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Getting real with youth-friendly services in Africa: Report of a satellite session at the XIX International AIDS Conference

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GETTING REAL WITH YOUTH-FRIENDLY SERVICES IN AFRICA

CONFERENCE REPORT

REPORT OF A SATELLITE SESSION AT THE XIX INTERNATIONAL AIDS CONFERENCE

Population Council

GETTING REAL WITH YOUTH-FRIENDLY SERVICES IN AFRICA

REPORT OF A SATELLITE SESSION AT THE XIX INTERNATIONAL AIDS CONFERENCE

Population Council Nigeria

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The Population Council confronts critical health and development issues—from stopping the spread of HIV to improving reproductive health and ensuring that young people lead full and productive lives. Through biomedical, social science, and public health research in 50 countries, we work with our partners to deliver solutions that lead to more effective policies, programs, and technologies that improve lives around the world. Established in 1952 and headquartered in New York, the Council is a nongovernmental, nonprofit organization governed by an international board of trustees.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndromes
ARV	Antiretrovirals
AU	African Union
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CCM	Country Coordinating Mechanism
DHS	Demographic and Health Surveys
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FSW	Female Sex Workers
HAICU	HIV/AIDS Insitutional Coordination Unit
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
ICASA	International Conference on AIDS and STIs in Africa
IDI	In-Depth Interview
IDU	Injecting Drug Users
KAIS	Kenyan AIDS Indicator Survey
KII	Key Informant Interview
MARP	Most At Risk Population
MOH	Ministry of Health
MSM	Men who have Sex with Men
NARHS	National HIV/AIDS and Reproductive Health Survey
NGO	Non-Governmental Organization
PLHIV	Person Living With HIV
RAHU	Reach A Hand Uganda
SRH	Sexual and Reproductive Health
UHSBS	Uganda HIV/AIDS Sero-Behavioral Survey

UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund

BACKGROUND AND INTRODUCTION

Africa's young people aged 15-24 years are disproportionately infected and affected by HIV/AIDS as evidenced by the nearly 4million of sub Saharan African youth who currently live with the virus and twenty countries in sub Saharan Africa accounting for about 69% of all new HIV infections in young people in 2009. [1] These figures reveal the disproportionate impact of HIV/AIDS on Africa's youth yet do not provide a comprehensive picture of the varied HIV prevalence and their effects among different sub-groups of young Africans since they are a highly heterogeneous population. Policymakers and program managers across the region urgently need sound and timely evidence to better target interventions that effectively address the HIV prevention, wellbeing and impact mitigation needs (including stigma and discrimination) of the various categories of youth who make up more than a quarter of the population and determine the continent's development prospects. Unfortunately, there is a dearth of robust data on youth that are sufficiently disaggregated to adequately reveal the specific HIV-related vulnerabilities, including stigma and discrimination faced by African youth.

With an aim to fill this unfavorable gap, the Population Council in collaboration with the Ford Foundation implemented a mixed method cross-sectional comparative study with an analytical focus on the commonalities and differences across six focal African countries: Egypt, Kenya, Nigeria, Senegal, South Africa and Uganda. The study aimed to provide a comprehensive evidence-based picture of the HIV related issues facing young people and the prevailing legal, policy, and programmatic responses in the six study countries. It comprised of extensive country-specific literature reviews, legal and policy assessments, secondary statistical analyses of recent national SRH/HIV-related behavioural survey datasets and focused qualitative inquiries (focus group discussions, in-depth interviews and key informant interviews).

On July 22nd, 2012, the Ford Foundation and Population Council co-sponsored a satellite session at the XIX International AIDS Society Conference (AIDS 2012) in Washington D.C., "Getting Youth-Friendly Services in Africa." The objective of the session was to stimulate young people to engage with and react to the study findings and in the light of the findings, discuss and share their perspectives, experiences and concerns about how responsive existing policies, programs and services are to the HIV prevention and impact mitigation needs of young Africans.

The session was moderated by Humphrey Nabimanya of Reach A Hand Uganda (RAHU) and the panelists included Babatunde Ahonsi (Population Council), Chris Castle (UNESCO), Phindile Sithole-Spong (AIDS Consortium; Rebranding HIV), Kikelomo Taiwo (Youth Advocate Group, Education As a Vaccine) and Eka Esu Williams (Ford Foundation). This report summarizes the research findings, expert panelist discussion on the findings, and the reaction of the audience to the findings.

[1] UNICEF (2011). Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood. New York: UNICEF.

STUDY DESCRIPTION AND FINDINGS

The study was designed to provide a rich evidence based picture of the HIV/AIDS issues facing young people across the continent and the prevailing legal, policy and programmatic responses in six study countries (Egypt, Kenya, Nigeria, South Africa, Senegal, Uganda) chosen to reflect the variations in HIV levels, country specific responses and legal/policy contexts observed around the continent.

The study countries are in different stages of the HIV epidemic as shown in the data in Table 1. While Kenya, Uganda, and South Africa have generalized epidemics, Senegal and Egypt have highly concentrated epidemics, and Nigeria lies in between with a mixed epidemic. There are also age and gender differentials in HIV prevalence with adolescent and very young adult females having a much higher HIV prevalence than their male counterparts.

Table 1: Population-based Estimates of HIV Prevalence among Persons aged 15-49 by Gender and Age

Country/Survey Year	Male			Female		
	15-19	20-24	15-49	15-19	20-24	15-49
Nigeria (2007)[1]	2.1	1.9	3.2	1.3	4.5	5.0
Senegal	0.0	0.2	0.4	0.2	0.8	0.9
Uganda (2004/5)[3]	0.3	2.4	5.9	2.6	6.3	7.9
Kenya (2007)[4]	1.0	1.9	5.8	3.5	7.4	9.2
South Africa (2008)[5]	2.5	5.1	*	6.7	21.1	*
Egypt (2005)[6]	n.a	n.a	0.02	n.a	n.a	0.02

Sources: 1. FMOH (2008) NARHS 2007; 3. MOH & ORC Macro (2006) UHSBS 2004/5; 4. MOH (2008) KAIS 2007; 5. HSRC (2009) National HIV Survey 2008; 6. World Bank(2005).

*The survey was limited to 10-24 year-olds; n.a – 'not available'.

RESEARCH OBJECTIVES

i) Systematically show the extent to which relevant national policies, program strategies, regional protocols and policy initiatives are responsive to the HIV vulnerabilities of young people;

(ii) Critically highlight the degree to which national HIV and SRH-related laws discriminate against youth vis-à-vis their ability to access HIV and other sexual health information and services; and the legal protection when violations occur.

(iii) Empirically show commonalities and contrasts within the vulnerabilities (including stigma and discrimination) of youth to HIV and AIDS in the six countries in terms of:

a. health seeking behaviors, sexual and reproductive health related to HIV risks, and their social, cultural, economic and legal determinants; and

b. the forms and nature of HIV stigma and discrimination that youth face and the consequences for their access to health and other services;

(iv) Document the extent to which the needs, concerns, and perspectives of youth are addressed in ongoing national HIV programs and whether youth are meaningfully engaged in the planning, implementation, and evaluation of HIV programs; and

(v) Identify key institutional stakeholders at regional, sub-regional, and national levels that are actively engaged in HIV/SRH-related policies and programs for young people.

METHODOLOGY

A mixed methods cross-sectional comparative research with analytical focus on commonalities and differences across the six focal countries was employed (c. 2005-2011) comprising:

- Extensive country-specific literature reviews;
- Legal and policy assessments on a country-by-country basis;
- Statistical analyses of recent national SRH/HIV-related behavioral survey datasets (10 national behavioural data sets—3 Nigeria, 2 Egypt, 2 Kenya, 1 Uganda, 1 South Africa, 1 Senegal); and
- Focused qualitative inquiries: focus group discussions (FGDs) with diverse groups of young people, in-depth interviews (IDIs) with HIV impacted young people including perinatally infected youth, married adolescents, LGBT youth, sex workers, etc., and key informant interviews (KIIs) with stakeholders who have policy and programmatic understanding of the salient SRH/HIV related issues facing youth.

HIGHLIGHTS OF RESEARCH FINDINGS

Law and Policy Assessment

There were several factors that exacerbated the vulnerabilities of youth to HIV including incomplete/partial domestication of key international and regional protocols (e.g. CEDAW, Maputo Protocol). Across the six countries, there was legal pluralism with the coexistence of several legal regimes (civil, customary, and religious) that created loopholes for human rights abuses and violations especially around the age at marriage, forced marriage for girls, and access to SRH services. There was also non-provision for marital rape in the laws (except in South Africa) which had negative implications for married adolescent females. In terms of stigma and discrimination, there were quite a few progressive laws and policies, except in Egypt, although there were challenges with proper implementation and enforcement of the laws and policies.

All countries had few policies that spoke to youth HIV and SRH vulnerabilities and were plagued

by a lack of specificity of these youth focused provisions and the activities tied to them. The few youth specific provisions/policies that existed also lacked robustness in terms of addressing the needs of the most vulnerable categories of young people and often times were silent on these issues. There were loud policy silences and even hostility around most at risk populations (MARPs) in general i.e. criminalization of sex work and same-sex sexual practice. There were also gaps between policy intentions and targets and actual program implementation and service delivery especially in terms of youth-friendly services.

Quantitative Analysis Findings

There was a wide range of current sexual activity among never married young people. The level of current sexual activity doubled from age group 15-19 to 20-24. The level of self-reported sexual activity was also higher among male youths than female youths across all age-sex categories except in Nigeria and among 20-24 year olds in Uganda. High risk sex (sex with a partner who is not a spouse or cohabitating partner) among sexually active young people is quite widespread ranging from approximately 9% in rural Nigerian females aged 20-24 to 100% among urban South African males aged 15-19. Egypt's data were challenging for the analysis as the DHS did not include questions on sexual activity among non-married young people however, according to a survey of young people in Egypt conducted by the Population Council in 2009, over 50% of male and female street youth engaged in multiple sexual partnerships.[2]

Apart from South Africa, where over 50% of youth had an HIV test in the last 12 months, most young people in Africa did not utilize HCT services. Female youth were more likely to have taken an HIV test and there was also a clear urban advantage. In terms of condom use during high risk sex in the last 12 months among sexually active young people, moderate to high levels of resorting to safer sex measures were reported but the consistent picture was that of male youth being more likely to report the use of condoms during high risk sex than their female counterparts. Urban youth were also more likely to report condom use than their rural peers. Looking at subsets of young MARPs (MSM and FSW) in Kenya and Nigeria (where data were available), young MARPs endorsed higher levels of risk exposure than the general youth population but also displayed stronger sexual health seeking behaviours.

In relation to HIV-related Stigma and Discrimination, findings were quite positive revealing much higher tolerance levels among youth than the general population in these countries. In terms of HIV related discrimination enacted through unwillingness to care for someone who is living with HIV, more than two-thirds of youth across all age and locational categories reported non-discriminatory attitudes. There was little or no male to female variation except among the West African countries where more male youth expressed non-discriminatory attitudes than female youth.

[2] Survey of Young People in Egypt: Final Report. 2011. Population Council West Asia and North Africa Office.

Multivariate analysis revealed that lack of education and marriage were the strongest predictors of engagement in unprotected sex. Age appeared to be the factor that was most strongly associated with uptake of HCT among young people once adjustment for six other variables was conducted (gender, area of residence, level of education, wealth quintile, marital status, employment status). In terms of stigma[3] the most significant outcome was that education and economic status appeared to be the greatest predictors of HIV non-discrimination.

Dominant Themes From the Qualitative Inquiries

It emerged that livelihood struggles were a major concern for young people and were viewed by them as one of the major factors of increased vulnerability to HIV. Surprisingly, there was a greater fear of pregnancy than HIV among some sexually active young people.

In terms of youth-friendly services, the narratives revealed many service provider issues. The most significant concern for young people with existing services was lack of confidentiality and social stigma linked to being a particular type of young person i.e. MSM, IDU, or FSW. The experiences that young people had within existing HIV programs and services were quite mixed but especially negative for certain key target populations.

Both key informants and youth stated that the few SRH services considered high quality and acceptable were provided by NGOs and were almost wholly funded by external donors which raised issues of coverage and sustainability. NGOs (local and international) also dominated the lists of institutions that are thought to be most actively engaged in youth-centred HIV programs and services. Funding, human resources, and infrastructures for youth-friendly services were unanimously reported to be grossly inadequate, more chronically so, in rural and urban poor areas.

The KIIs with policymakers and program managers revealed again that the policies as they were lacked a well-defined youth focus. Respondents also emphasized the gap between policies and program development and service delivery. Young people's awareness of relevant policies and laws was limited or too general but seemed better among young MARPs. There was minimal youth participation in policy development, program implementation, and service delivery. Youth involvement rarely went beyond consultation or basic involvement in service delivery i.e. peer education. Youth interviewed felt that participation was status and context dependent for example out-of-school youth and street youth were rarely engaged.

[3] Stigma levels were obtained by proxy through expression of the following attitudes a) wanting to keep secret that a family member has HIV; b) unwillingness to care for someone with AIDS; c) unwillingness to buy fresh vegetables from a shopkeeper who has HIV d) saying that a teacher with HIV who is not sick should not be allowed to continue teaching. More information on this indicator can be found at http://hivdata.measuredhs.com/ind_detl.cfm?ind_id=6&prog_area_id=3

PANEL DISCUSSION

Upon presentation of the findings (delivered by Babatunde Ahonsi of the Population Council), panelists were invited to react to the findings and share their individual perspectives. Panelists included Chris Castle (UNESCO), Phindile Sithole-Spong (AIDS Consortium; Rebranding HIV), Kikelomo Taiwo (Youth Advocate Group, Education As a Vaccine) and Eka Esu Williams (Ford Foundation).

POLICY ANGLE

Chris Castle stated that in most cultures and contexts there remains a discomfort and sensitivity to the fact that young people are sexually active. He noted that youth continuously raise the same issues when asked about their primary needs but they continue to be ignored. He encouraged the meaningful engagement of youth and the need to continue to listen to youth voices.

UNESCO is particularly concerned about sexuality education for young people and unsurprisingly, the study also highlighted the impact of education as a key factor of HIV risk. Young people need to be in school and to have access to quality education. They also need education about sex, relationships, sexuality education broadly and access to youth-friendly services. He also emphasized the need to ensure that youth are comfortable accessing these services.

In terms of policy actions, UNESCO is currently embarking on a project that aims to enable a stronger policy and political commitment by East and Southern African leaders to young people as regards their SRH, education and their service access needs similar to what was done with the Latin American/Caribbean Declaration of 2008. UNESCO will utilize research findings and the voices of young people to call to account and encourage leaders in these countries to make commitments to young peoples' SRH education and services. He ended his commentary stressing that young people should be at the core of all HIV prevention and care efforts.

YOUTH VOICES

Phindile Sithole-Spong was taken aback and intrigued by the study findings. Speaking from her experience living with HIV in South Africa, which had led her to work in the sector and to seek to "rebrand" HIV, she re-emphasized the importance of listening to youth. Youth voices are often not heard because they are supposedly too young and naïve lacking in the years of life experience required to know enough about the issues. But listening to youth voices is paramount to eradicating HIV/AIDS and stigma. Young people have valuable knowledge to share especially as they are personally experiencing these circumstances and situations and are exposed to the discourse on these issues.

She spoke of the "one size fits all" approach of youth-focused policies and strategies in her country. She said that such interventions do not cater to the youth and take into account their heterogeneity. Campaigns and programs need to listen to youth and to understand their different needs, wants, backgrounds, and stories to be effective. She pointed out the contradiction in a

currently running campaign that states “imagine an HIV free generation” when policies and programs are not dealing appropriately or adequately with the current HIV positive generation.

Kikelomo Taiwo, who works for a youth focused NGO, Education as a Vaccine (EVA), that manages youth-friendly services in Nigeria, reflected on the challenges in Nigeria. She reported a high negative perception of sexuality education which makes it difficult for young people to obtain information and to ask questions about their sexuality and their bodies. At the level of policy implementation and service delivery, there are issues with accountability and transparency. Despite budgetary provisions for youth-friendly public facilities, these facilities remain non-functional and therefore unavailable to youth. The attitudes of providers at existing facilities are poor and youth experience high levels of stigma. The climate in these facilities prevent youth from making informed decisions and being confident about accessing services they need.

She highlighted the need to educate youth in innovative ways. For example, the organization she works for uses mobile phones to ensure that young people get access to SRH information confidentially without incurring costs. Young people are able to call into a hotline where they can obtain information anonymously and for free. Knowledge is insufficient; it is also important to teach youth how to use the information they receive. For instance, some youth know that they should use condoms during sex to protect themselves but they do not know how to negotiate safer sex.

On improving youth participation in HIV policy development and programming, she mentioned mentoring as a way to build the capacity of youth. She encouraged older people to invest in youth and appropriately functioning systems as a continually living testament of their legacy.

DONOR’S PERSPECTIVE

Eka Esu Williams spoke from her experience in supporting programs around adolescents and young people at the South African office of the Ford Foundation. The key concern for donor institutions is how to balance the work done at the local, national and regional levels. The problems are interconnected at all these levels which is why it is important that this study focuses on the commonalities across the countries and the divergences and complexities around work with young people adding value to current understanding.

On youth participation, she urged youth not to sit passively awaiting involvement but to be active in getting involved. Youth participatory efforts need to go beyond consultation and basic involvement to developing the leadership and expertise of youth. There are instruments like the African Union’s Africa Youth Charter and the Decade for the Empowerment and Development of Youth that have been inaugurated and adopted. Little is being done with these instruments but there is some action at the level of the African Union (AU). The Ford Foundation is supporting the AU on a project with its Youth Division that aims to develop youth expertise while trying to transform the AU into a more youth friendly organization.

Unfortunately the Country Coordinating Mechanisms (CCMs) of the Global Fund, a major source of funding for HIV prevention programs in most African countries, have poor youth participation although such provisions have been made. In terms of participation of marginalized young people

(MSM and sex workers), the defense often given by the CCMs is that the activities of these young people are illegal hence, their involvement is closed for discussion. Despite this, she was heartened by the statements made by the Malawian President with regard to her willingness to repeal archaic laws and embrace more progressive policies.

In terms of youth-specific policies, she was most concerned that those who should be aware of such policies are not or are confused about them because they are often contradictory. For example, in South Africa, sexual intercourse below age 16 is illegal even if consensual but youth are legally able to access HIV and SRH services at age 12 or 13. There is also the fact that civil society organizations and governments spend a significant amount of time and funds on advocacy and developing guidelines and frameworks leaving no time for actual implementation. Policy implementation is also plagued by the lack of available resources and an aligned roadmap to make these programs available. Stakeholders need to focus on how to hold all actors accountable for policy and program implementation.

She was wary about the nature of current youth-friendly services that are often stand-alone, dedicated, and separate within health facilities, which has implications for sustainability in terms of available resources. She also pointed out that there remains limited integration between reproductive health and HIV services. The other important cause of death for young people in the region aside from HIV is maternal mortality and contraception is often the first entry point of young people for accessing health services and a possible gateway for testing and sexuality education. She stressed the need for fresh ideas about how currently available resources can be utilized to obtain greater results and impacts.

AUDIENCE DISCUSSION INSIGHTS

Upon completion of the panel discussion, the audience was given the opportunity to interact with the panelists, react to the study findings and to share their experiences and opinions on improving access to youth-friendly HIV and SRH services in Africa. The following is a summary of the insights gained from this exchange of ideas:

- Youth participatory efforts in Africa need to go beyond consultation and basic involvement to providing opportunities for building their expertise and leadership abilities. Young Africans need to be empowered to advocate for their issues actively and to hold policymakers accountable to their commitments to youth development. Youth should be innovatively engaged utilizing mediums that are accessible to them.
- Education of youth, providers, and policymakers remains paramount along the following lines.
    - Youth need access to comprehensive sexuality education and need to be armed with evidence such as that revealed in this study as tools for advocacy to begin to mount pressure on policy processes and actors.
    - Sensitization of service providers to the unique needs of youth and values clarification around youth sexuality is essential to curbing the issues around confidentiality and stigma that hinder youth from adequately accessing SRH services.
    - The findings of this study and others like it should be drawn to the attention of the region's policymakers and opportunities for consensus building around the implications of such findings should be created. It is from such consensus building that authentic actions for change will emanate.
- The gendered aspects of youth HIV vulnerability and the heightened risks of female youths to HIV infection need to be highlighted and brought to the fore of youth-focused HIV programming and policies in the region.
- Youth focused policies and programs must be tailored to the heterogeneity of youth and their varied contexts to be effective.

POLICY RECOMMENDATIONS

Overall, the session gave rise to a number of important policy recommendations. First, improving sexual health-seeking behaviours especially uptake of HIV counseling and testing by male youth and condom use by female youth through a combination of youth-empowering communication and poverty reduction interventions is imperative. Second, evidence-based advocacy needs to be targeted at policymakers and donors to generate more commitment to paying greater attention to the youth dimensions of the HIV epidemic and national responses to it especially in relation to neglected but disadvantaged categories of youth. In addition, efforts to promote the mainstreaming of youth-friendly SRH and HIV services are required given the challenges of scaling up and sustaining the few model stand-alone servies provided largely by non-governmental organizations. Finally, innovative operations research is called for to better understand how to increase the meaningful involvement of young people in the conception, planning, and implementation of SRH and HIV/AIDS policies and programs.

APPENDIX A: LIST OF CONTRIBUTORS

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