POLICY BRIEF

REVIEW OF LEGISLATION AND NATIONAL HIV POLICIES IMPACTING ADOLESCENTS AND YOUNG PEOPLE LIVING IN EAST AND SOUTHERN AFRICA

INTRODUCTION

The adolescent and youth HIV epidemic is one of the most challenging and persistent public health issues facing East and Southern Africa.

Adolescents and young people (AYP) ages 10-24 years account for an estimated 45% of new HIV infections worldwide, with 70% residing in sub-Saharan Africa.

In this region, AIDS-related illness remains the leading cause of death amongst AYP due to a convergence of structural, cognitive, behavioural, health systems, legislative, policy and programming factors[1–5].

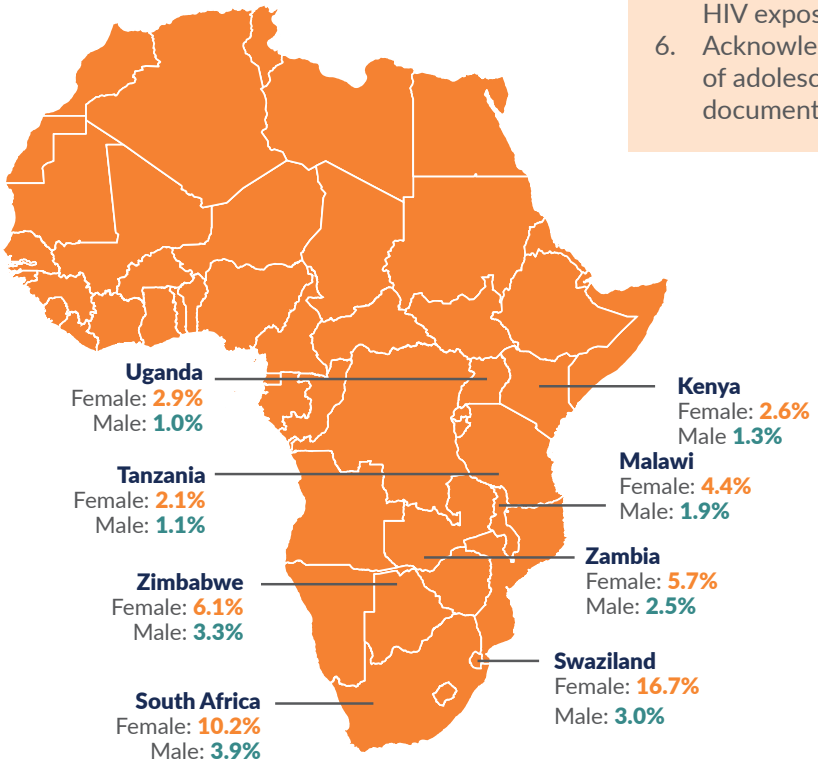
METHODOLOGY

PATA conducted an environmental scan of eight countries in East and Southern Africa, specifically Kenya, Malawi, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

This review highlights key health systems factors, alongside legislative and policy components that either enable or impede access to HIV prevention, treatment and care for AYP with reference to:

1. Laws on age of consent to engage in sex, including close age provisions between partners;
2. Laws on age of consent to access HIV testing and treatment services;
3. The roll-out of universal test and treat;
4. Laws relating to same-sex practices;
5. Laws relating to the criminalisation of HIV exposure or transmission; and
6. Acknowledgement and positioning of adolescents within key strategic documents.

HIV PREVALENCE IN YOUNG PEOPLE (AGES 15-24):



Source: UNAIDS. HIV Prevalence Estimates 2018.

REVIEW FINDINGS

1 Age of consent to engage in sex

Background:

Criminalising consensual sex amongst adolescents can stigmatise normal sexual developments and impede access to sexual and reproductive health and HIV services[7].
A balance between protecting the rights of young people and recognising their evolving capacity and autonomy as they get older is important[7].

International best practice recommendations:

1. Age of consent should not be higher than 16 years;
2. Allow for close age exceptions so AYP are not prosecuted for having sex with a peer of a similar age;
3. Harmonise age of consent for girls and boys[7,8].

Findings:

A majority (62.5%) of review countries had age of consent policies that allowed young people aged 16 years and older to consent to sex, in line with international recommendations. The remaining reviewed countries of Kenya, Tanzania and Uganda had 18 years as their legal age of consent. Most countries did not have close age exemptions, and half of the countries did not harmonise age of consent for girls and boys.

Key messages:

Countries are urged to review and align their laws and policies with international best practices. Restrictive age of consent laws are often deeply rooted in personal, cultural and/or religious beliefs[9].

Even when countries adhere to age of consent best practices, it is important to create non-stigmatising health facility environments that acknowledge and affirm adolescent and young peoples' sexual rights and autonomy.

2 Age of consent to access HIV testing and treatment

Background:

Requiring parental consent to access testing services may reduce access, representing a barrier to the uptake of testing and other health services[10,11]. In considering age of consent for testing and treatment, it is important to uphold the rights of adolescents to make choices about their health and well-being, while balancing their different levels of maturity and understanding[10,11].

International best practice recommendations:

HIV counselling and testing (HCT), including linkages to prevention, treatment and care should be provided for all adolescents[12]. Age of consent for HIV testing, pre-and post-counselling and contraceptives without parental consent should be 12 years[7]. In addition, there should be provisions for health provider discernment to assess an adolescent's sufficient maturity to understand the risks, benefits and consequences of the medical treatment[7].

Findings:

Of the countries reviewed, the majority were in line with international recommendations of (1) an age of consent to voluntary HIV counselling and testing at 12 years, and (2) the provision for consideration of maturity in determining if an adolescent could consent to testing. In terms of age of consent to access HIV treatment and services, most countries were not explicit about age requirements.

Key messages:

Countries should align with international best practice and make provision for HIV testing without parental consent from the age of 12 years. Issues of stigma, discrimination and moralising in relation to sexual activity for AYP at the health facility level remain a problem* even in countries with conducive legal and policy environments for AYP to access HIV testing and treatment services. Age-related stigmatising health provider attitudes, including imposed moral values, discrimination, shame and scolding, are a major barrier in the uptake of, and retention in HIV and SRH services for young people[12–16]. Sensitising health providers[9,17], and involving young people in the provision of services[18,19] are two key strategies to ensure that AYP can exercise their sexual and reproductive health rights and access services without discrimination.

*Adults are also subject to unfriendly treatment, but AYP presenting for SRH/HIV services are at additional risk of age-related discrimination and may also have greater difficulty responding to inappropriate health worker conduct[29].

3 National treatment guidelines and universal test and treat

Background:

Universal test and treat supports the UNAIDS targets of ensuring that 90% of people living with HIV know their status, 90% of those diagnosed receive sustained ART, and 90% of those receiving ART are virally suppressed. In comparison to adults, ART access among adolescents is low, and a significant proportion of AYPLHIV struggle to initiate and remain on treatment[4,5].

International best practice recommendations:

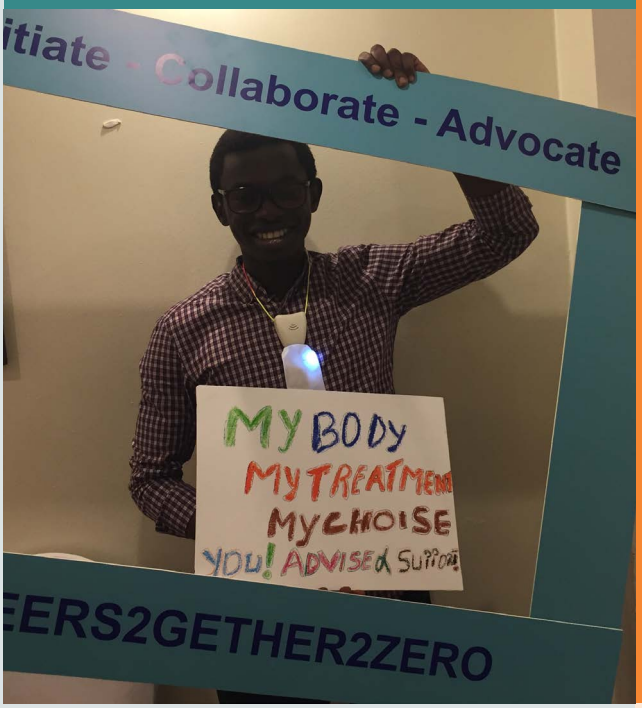
In 2015, the World Health Organization (WHO) recommended that all people living with HIV, including adolescents be initiated on ART regardless of clinical stage and CD4 count[20]. This guidance is reflected by the Southern African HIV Clinicians Society[21].

Findings:

All review countries had policy commitments in support for Universal Test and Treat.

Key messages:

The commitment to providing access to ART for all AYPLHIV is encouraging. However, significant treatment gaps persist in this age group. The importance of structural and programmatic interventions that facilitate effective case funding, linkage and ongoing adherence and retention to support AYPLHIV, cannot be understated.



4 Acknowledgement of adolescents as a unique group requiring targeted services

Background:

AYP are a heterogeneous group with unique challenges and needs. Countries need appropriate laws, policies and systems that protect rights, acknowledge diversity and provide equitable access to non-discriminatory healthcare for AYP[9].

International best practice recommendations:

The WHO states that 'the heterogeneity of adolescents (should be) recognised and requires flexibility and adaption of services and approaches, in addition to context and local epidemiology'[10].

Findings:

All countries in this review acknowledge adolescents and/or young people as a population requiring specific attention in their national HIV/AIDS planning, with specific focus on adolescents or young people and their health. The language used to categorise this age group varied from 'vulnerable' to 'key' or 'target group/ population'. Whilst AYP are recognized as a key target group, diversity within this group is however not recognised or acknowledged sufficiently.

Key messages:

This finding points to promising recent developments and highlights the success of international advocacy efforts to prioritize AYP as a unique group requiring targeted services. This is an opportune moment to build on this momentum and ground policy and legislative commitments in practice.

These should focus on a comprehensive package of integrated HIV and SRHR services that are delivered in a manner that is confidential, non-judgmental and stigma-free[9]. To make the aims of optimal treatment, care and support for AYPLHIV a reality, strong implementation, service delivery and monitoring are required. AYPLHIV should be meaningfully involved at all levels in the development and implementation of policies and programmes that target them.

Participation of young people must be recognised through formal national-level country coordinating mechanisms.

5 Criminalisation of HIV exposure or transmission

Background:

The criminalisation of HIV exposure and transmission is an ineffective public health tool and is influenced by social stigma rather than knowledge about HIV[22–25]. Rather than preventing HIV transmission, such laws may discourage people from testing, accessing treatment and/ or choosing to disclose[22]. Prosecutions continue to occur in situations where harm was unintended, risk of transmission unlikely and/ or burden of proof is questionable[23,24,26].

International best practice recommendations:

Although not framed as an international best practice, a 2018 expert group statement[24] recommended more caution in HIV-related criminal prosecutions.

Findings:

In this review, four countries (Kenya, Malawi, South Africa and Swaziland) did not have a specific law criminalising HIV non-disclosure, exposure or transmission. Of the remaining countries, criminalisation laws for HIV exposure and transmission were largely focused on willful and deliberate transmission.

Key messages:

In line with a 2018 expert statement[24], it is recommended that public health initiatives, rather than legal instruments, be used to address HIV transmission and prevention. These may be especially important for AYP and may include stigma reduction, protection against discrimination, and the provision of conducive environments that facilitate HIV testing, treatment and linkage to care.

6 Criminalisation of same-sex relationships

Background:

The discrimination and exclusion of Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex (LGBTQI) people persists, particularly for AYP who are further marginalised through the criminalisation of same-sex practices[27]. This undermines their sexual and reproductive health rights and creates further barriers in accessing services[7].

International best practice recommendations:

Freedom from discrimination on the basis sexual orientation is a human right[28] and should not impede access to sigma free and comprehensive sexual and reproductive health services.

Findings:

All countries in this review, with the exception of South Africa, criminalise same-sex practices.

Key messages:

Criminalisation of same-sex practices is an infringement of human rights, and inhibits LGBTQI AYP from accessing HIV testing, treatment and care. This infringement is further exacerbated by health provider and facility-level stigma[27]. Removing discrimination and creating more supportive environments for LGBTQI AYP is an urgent matter requiring legislative and operational reform. Even when laws are not restrictive, stigma, discrimination, lack of awareness and understanding can inhibit service access, uptake and retention for LGBTQI AYP[17]. Health provider sensitisation and training, and the delivery of targeted services is critical for this inadequately served population.

KEY ADVOCACY MESSAGES:

- More affirming and supporting environments that are non-discriminatory are needed for AYP to promote access and uptake of HIV and sexual and reproductive health services.
- A review and shift in law and policy is required in countries where age of consent to engage in sex and independently access testing services is higher than international best practice.
- LGBTQI AYP must be fully recognised and protected through discriminatory legislation being repealed or reformed and relevant shifts in operational practice made.
- Stigmatising health provider attitudes and behaviour towards adolescent and young peoples' sexual decisions and sexual orientation must be addressed. Moralising tactics should be supplanted with public health standard of care adopted that affirms the rights and autonomy of AYP and are proven to work.
- AYP should be recognised as key partners in health. They should be meaningfully involved in the design, delivery and evaluation of policies and services that affect them. Emerging best practices include peer models, the engagement and support of national youth networks, and the integration of mechanisms that promote service evaluation by AYP.
- The engagement of health providers in creating non-stigmatising environments, delivering adolescent and youth-friendly services, and reducing barriers to service uptake is fundamental. Ongoing sensitisation training and regular monitoring of service standards against a stigma and discrimination index is recommended.

Additional resources

Visit the Team PATA Resource Hub, which includes promising practices, policy briefs and other key documents.

CONCLUSION:

Through the advocacy efforts of AYPLHIV, health provider activists, grassroots organisations, governments, international bodies, research institutions and other non-governmental organisations, progress has been made in highlighting policy and legal barriers that impede the delivery of comprehensive, and stigma-free services to all AYP in their diversity.

Ongoing investments for legal, culture and service delivery reform is needed to facilitate an enabling environment where AYP can freely and without fear of stigma, exercise their rights to comprehensive sexual and reproductive health services.

References

1) UNICEF. *United Nations Children's Fund. Annual Results Report: HIV and AIDS.* New York; 2017.
2) World Health Organization. *Health for the World's Adolescents: Second Chance for a Second Decade.* Geneva, Switzerland; 2014.
3) UNICEF and UNAIDS. *ALL In, in Eastern and Southern Africa: Catalysing the HIV Response for Adolescents.* New York, USA; 2018. http://childrenandaids.org/sites/default/files/2018-07/ALL-IN-in-%0AEastern-and-Southern-Africa-WEB_2018.pdf.
4) Hudelson C, Cluver L. Factors associated with adherence to antiretroviral therapy among adolescents living with HIV/AIDS in low- and middle-income countries: a systematic review. *AIDS Care.* 2015;27(7):805-816. doi:10.1080/09540121.2015.1011073.
5) Nachega JB, Hislop M, Nguyen H, et al. Antiretroviral Therapy Adherence, Virologic and Immunologic Outcomes in Adolescents Compared With Adults in Southern Africa. *J Acquir Immune Defic Syndr.* 2009;51(1):65-71. doi:10.1097/QAI.0b013e318199072e.Antiretroviral.
6) UNAIDS. HIV Prevalence Estimates 2018.
7) UNFPA ESARO. *Harmonizing the Legal Environment for Adolescent Sexual and Reproductive Health and Rights: A Review of 23 Countries in East and Southern Africa.* Johannesburg; 2017.
8) SAT. *Age of Consent: Global Legal Review.* Johannesburg; 2017.
9) Soeters H, Mark D, Ronan A, Walker D, Ameyan W, Hatane L. Sensitizing health workers to providing responsive care for adolescents and young people living with HIV. 2018.
10) WHO. *HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV: Recommendations for a Public Health Approach and Considerations for Policy-Makers and Managers.*; 2013. http://www.who.int/iris/handle/10665/94334%250A.
11) Maradiegue A. Minor's rights versus parental rights: review of legal issues in adolescent health care. *J Midwifery Womens Health.* 2003;48(3):170-177.
12) World Health Organization (WHO). *A Standards-Driven Approach to Improve the Quality of Health-Care Services for Adolescents.* Geneval; 2015.
13) Mark D, Armstrong A, Andrade C, et al. HIV treatment and care services for adolescents: A situational analysis of 218 facilities in 23 sub-Saharan African countries. *Under Rev.* 2017.
14) Toska E, Cluver LD, Boyes ME, Isaacsohn M, Hodes R, Sherr L. School, Supervision and Adolescent-Sensitive Clinic Care: Combination Social Protection and Reduced Unprotected Sex Among HIV-Positive Adolescents in South Africa. *AIDS Behav.* 2017;21(9):2746-2759. doi:10.1007/s10461-016-1539-y.
15) Bernays S, Paparini S, Gibb DM, Seeley JA. When information does not suffice: young people living with HIV and communication about ART adherence in the clinic. Vulnerable Child Youth Stud. 2016;(February 2016):1-9. doi:10.1080/17450128.2015.1128581.
16) Chilinda I, Hourahane G, Pindani M, Chitsulo C, Maluwa A. Attitude of Health Care Providers towards Adolescent Sexual and Reproductive Health Services in Developing Countries: A Systematic Review. *Health (Irvine Calif).* 2014;06(14):1706-1713. doi:10.4236/health.2014.614203.
17) Paediatric Adolescent Treatment Africa (PATA). *"If You Come, They Will Help You with a Smile on Your Face". Promising Practices in Health Provider Sensitisation for Adolescents and Young People Living with HIV.* Cape Town, South Africa; 2017. www.teampata.org.
18) Paediatric Adolescent Treatment Africa (PATA). *'If You Trust Us, Help Us to Do It by Ourselves." Promising Practices in Peer Support for Adolescents and Young People Living with HIV.* Cape Town, South Africa; 2017. http://www.teampata.org/.
19) Mark D, Bloch K, Cluver L, Toska E, Ronan A, Gittings L, Hodes R, Malunga S, Burdock T, Hatane L. The power of peers: Multi-country analysis of adolescent viral suppression in sub-Saharan Africa. In: *The 2nd Edition of the International Conference on HIV and Adolescence.* Cape Town; 2018.
20) WHO. *Guidelines on When to Start Antiretroviral Therapy and on Pre-Exposure Prophylaxis for HIV.* Geneva, Switzerland; 2015.
21) Southern African HIV Clinicians Society. *Guidelines for Adherence to Antiretroviral Therapy in Adolescents and Young Adults.* Johannesburg; 2017.
22) Canadian HIV/AIDS legal network. Criminalization of HIV transmission: poor public health policy. *HIV/AIDS policy law Rev.* 2009;14(2).
23) UNAIDS. *Guidance Note on Ending Overly Broad HIV Criminalisation.* Geneva; 2013.
24) Barré-Sinoussi A, Karim S, Albert J, Al. E. Expert consensus statement on the science of HIV in the context of criminal law. *J Int AIDS Soc.* 2018;(21:e25161).
25) UNDP. *Global Commission on HIV and the Law: Risks, Rights & Health.* Geneva; 2012.
26) Bernard E, Cameron S. Advancing HIV Justice 2: *Building Momentum in Global Advocacy against HIV Criminalization.*; 2016.
27) WHO. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. 2016.
28) International Commission of Jurists. *Yogyakarta Principles - Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity.*; 2007.
29) Fick C, Fairlie L, Moultrie H, et al. *Working with Adolescents Living with HIV: A Handbook for Healthcare Providers.* Johannesburg; 2015.

Acknowledgements:

Lesley Gittings (Independent Consultant)
Heleen Soeters (Programmes Manager, PATA)
Agnes Ronan (Head of Programmes, PATA)
Luann Hatane (Executive Director, PATA)
Adrian Di Lollo (Independent Consultant)

For more information, visit www.teampata.org

P2Z PEERS2ZERO

ROBERT CARR FUND for civil society networks