescents are excluded from harm reduction services, as these are only made available to older people.⁷⁴ As a result, these young women experience higher risks of HIV infection and negative SRH outcomes than do women in the general population.³⁰

iv. Violence against women and harmful gender norms

Harmful gender norms and practices, especially those underlying violence against women and girls, have severe repercussions on young women's SRHR. Surveys undertaken in Haiti, Kenya, Tanzania, Swaziland and Zimbabwe through the *Together for Girls Initiative* revealed that one in five girls under the age of 15 has experienced forced first sex.⁵⁸ Intimate partner violence (IPV), one of the most common forms of violence, is closely linked to harmful gender norms, particularly female subordination, the acceptance of wife beating, and childhood abuse.⁵⁹

Numerous studies demonstrate that partner violence increases the risk of HIV infection and unwanted pregnancies.^{9–12} A recent South African study found that young women (ages 15–26) who

experienced IPV were 50% more likely to have acquired HIV than were women who had not experienced violence.⁶⁰ Young women in key populations have a greater risk of sexual violence due to discrimination and lack of legal and social protection.⁶¹ Young women living with HIV often experience increased levels of partner violence due to their HIV status, especially when post-diagnosis support is not in place.⁶² Young women living with HIV have also experienced forms of institutional violence, including forced sterilisation, forced abortion, and denial of voluntary sterilisation or safe abortion services.^{23,24,63}

Despite a global trend towards increasing the age of marriage, approximately one-third of young women in low- and middle-income countries^{vi} are married before the age of 18- approximately 39,000 girls per day.⁶⁴ Early and forced marriage is associated with a high risk of untimely pregnancies, IPV, and potential HIV transmission.^{65–67} Young married girls are more likely to be exposed to early, frequent and unwanted sexual relations, and often have limited access to contraception and other SRH services and information.⁶⁵ This not only leads to pregnancy and childbirth before being physiologically ready but also can result in obstetric fistula and other pregnancy-related complications, including death.^{15,65}

v. Socioeconomic Inequalities

Around the world, young women are often denied their social and economic rights, contributing to detrimental inequalities that have a direct impact on their SRHR and their resilience to HIV.²⁸

Poverty and limited access to social protection

Poverty, stemming from violations of social and economic rights, can be both a risk factor and consequence of negative SRHR outcomes and HIV.^{6,17,29–32} Poverty is associated with early sexual debut, concurrent sexual partners and engagement in transactional sex with older male partners, which all increase the risk of HIV and early pregnancy for young women.^{32,34–37} Studies demonstrate that adolescent pregnancy and childbirth, exacerbated by school drop-out rates including because HIV-affected family members,

^{vi} Excluding China

result in lost future economic opportunities for girls and young women.^{15,33}

In addition to low wages, unpaid labour, and limited social protection faced by many young women around the world, working conditions are often also characterized by abuse and mistreatment.³⁸ Young women are often excluded or unable to access social protection entitlements, which can increase their vulnerability to HIV and poor SRH outcomes.⁴⁰ Moreover, few national social protection schemes include young women's empowerment or the transformation of gender norms as primary outcomes.³⁹ Access to social protection is especially limited for young women from socially excluded groups, including young women who use drugs, young sex workers, young transgender women and young migrants.

Lack of property and inheritance rights for women is another manifestation of socioeconomic inequality that hinders young women's health and well-being. In many sub-Saharan African and South Asian countries, women are systematically denied the right to access, own or inherit land and property. Even where national laws recognize women's right to land and property ownership, customary laws and discriminatory institutional practices often prevent women from exercising these rights.^{41,42} Evidence shows that when women's property and inheritance rights are denied, their economic security is threatened and their vulnerability to domestic violence, unsafe sex and other HIV-related risk factors are increased.⁴¹ In addition, female-headed households are less able to mitigate the negative economic and social consequences of HIV when women are denied the right to access land, property and inheritance assets.⁴²

Limited access to education

Access to education is widely recognized as a human right and is critical for a gender-transformative response to HIV^{vii}. Since the onset of the MDGs, the net enrolment rates for girls at primary level and the proportion of girls who complete a full primary cycle have increased in all regions.⁴³ Nevertheless, large inequalities persist in terms of girls' and young women's access to

education, with approximately 34 million adolescent girls around the world being out of school,⁴⁴ and girls' enrolment and completion of secondary school remaining low. For example, in sub-Saharan Africa, 80% of young women have not completed secondary education and a third of young women cannot read.³⁸

In low- and middle-income countries, parents may be reluctant to invest in girls' education, especially in poor and rural areas, when return on investment is not perceived.⁴⁶ For example, indigenous girls in Peru generally complete four years less education than the national average.⁴⁵ For girls who are able to attend school, socio-cultural gender factors often limit their fields of study, making it difficult for them to study or work in fields that are traditionally associated with men, such as sciences, business and technology. Furthermore, schools are often ill-equipped to ensure a safe and productive learning environment for young women. For example, 30% of young female rape survivors in South Africa report that they were raped in or around their schools.⁴⁹

In addition, many national curricula offer sexuality education that is limited in scope and poor in quality, particularly lacking gender transformative content. According to the UNAIDS Report on the Global AIDS Epidemic 2010, only a third of countries reported that life-skills-based education was widely available in schools.²⁷ A recent in-depth review of sexuality education in Eastern and Southern Africa revealed that most curricula were weak on gender and had major gaps in content related to condoms, contraception and other SRH topics^{viii}.⁴⁷ Teachers also often lack sufficient training and support to deliver sexuality education, and often fear censure by their colleagues or communities for addressing sensitive issues in class.⁴⁸

^{vii} The right to education (Art.13) : . 08/12/1999. E/C.12/1999/10. (General Comments) <http://www.unhchr.ch/tbs/doc.nsf/0/ae1a0b126d068e868025683c003c8b3b?OpenDocument>

^{viii} Notably, STIs, abortion, sexual abuse and where to access services.

Promising practices building on evidence

Despite the challenges outlined above, there is a growing body of evidence demonstrating what works to fulfill young women's sexual and reproductive rights and reduce new HIV infections. By galvanising commitments and bolstering action around proven and promising practices, governments, civil society and the international community will be able to make great strides toward ensuring an effective gender-transformative HIV response while fulfilling young women's rights throughout their life cycle and improving young women's health and resilience. Many of these proven and promising practices are not new, yet greater investment is required to scale-up and to adapt strategies for specific contexts and to increase the meaningful participation of young women.

Ensuring a protective legal environment for young women in the context of HIV

Discriminatory laws that restrict the realisation of young women's rights must be repealed to reduce new HIV infections and to improve SRH. Of particular importance is the removal of mandatory parental or spousal consent requirements for accessing SRH and HIV services.

Young women are disproportionately affected by complications resulting from unsafe abortions, in relation to older women.²⁰ It is therefore important to guarantee access to safe abortion services for young women through national legislation. The liberalisation of abortion laws should be accompanied by increased access to contraceptive services and comprehensive sexuality education for young women.⁹³ A recent study by the Guttmacher Institute and the World Health Organisation demonstrated that rates of unsafe abortion are highest in regions with restrictive abortion law, while overall abortion rates are lower in regions where women live under liberal abortion laws.¹⁰⁰

↘ Some illustrations of good practices of laws and policies that fulfil young women's right to access safe abortion services include South Africa's *Choice on Termination of Pregnancy Act* (1996), New Zealand's *The Care of Children Act* (2004) and the Zambian Ministry of

Health's *Standards and Guidelines for Reducing Unsafe Abortion Morbidity and Mortality* (2009). These legal and policy documents explicitly state that minors can consent to safe abortion services without mandatory authorisation from parents and guardians. As such, these laws and regulations have reduced mortality and morbidity associated with unsafe abortion among young women.¹⁰¹ For example, a study in South Africa demonstrated that the introduction of the *Choice on Termination of Pregnancy Act* reduced the incidence of unsafe abortion among young women (under 20 years), contributed to a reduction in morbidity from incomplete abortion among young women.¹⁰²

Experience shows that criminalisation of HIV transmission, exposure, and non-disclosure, along with punitive laws against sex work, drug use and same-sex sexual activity reinforce stigma and discrimination. This in turn amplifies risk factors for HIV rather than reducing them. Repealing such laws and enhancing public policies that address the underlying causes of young women's vulnerability to HIV transmission is acknowledged as an effective rights-based approach to advancing health and rights outcomes.¹⁰³

↘ Recently, a number of countries, including Guinea, Togo and Senegal, revised their HIV-related legislation or adopted new laws to restrict criminal law solely to cases of intentional transmission.¹⁰⁴

Expanding participation for young women in decision-making that affects their lives

Young women's participation is recognized as both a human right and a lever for success to achieve health equity and global development goals.¹⁵⁹ Several international agreements^{ix} explicitly call on governments to expand youth participation as a component of SRHR and HIV programmes. Around the globe, youth-led organisations working on SRHR and HIV have burgeoned into important stakeholders at national, regional and

^{ix} Including the ICPD Programme of Action (1994), Key Actions for the Further Implementation of the Programme of Action of the ICPD (1999) and the Declaration of Commitment on HIV and AIDS (2001)

international levels. Young women activists and advocates have made, and are making, considerable contributions to the response to HIV and the advancement of SRHR. Youth-led organisations often have first-hand knowledge of the challenges faced by young women and their capacity as agents of change. Young-women-led organisations are often able to access hardest to reach populations in their networks.¹⁶⁰

Emerging evidence suggests that effective approaches for meaningful youth participation include designing or modifying organisational structures to facilitate youth participation, introducing metrics to assess the level and quality of youth participation, engaging young people in youth-led participatory action research, undertaking community youth mapping into programmes and applying youth participation evaluation methods to assess performance.^{161–163} Formal systems for youth participation in decision-making, such as youth advisory committees, youth representatives in high-level decision-making panels, youth-led advocacy initiatives and youth councils, can also make significant contributions to creating a favourable political and legal context for young women's health and rights.^{164,165}

➤ An example of a national-level promising practice is a project in Rwanda that supported young women from the *Rwandan Youth Action Movement* to run advocacy efforts to increase access to safe abortion services. The group combined qualitative research with various advocacy, communications and community engagement strategies. These youth-led efforts played a significant role in advocacy that resulted in revisions to the penal code, which decreased criminal penalties related to abortion.¹⁶⁴

➤ Examples at the international level include the work of the *Global Youth Coalition on HIV/AIDS*, the *Youth Coalition for Sexual and Reproductive Rights*, *Y-PEER* and *Youth RISE*. Entirely youth-led, these international organisations have influenced progressive outcomes from important high-level decision-making processes^x, through supporting young

people to become effective advocates, activists and researchers. UN agencies, including UNFPA, UNAIDS, UNESCO and UNICEF have created formal mechanisms for youth participation at global and regional level, to ensure that youth perspectives are integrated into the agencies' strategies, programmes and policies. For example, in 2013 UNAIDS established a Youth Advisory Forum to inform UNAIDS work on and with youth. Another good practice is the *International Planned Parenthood Federation's (IPPF)* policy on youth participation in governance, which states that at least 20% of its international and national governance structure should be composed of young people.¹⁶⁶

Scaling up effective HIV prevention and SRH interventions for young women

There is increasing evidence on proven and promising HIV prevention and SRH interventions for young women, as outlined below. If brought to scale, these interventions could have a powerful impact on the health and rights of young women.

Comprehensive sexuality education

There is strong evidence that comprehensive age-appropriate sexuality education is pivotal to improving young women's SRH and in preventing new HIV infections. Several studies show that sexuality education programmes based on comprehensive and accurate information and offered to young people prior to sexual debut result in improved health outcomes.^{15,124,128–130}

Studies in numerous countries reveal that comprehensive sexuality education in school settings can increase condom use and voluntary HIV testing among young women, reduce adolescent pregnancy and reduce stigma against people living with HIV.^{17,131,132} Particular focus should be placed on increasing access to age-appropriate comprehensive sexuality education for younger adolescents (ages 10 – 15). When young people have access to gender-transformative comprehensive sexuality education prior to becoming sexually active, they are more likely to make informed decisions about their sexuality and interpersonal relationships.^{116,128,129}

Comprehensive sexuality education at an early age can also contribute to decreased stigma and discrimination against people living with HIV and

^x Including the MDG review processes, the Commission on the Status of Women, the Commission on Population and Development, High-Level meetings on HIV and AIDS, etc.

help young adolescents gain confidence and communication skills to report incidences of sexual abuse or harassment.¹³¹

Peer education is an important strategy for young women, especially in key populations. Peer education programmes have contributed to increased protective behaviours such as condom use and safe injection practices among women who use drugs and female partners of men who use drugs.¹³¹ Peer education programmes for transgender young women have also been identified as a useful instrument to reduce risky sexual behaviours.¹³³

Coordinated political commitment from the Ministries of Health and Ministries of Education can greatly expand access to comprehensive sexuality education.

✦ In 2008, 30 Ministries of Health and 26 Ministries of Education in Latin America and the Caribbean signed the ministerial declaration “*Preventing through Education*.”¹³⁴ An annual evaluation of the ministerial declaration’s implementation reveals significant advances in the region toward increasing access to comprehensive sexuality education and SRH services for young people.¹³⁵ A similar declaration was signed in December 2013 by 21 governments from Eastern and Southern Africa, pledging commitment to scale-up sexuality education and SRH services for young people as key components of the response to HIV.⁴⁷ Efforts should be made in other regions around the world to develop similar political declarations with the full involvement of civil society and young women.

Numerous studies show that increasing girls’ and young women’s educational attainment is linked to better HIV and SRH outcomes.¹³⁶ Therefore, efforts to scale up in-school comprehensive sexuality education should be accompanied by actions to increase girls’ school enrolment and completion rates and to improve the quality of education. A process evaluation in Tanzania highlighted how overall poor quality of school-based education can significantly limit the results of sexuality education.¹³⁷ It is therefore important to ensure adequate training and supportive supervision for teachers and to adapt educational

content, delivery methods and pedagogical approaches to the realities of young women living with HIV and affected by HIV.¹³¹

Integrated youth-friendly HIV and SRH services

Evidence demonstrates that providing integrated youth-friendly HIV and SRH services to young women results in improved health outcomes.^{131,138} Health services should be conveniently located, free of charge or affordable, confidential, private and delivered by competent, non-judgemental healthcare providers.

✦ Recent studies from Southern Africa found that offering youth-friendly SRH services and adolescent support groups to young people living with HIV was associated with lower levels of ART attrition.^{71,72} Studies also demonstrate that offering quality contraceptive services and antenatal care to adolescents living with HIV can effectively reduce unintended pregnancies and vertical transmission of HIV.^{139,140} Youth-friendly distribution of female and male condoms can help young people who are sexually active feel more confident in accessing condoms and increase condom use.¹⁴¹⁻¹⁴⁴ Promoting pleasure in male and female condom use can increase the practice of safer sex.^{145,146}

Offering health services outside clinical settings is a vital component of youth-friendly health care, especially for marginalised groups of young women, including young women living in rural areas, young women living with disabilities, poor young women and young women who sell sex.¹³¹ Programmes that offer health services close to where FSWs work can increase condom use and decrease STI prevalence rates.¹³¹ Other evidence suggests that home-based HIV testing can increase the number of people who learn their HIV status.^{147,148} Outreach services in schools have also been proven to increase access to health services for young women.¹¹⁶

✦ For example, an evaluated two-year programme in Vietnam that ran outreach services^{xi} in 111 secondary schools increased the uptake of health services by young people by 68%.¹¹⁶

^{xi} Consisting of voluntary counselling, contraceptive services and testing for STIs and HIV.

Multi-sector approaches for young women: health, education, community mobilisation and advocacy

Increasing evidence demonstrates that the most effective programmes for young women take a multi-sectoral approach, integrating health services, education including comprehensive sexuality education, advocacy and community engagement.¹³¹ Evaluated multi-sectoral approaches in many countries have resulted in increased uptake of SRH and HIV services by young people, increased use of modern contraception, enhanced empowerment outcomes for young women and increased age of marriage.¹¹¹

➤ For example, the *A+ programme* was a three-year multi-sectoral intervention implemented in 16 countries in Sub-Saharan Africa, South Asia and Central America. *A+* programme used an approach aimed at increasing access to quality youth-friendly services and comprehensive sexuality education while also building supportive communities and advocating for policy changes to advance young people's sexual rights. *A+* programme resulted in a 63% increase in the uptake of youth-friendly SRH services and over two million new young users of SRH and HIV services. An evaluation also demonstrated that the approach helped young women to gain confidence, develop positive social networks and improve communication skills.¹⁴⁹

Integrated approaches tailored to key populations have also proven to be effective. For example, when sexuality education, integrated HIV and SRH services and harm reduction strategies are accessible to young women, HIV and STI rates decrease.¹⁰⁴ Programmes for FSWs that include peer education, health services, support groups, condom social marketing, community advocacy and socio-economic support can enable FSWs to adopt safer sex practices and increase HIV counselling and testing.^{131,150} Programmes for orphans and vulnerable children that combine community development projects and HIV services can reduce stigma while also improving health outcomes.¹³¹

Harm reduction services for young women

A growing body of evidence demonstrates that harm reduction services are important to prevent HIV and improve SRH outcomes for young women who inject drugs and for young women with partners who inject drugs.^{131,151,152} Comprehensive programmes, including needle exchanges, opioid agonist therapy^{xii} and condom distribution are particularly promising.^{131,153,154} The literature also highlights the importance of removing age restrictions on harm reduction services to ensure access to young women of all ages.

➤ A promising practice is the *Opening Doors* project, which worked with young people (ages 10 to 25) who use drugs in China, Nepal and Thailand to develop innovative harm reduction approaches that meet the needs of young people. An evaluation of the project suggested that *Opening Doors* resulted in an increased engagement of young people with harm reduction services and improved self-reported mental health outcomes, a reduction in sharing of injection equipment and increased condom use.⁷⁴ Access for young women to drug treatment and rehabilitation facilities where they can access support to leave a problematic substance dependency situation is also an important strategy.

Harm reduction services should also be expanded for women living in prisons. Studies of harm reduction programmes in prisons in various Eastern and Western European and Central Asian countries suggest that needle and syringe programmes are feasible in women's prisons and that such programmes can also reduce HIV and Hepatitis C prevalence and reduce HIV-related stigma and discrimination.¹³¹

Safe spaces for girls and young women

Various models of safe spaces exist, generally involving regular and coordinated gatherings in a space that ensures physical safety while also providing an environment in which young women feel safe to express themselves, to develop new skills, to form friendships, to access peer support, to receive mentoring support from appropriate and trusted adults and to access information on

^{xii} particularly maintenance programs with methadone and buprenorphine

various topics. Creating safe spaces for young women and girls is a cornerstone for HIV and SRHR programmes, especially for young women who experience stigma and discrimination. Evidence suggests that mixed-sex programmes are often inappropriate for the most disadvantaged girls and young women.¹⁵⁵ Several reviews demonstrate that single-sex interventions and programmes that place an emphasis on creating safe spaces for young women can reduce the HIV-related risks associated with sexual and drug-related behaviours, while simultaneously increasing the uptake of health services among young women.^{131,149}

✎ The *Biruh Tesfa* project in Ethiopia organised regular meetings for young domestic workers, orphans and migrants in safe spaces with other female peers and mentors and shared information on HIV, offered life skills training and taught basic financial literacy skills. Young women could also access wellness check-ups and acquire identification cards. An evaluation showed that girls who participated in the programme were more likely to have accurate knowledge about HIV, were more likely to access voluntary counselling and testing services and were twice as likely to have social support and safety nets as compared with girls in the control group.¹⁵⁶

However, some studies also note that girl-only spaces can have an unintended consequence of increased harassment of girls and young women. It is therefore vital to work closely with communities and garner support from parents, men and boys.⁹⁸

Bringing interventions to scale

In order to effectively scale-up these interventions, the literature recommends the following:

- Select technically simple interventions that can be adapted to different contexts and scaled up in existing systems;
- Gain a clear understanding of the actual issues, the perceived need and demand for the interventions;
- Ensure local and national ownership and clarify the aims of scaling-up as well as the roles of different players;
- Obtain and disseminate data on the effectiveness of pilot programmes before scaling up (including documentation about the impact of changes made to interventions on programme effectiveness);
- Ensure the availability of resources to bring promising pilots to scale;
- Galvanise political commitment reinforced by supportive policies;
- Include all stakeholders; ensure accountability mechanisms are in place;
- Ensure that gender equality and human rights considerations are addressed.^{157,158}

Tackling all forms of violence against young women and harmful gender norms

Violence against women is an extreme expression of gender inequality and a fundamental human rights violation with serious health consequences. Evidence shows that enforcing laws that protect young women from gender-based violence while expanding gender-transformative social services and programmes that enhance women's access to justice, can increase young women's confidence to report cases of violence and shift permissive norms about gender-based violence and hate crimes.⁸ One proven practice is offering integrated health, social and legal services for women who experience violence.

✎ Several countries, including Bangladesh, Malaysia, Namibia, South Africa and Thailand, have introduced a promising concept of "one-stop" centres, which bring together a wide range of integrated services in one location to address IPV, including health, legal, social welfare and counselling services.¹⁰⁵ The strengthened cooperation among sectors has been shown to increase the likelihood that survivors will receive services such as forensic exams, counselling, emergency contraception and STI prophylaxis.¹⁰⁶ In addition, the one-stop "*Thutuzela Care Centres*" in South Africa have reported improved prosecution and conviction rates as well as a reduction in the time spent to investigate, prosecute and

convict perpetrators from 3-5 years to 6 months.¹⁰⁶ By confronting the multi-layered forms of discrimination that converge in young women's lives, integrated services can reinforce young women's ability to create alternatives to abusive relationships.

Integrated economic empowerment and gender equity programmes may contribute to reduce IPV and to improve HIV outcomes, if gender dynamics are taken into consideration.^{59,97} A systematic review of 41 studies points towards the potential for integrated economic empowerment programmes to reduce IPV, when training on gender empowerment and relationship negotiation skills and/or community interventions to reduce the risk of gender-related conflict in the household are included.⁹⁷ However strategies must be in place to mitigate potential negative reactions from men, including violence. The literature also points out that economic empowerment programmes must be tailored to the specific realities of adolescents and young women. For example, it is often unrealistic to expect adolescent girls to have high repayment rates if they are not equipped with business skills and supported to engage in income-generating activities. Programmes that aim to build self-confidence and to develop skills through vocational or livelihood skills training might be more appropriate for adolescent girls than direct participation in micro-financing schemes.⁹⁷

Several case studies have demonstrated the potential for civil society and women's rights organisations to utilise international human rights instruments, such as the Convention on the Elimination of Discrimination against Women (CEDAW), to encourage governments to comprehensively address violence against women. To better understand the realities on the ground, the United Nations Committee on the Elimination of Discrimination against women welcomes reports from civil society.

✎ For example, advocacy by women's rights organisations in Afghanistan using CEDAW contributed to the introduction of article 22 in the 2004 constitution, which recognises equal rights for women and men.¹⁰⁷

Tackling violence against young women also requires a concerted effort to end forced and early

marriage. Programmes that aim to offset financial incentives for parents to marry their daughters at a young age appear to be effective.¹⁰⁸

✎ For example, the *Berhane Hewan* programme in Ethiopia included economic incentives for girls' school enrolment, as well as community conversation sessions, female mentor groups and access to non-formal education and livelihood training. An evaluation of the programme demonstrated that it contributed to a decreased proportion of ever-married girls ages 10 to 14 years.^{109,110}

Another promising approach to ending child marriage is to adopt a comprehensive multi-sector approach, designed to reach girls and young women.

✎ For example, the *DISHA* programme in India combined community-level mentoring and community dialogue with youth-friendly SRH services, comprehensive sexuality education and life skills training. An evaluation of the programme showed that it contributed to increasing the age of marriage among participants by two years and increased reported use of modern contraception among married young people.¹¹¹

Hate crimes, especially against young transgender women, young WSW and young women living with HIV must be addressed to tackle violence against women. Experience shows that a comprehensive approach may work best to address hate crimes, including the following:

- collecting accurate data on bias-motivated violence;
- introducing and enforcing context-specific hate crime laws;
- training criminal justice personnel; establishing anti-discrimination and anti-bullying bodies;
- fostering collaboration between law enforcement, health services and community groups to build functional reporting and referral systems;
- and investing in non-discrimination education programmes, especially for young people.¹¹²

Some promising practices include the establishment of a specialist prosecutor unit for victims of gay, lesbian and transsexual violence in Berlin; an online hate crime reporting platform in Georgia that allows victims to report crimes anonymously; a multi-country programme run by *ILGA-Europe*, which works with police to challenge hate crimes; and the *Philippine Commission on Human Rights'* HIV action plan, which focuses on strengthening redress mechanisms for HIV- and AIDS-related discrimination, hate crimes and other human rights violations.^{113–115}

Evidence from Brazil, Kenya, Tanzania and Uganda shows that involving young men and boys in gender-transformative programmes is a promising approach to address gender-based violence and to improve HIV prevention, testing, treatment and care.^{46,116–120}

For example, *Program H* is a multi-component intervention that supports adolescents, young men, and communities to promote gender equitable norms. An evaluation of the programme in Brazil demonstrated a positive impact on increasing gender equitable attitudes and a decreased incidence of reported STI symptoms among young men.¹²¹ Program M, an education curriculum for young women 15–24 to engage in questioning harmful masculinities, became available in 2003.⁵⁹ Another promising practice is the *Addis Berhan* programme in Ethiopia, which engages men who are married to adolescent girls in regular group discussions on topics related to young women's SRHR. A midline evaluation demonstrated that programme participants were more likely to have gender equitable attitudes and were less likely to accept IPV than a control group.¹²²

Community-based participatory learning approaches that involve young men and young women can also contribute to creating more gender-equitable relationships and decrease violence.^{117,118,123,124}

Promising practices include the *SASA!* Programme in Uganda, which uses a community mobilization approach that facilitates dialogue about power dimensions, gender norms and gender roles to change attitudes and behaviours that promote HIV risk behaviours and violence against women. Preliminary findings from a cluster randomised controlled trial to assess the programme's impact and cost-effectiveness show promising results.¹²⁵ Another good practice is *Stepping Stones*, which is a training programme on gender, communication skills and relationships. Evaluations demonstrated that the programme was able to reduce HIV-related risk factors while also generating a positive impact on gender-related attitudes and beliefs that underlie violence against women.^{126,127}

Tackling socio-economic inequalities and expanding social protection for young women

Several evaluations demonstrate that expanding HIV-sensitive social protection for young women can enhance SRH outcomes, and contribute to gender-transformative responses to HIV.³⁹ The literature highlights that social protection schemes with clear objectives related to gender equality are most effective.³⁹ Key components for effective social protection schemes include social transfers for young women and/or their families (e.g., in cash or kind to enhance food security, minimum income, access to education), access to social support and care services adapted to the diverse realities of young women, programmes to improve quality and availability of public services for young women (including harm reduction services) and policy or legislative reform to ensure equity and non-discrimination.^{82,83}

The *Juntos* programme in Peru and the *Challenging the Frontiers of Poverty Reduction (CFPR)* in Bangladesh are examples of national-scale social protection programmes that are grounded in a social equity and gender-transformative approach. The programmes link cash and asset transfers to services and programmes that address gender-based violence and work with male household members and communities to promote more equitable

gender dynamics.³⁹ Evaluations of the *CFPR* and *Juntos* programmes showed that they generated several economic and social benefits for women living in poor households, including increased financial and income-generating assets, increased levels of confidence, enhanced social capital, increased school enrolment among girls, increased uptake of antenatal care and contraceptive services, and improved status of women in families and communities.^{84–87}

Several evaluated economic asset programmes for young women have also shown promising results in terms of HIV and SRH outcomes. Of particular note are programmes that provide young women with vouchers for free health services, increase employment opportunities, provide social and cash transfer and combine microfinance or income-generating activities with health education.^{88,89}

✦ A randomised control study of a cash transfer programme in Malawi demonstrated that both conditional and unconditional cash transfers can help reduce HIV infections in adolescent schoolgirls in low-income settings.⁹⁰ A randomised control study in Tanzania demonstrated that STI prevalence rates were 25% lower among young people who benefited from conditional cash transfers than among those in a control group.⁹¹ Evidence is also emerging that cash and food transfers as well as vouchers can help build resilience in poor households affected by HIV, thereby limiting the economic consequences of HIV, including for orphans.^{40,92–94}

However, experience shows that certain types of social protection schemes that explicitly target individuals and households of people living with or affected by HIV can lead to increased stigmatization and other undesirable unintended consequences. It is therefore critical to design social protection schemes with the full participation of people living with or affected by HIV.⁴⁰ The literature also suggests that economic empowerment programmes can lead to increased incidences of IPV or harassment in the short term, particularly when there is insufficient consideration for the gender dimensions of economic empowerment strategies and how they could be perceived as a threat to men.^{89,95,96}

Therefore, it is important to include strategies that can mitigate these effects, including incorporating explicit gender-transformative objectives as well as working with young men, boys and communities through participatory methods to change gender norms in an inclusive manner.^{97,98}

Recommendations and Conclusion

The imminent Post 2015 Development Framework provides a unique opportunity to advance young women's rights, health and resilience, as it is this agenda that will set the priorities for the future. As governments, civil society and the international community move forward with important decision-making around the new development framework, it is vital to make young women's SRHR in the context of HIV a priority. As countries take stock of the progress made in relation to key international agreements, including the ICPD Programme of Action and the Beijing Platform for Action, it is key to focus on the progress yet to be made in order to achieve social justice and health equity for young women in all their diversity. Specifically, the evidence on proven and promising practices makes a clear case to move forward with seven key actions, to inform the post 2015 development framework, ICPD Beyond 2014 and Beijing+20 reviews:

1. Recognize all young women as autonomous rights holders and ensure a protective legal environment.

Governments and the international community should be called on to explicitly recognize young women as rights-holders in the new development frameworks. Specific measures should be taken to protect and fulfil young women's human rights, including their sexual and reproductive rights. Laws that violate young women's sexual and reproductive rights should be repealed, including parental and spousal consent requirements for accessing health care; laws that criminalize HIV transmission, sex work, drug use and same-sex sexual activity; and laws that restrict young women's access to safe abortion services. At the same time, programmes that help increase young women's awareness about their sexual and reproductive rights and young women's capacity to prevent and report human rights violations should be expanded.

2. Ensure meaningful participation of young women in decision-making processes.

Participation of young women is critical to ensure that policies and programmes meet their needs. As such, young women's full participation should be central in the Post-2015 development framework and to the ICPD and Beijing review processes. Governments, development and civil society partners must also enable young women's participation in the development of national youth, health, education, HIV and poverty reduction policies and programmes. This requires greater investment in leadership skills among diverse young women to participate meaningfully in advocacy and decision-making processes at the community, national and international level. Moreover, opportunities for young women to build skills and to participate in the governance, design, implementation and monitoring and evaluation of programmes and policies should be expanded.

3. Explicitly recognize young women's sexual and reproductive health and rights in the context of HIV within the post 2015 development framework.

Goals related to health and to young people in the post 2015 development framework should recognize the importance of sexual and reproductive health and rights, and its linkage with HIV for sustainable development. These goals must build on internationally agreed definitions of sexual and reproductive health and rights. Specific commitments should be made to reduce inequalities in access to services for young women in all their diversity and include clear targets on comprehensive sexuality education.

4. Increase access to quality, rights-based integrated HIV and SRHR services and comprehensive sexuality education.

Young women in all their diversity must be able to access a full range of quality youth-friendly, integrated SRH and HIV services, including counselling and harm reduction services. SRH and HIV services should also be offered through outreach strategies tailored to the specific realities of diverse young women. Age-based restrictions for accessing HIV, SRH and harm reduction services should be repealed. SRH and HIV services should include referrals for legal and social protection services. Young women in all their diversity should

access comprehensive sexuality education, either in formal or non-formal education settings. Investments should be made to align national curricula with evidence-based guidelines on effective gender-transformative comprehensive sexuality education.

5. Advance gender equality with a focus on ending all forms of violence against young women.

A stand-alone goal on gender equality and women's empowerment should be incorporated in the post-2015 development framework, with a specific focus on ending violence against young women. Recognizing the link between gender inequality, violence, HIV, and sexual and reproductive health and rights, specific targets for young women must be set accordingly. Special considerations should also be made to eliminate rape within marriage, hate crimes against young women in all their diversity, and ending child marriage, as well as access to social protection and legal services for young women who experience violence. Continued investments should be made to engage young men and boys in interventions aimed at changing discriminatory attitudes and gender norms.

6. Expand the availability and quality of strategic data on young women.

To scale-up effective multi-sectoral interventions, it is vital to expand the availability and quality of strategic information on young women in the context of HIV. The call by the High Level Panel on the Post-2015 Development Agenda for a "data revolution"¹⁷⁰ to ensure that the data gathered is disaggregated by gender, geography, income, HIV status and key population, so that no group is left behind, and that all young women count. A data revolution would draw on existing and new sources of data to fully integrate statistics into decision making, promote open access to, and use of data and ensure increased support for statistical systems.^{xiii}

The new development framework should include specific qualitative and quantitative indicators related to young women's SRHR and HIV, including data on key populations. Increased investments

^{xiii} Data collection on HIV status must be done in a confidential, protective and rights-based manner.

should be made to harness the power of new technology, crowd sourcing and innovative formats for databases in order to empower institutions and individuals, including young women, with improved access to strategic information.

7. Place young women's social protection at the core of poverty eradication

Governments, civil society and the international community should invest in integrated programmes that foster young women's economic

empowerment through appropriate social transfers and skills development while also ensuring access to quality social services and promoting inclusive community dialogue on gender and non-discrimination. Social protection and economic empowerment programmes should be designed with the meaningful participation of young women living with and affected by HIV, with well-defined gender outcomes. The post-2015 development framework should make clear commitments to extend the coverage of social protection for young women, especially those from key populations, in the context of HIV.

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