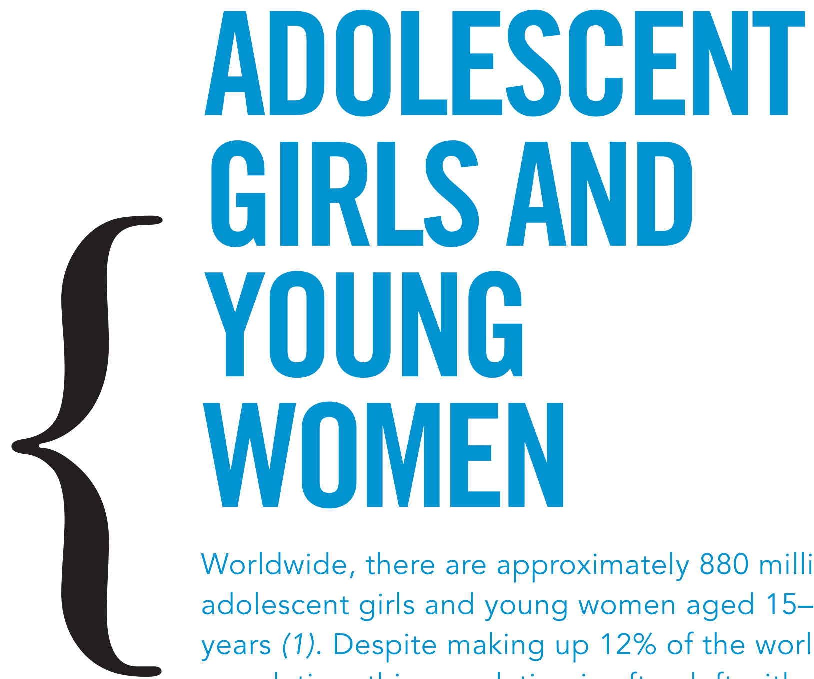

ADOLESCENT GIRLS AND YOUNG WOMEN

Worldwide, there are approximately 880 million adolescent girls and young women aged 15–24 years *(1)*. Despite making up 12% of the world's population, this population is often left without a voice or control of their own bodies.

Gender-based violence and limited access to health care and education, coupled with systems and policies that do not address the needs of young people, are obstacles that block adolescent girls and young women from being able to protect themselves against HIV, particularly as they transition into adulthood.

ADOLESCENT GIRLS AND YOUNG WOMEN

I am a young woman.
I face these issues.

WHY ADOLESCENT GIRLS AND YOUNG WOMEN ARE BEING LEFT BEHIND

Worldwide, there are approximately 880 million adolescent girls and young women aged 15–24 years *(1)*. Despite making up 12% of the world's population, this population is often left without a voice or control of their own bodies.

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HIV burden

Over the past three decades, in some regions young women and adolescent girls have remained at a much higher risk of HIV infection than their male peers. As a result, young women and adolescent girls account for a disproportionate number of the new infections among young people and the number of young people living with HIV.

There are about 380 000 [340 000–440 000] new HIV infections among young women aged 15–24 every year. In 2013, almost 60% of all new HIV infections among young people aged 15–24 occurred among adolescent girls and young women *(2)*. Globally, 15% of women living with HIV are aged 15–24, of whom 80% live in sub-Saharan Africa.

There are 35 million people living with HIV globally.

There are 3.2 million children and 2.1 million adolescents living with HIV.

There are 4.2 million people 50 years and older living with HIV.

Gender-based violence

Gender inequalities and gender-based violence prevent adolescent girls and young women from being able to protect themselves against HIV. Equally, adolescent girls and young women are often not able to access treatment *(3)*.

In some settings, up to 45% of adolescent girls report that their first sexual experience was forced *(5)*. Numerous studies demonstrate that partner violence increases the risk of HIV infection and unwanted pregnancies *(6,7)*.

THE TOP 4 REASONS

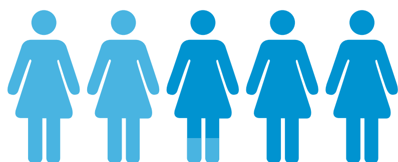
01
Gender-based violence

02
Lack of access to health services

03
Lack of access to education

04
Policies that do not translate into action

Violence, abuse and exploitation: increasing risk and vulnerability



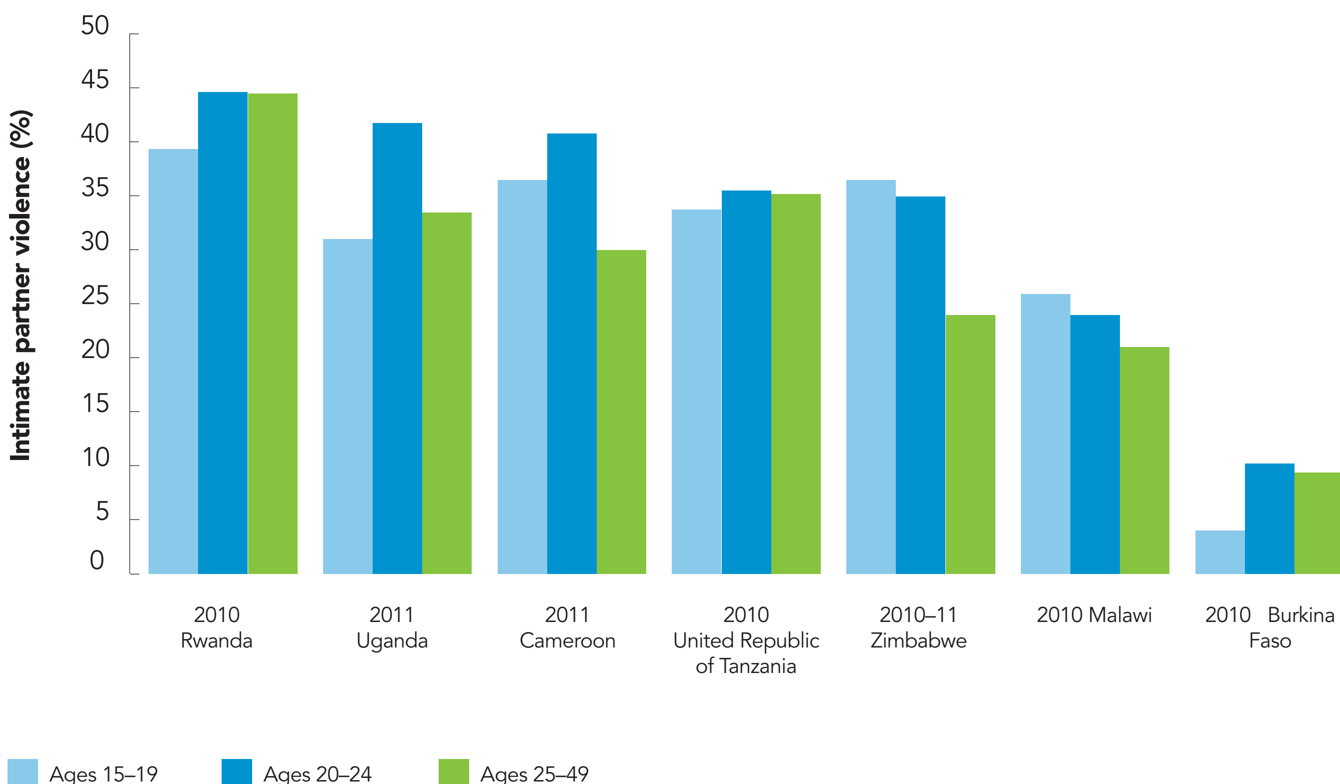
45%

Source: Multi-country study on women's health and domestic violence against women. Geneva: World Health Organization; 2005.

A review of more than 45 studies from sub-Saharan Africa revealed that relationships between young women and older male partners were common. Relationships with large differences in age are associated with unsafe sexual behaviour and low condom use *(8)*.

A study in South Africa found that young women who experienced intimate partner violence were 50% more likely to have acquired HIV than women who had not experienced violence *(9)*. The available data suggest that ever-married adolescent girls and young women aged 15–24 years are the most affected by spousal physical or sexual violence *(10)*.

Percentage of ever-married women who have experienced spousal physical or sexual violence by their current or most recent husband or partner in the past 12 months, by age



Source: Demographic and Health Survey data, countries with available data in sub-Saharan Africa.

Over half of adolescent girls and young women who are married in sub-Saharan countries with available data do not have the final say regarding their own health care *(10)*. Respect for and the protection and promotion of women's autonomy are central to ensuring access to comprehensive sexual and reproductive health and HIV services.

Young women who experience intimate partner violence are 50% more likely to acquire HIV than women who have not.

Lack of access to health services

Adolescent girls and young women often do not have the final say on matters related to their own health care. Punitive and age-restrictive laws and policies present barriers to young women accessing health services. These include laws that govern the age of consent for HIV testing and access to sexual and reproductive health services, the criminalization of HIV non-disclosure, exposure and transmission, and punitive laws related to key populations *(11)*. Negative gender stereotypes and harmful norms are equally damaging.

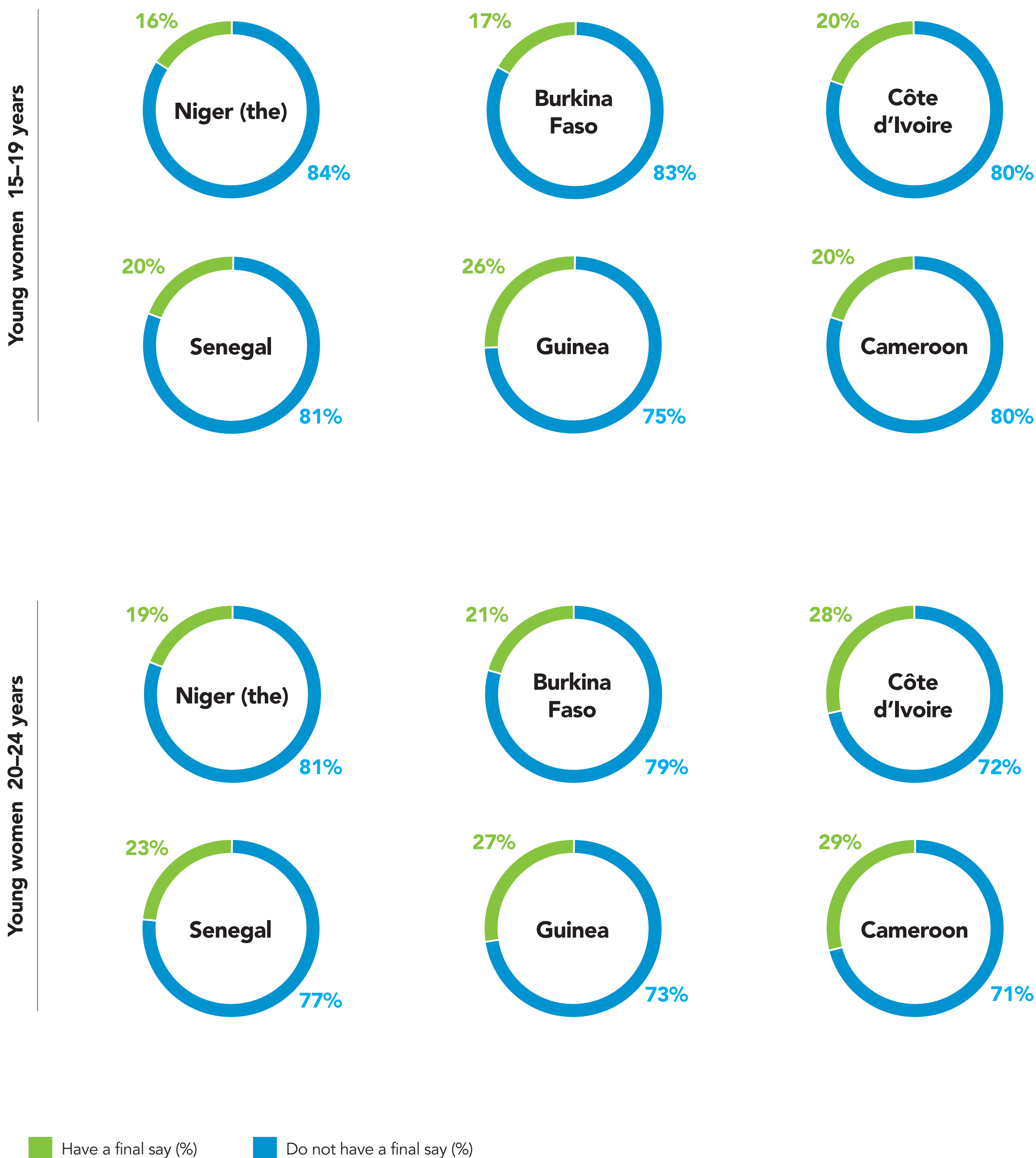
Adolescent girls and young women face significant barriers in accessing health services or protecting their own health. Lack of access to comprehensive and accurate information on sexual and reproductive health means that adolescent girls and young women are not equipped to manage their sexual health or to reduce potential health risks.

Furthermore, adolescent girls and young women are less able to negotiate condom use, have limited access to HIV testing, modern contraception and family planning and are less able to adhere to HIV treatment. In sub-Saharan Africa, only 26% of adolescent girls possess comprehensive and correct knowledge about HIV, compared with 36% of adolescent boys. In this context, according to UNICEF, among girls aged 15–19 who reported having multiple sexual partners in the past 12 months, only 36% reported that they used a condom the last time they had sex.

Many adolescent girls and young women in this age group are having sex for the first time. Restricted access to sexual and reproductive health services tailored to their specific needs, including comprehensive sexuality education, has a particularly negative impact. Health services must be adapted to the needs of adolescent girls and young women. However, some countries lack adequate, integrated and comprehensive youth-friendly sexual and reproductive health and HIV services that respond to the specific needs of adolescent girls and young women *(11)*.

In some contexts, HIV-positive women have been forced, or feel pressured by, health-care workers to be sterilized. In addition, HIV-positive pregnant women may choose to have an abortion because they are misinformed about their sexual and reproductive health options to preserve their children's and their own health *(12)*.

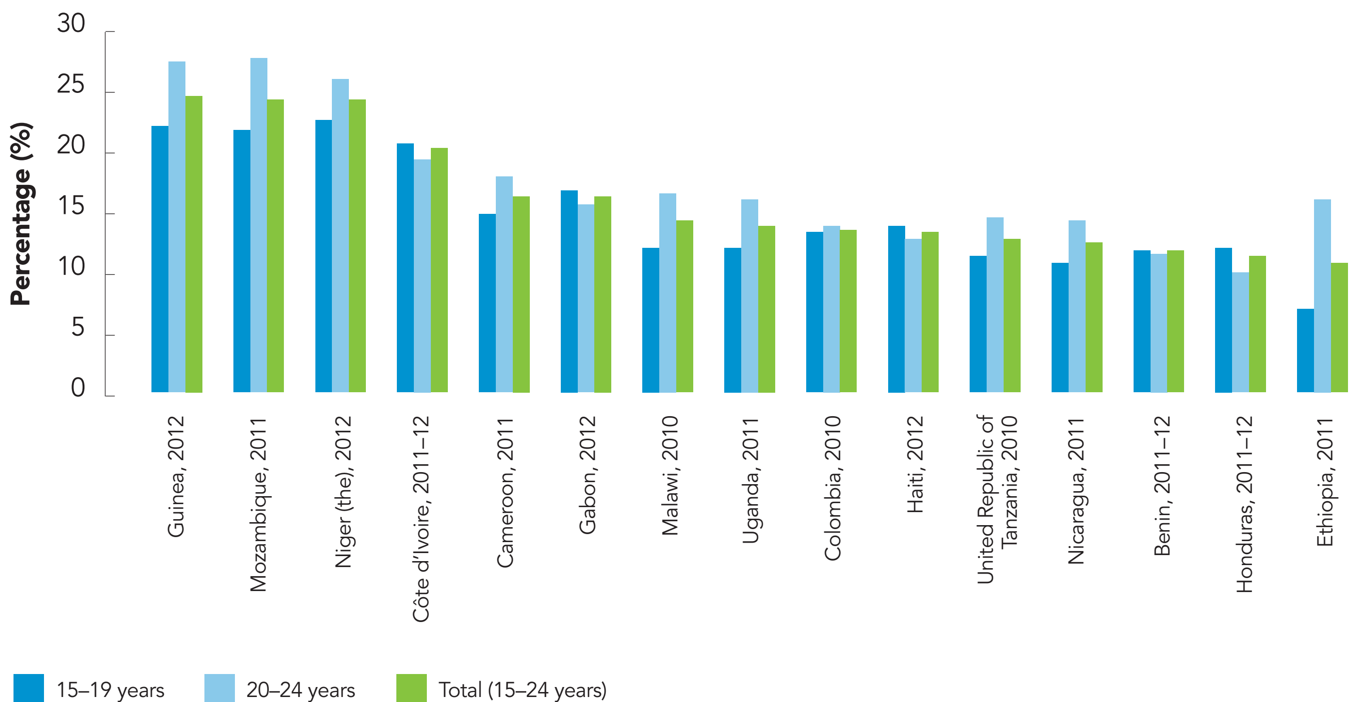
Currently married women who do not have the final say on their own health care by age groups in selected countries, 2010–2012*



* Reciprocal of currently married women who report having a final say in their own health.

Source: Demographic and Health Surveys, 2010–2012.

Sex before the age of 15 among young women by age groups in selected countries, 2010–2012



Source: Demographic and Health Surveys, 2010–2012.

Another gap in services for adolescent girls and young women can be found in HIV testing. The proportion of young people who have received an HIV test and have learned the result has increased globally since 2000. Yet, in sub-Saharan Africa, the region most affected by the AIDS epidemic, only 15% of adolescent girls and young women aged 15–24 are aware of their HIV status *(13)*.

In sub-Saharan Africa, only 15% of young women aged 15–24 are aware of their HIV status.

In general, young people living with HIV have lower levels of awareness of their HIV status compared to older people living with HIV. In Gabon, for example, people living with HIV 15–24 years old were seven times less likely to know their HIV status compared to people living with HIV 25–34 years old *(10)*.

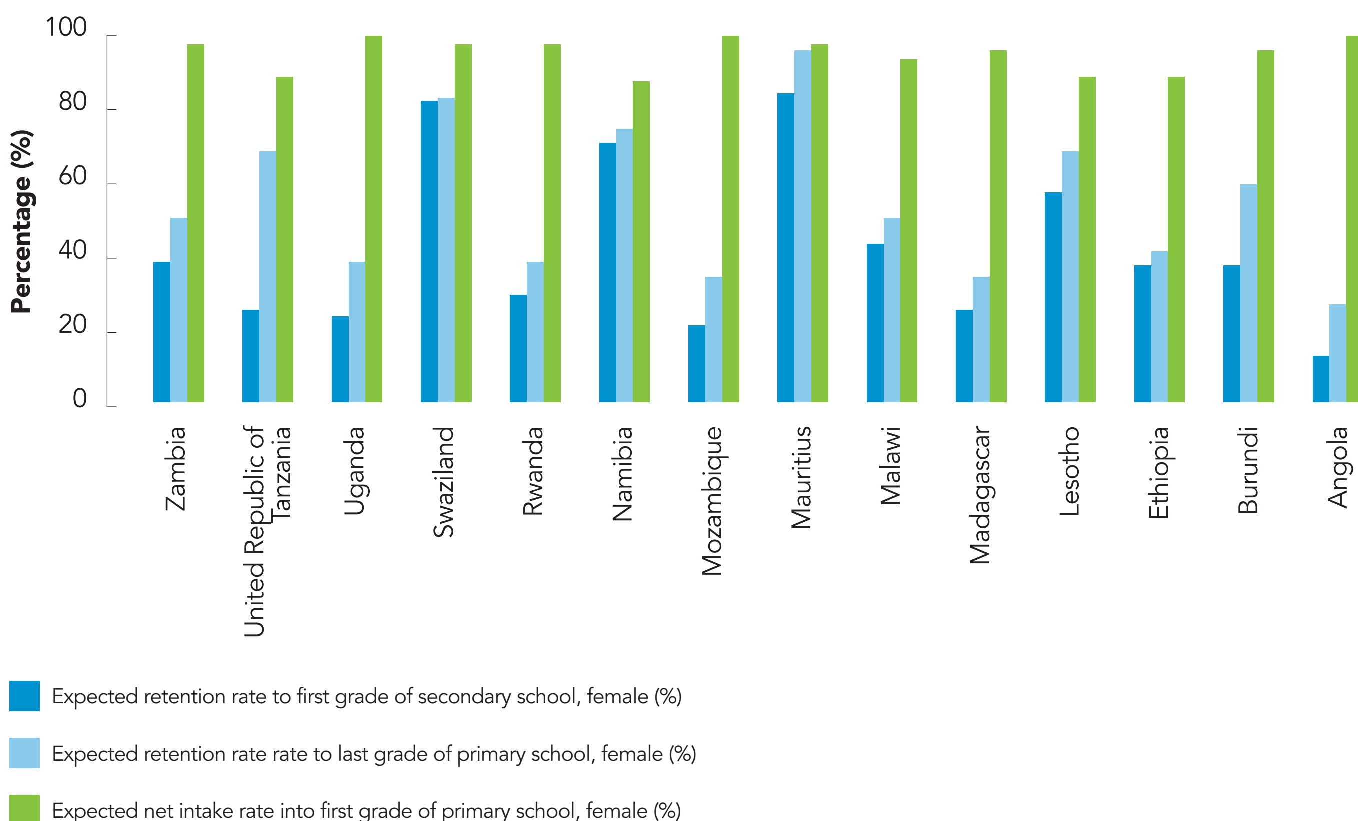
Lack of access to education

Learning to count, read, write and expand the ability to reason critically can improve people's future life prospects considerably *(14)*. Many studies show that increasing girls' and young women's educational achievement is linked to better HIV and sexual and reproductive health outcomes. When girls attend school, the risk of being married or becoming pregnant decreases, and it is more likely that they will have healthier pregnancies and birth outcomes in the future. Not having access to education, on the other hand, or leaving school because of pregnancy or other reasons, can jeopardize a girl's future *(15)*.

However, one child in every four who starts school will leave before finishing her or his primary education. More than 200 million young people aged 15–24 do not complete primary school. In sub-Saharan Africa, approximately 80% of young women have not completed their secondary education, and one in three young women cannot read *(16)*.

A 32-country study found that women with post-primary education were five times more likely than non-literate women to have knowledge about HIV, while non-literate women were four times more likely to believe that it is not possible to prevent HIV *(17)*.

Expected cohort retention rate to last grade of primary school and first grade of secondary school among girls in selected eastern and southern African countries, 2010



Source: Young people today. Time to act now. Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in eastern and southern Africa. Paris: United Nations Educational, Scientific and Cultural Organization; 2013.

Owing to the high dropout rate, adolescent girls and young women are less likely than their male peers to access comprehensive sexuality education. This education includes HIV awareness and negotiating power relationships, which are crucial to enabling young women to protect themselves.

However, even those young women who are able to remain in school often do not receive quality, comprehensive sexuality education that includes information on HIV *(18)*. In sub-Saharan Africa, only 28% of young women have knowledge about how to protect themselves from HIV *(19)*. In some settings, schools are often not equipped to guarantee the safe and productive learning environment for adolescent girls and young women needed to achieve their full potential *(11)*. A study in South Africa found that 30% of young female rape survivors were assaulted in or around their school *(20)*.

In sub-Saharan Africa, approximately 80% of young women have not completed their secondary education, and one in three young women cannot read.

Policies that do not translate into action

At this critical stage in their lives, adolescent girls can become lost as they transition out of systems designed for children but are not yet covered by services for adults. Often, legal frameworks bar adolescent girls and young women from exercising their basic human rights.

In 2014, 9% of all reporting countries had laws that created obstacles for women and girls accessing HIV prevention, treatment, care and support services *(21)*. These barriers include coercive HIV testing and age-of-consent requirements *(22)*. Furthermore, mandatory parental consent notification requirements have detrimental effects on the decisions of adolescents to access HIV testing *(4)* and inhibit adolescent girls' use of sexual health-care services *(23)*.

A significant proportion of women who experience physical and/or sexual violence do not seek help. The proportion of women survivors of physical and/or sexual violence who do seek help ranges from 18% in Azerbaijan and the Philippines to 52% in Colombia *(24)*.

Discriminatory social and cultural norms—particularly when translated into customary or statutory laws—result in public denial and, at times, repression of the sexuality and autonomy of young women. In some developing countries, many adolescent pregnancies occur within child marriage *(15)*. In 158 countries, 18 years old is the minimum legal age for women to marry without parental consent. Nevertheless, state or customary laws allow girls younger than 18 to marry with the consent of their parents or other authorities in 146 countries, while in 52 countries girls under the age of 15 can marry with the consent of their parents *(15)*.

Approximately 40% of women of reproductive age live in countries with restrictive abortion legislation *(25)*. In countries where abortion legislation is restrictive, the incidence of unsafe abortion is generally high, contributing to increased rates of maternal mortality and morbidity *(26)*.

Every year, there are approximately 16 million births among adolescent girls aged 15–19 *(27)*, accounting for 11% of all births worldwide *(28)*. Adolescent girls experience a disproportionate 23% of the global burden of disease associated with pregnancy *(29)*.

Often, legal frameworks bar adolescent girls and young women from exercising their basic human rights.

CLOSING THE GAP

Gender-based violence is a violation of human rights that affects adolescent girls and women in all their diversity. Violence undermines the HIV response by creating a barrier to accessing HIV services. Adolescent girls and young women in all their diversity—especially those living with and affected by HIV—continue to experience multiple layers of stigma, discrimination, exclusion and gender-based violence, resulting in negative health and rights outcomes *(11)*. Stigma, discrimination and violence based on age, gender and sex must be stopped.

Discriminatory laws that present obstacles to the realization of young women's rights, including their sexual and reproductive rights, must be revoked to reduce new HIV infections, AIDS-related deaths and gender-based violence and to improve adolescent girls and young women's sexual and reproductive health. It is especially important to remove mandatory parental or spousal consent requirements for accessing sexual and reproductive health and HIV services *(11)*.

According to the World Health Organization, there are four overarching approaches that can help to reduce women's vulnerabilities to violence and HIV *(30)*:

- Empowering girls and young women through multisectoral approaches, for example through integration with economic empowerment interventions and possibly through engagement with families.
- Transforming harmful cultural and social gender norms through effective school-based interventions, for example by focusing on the socialization of boys and girls.
- Integrating services against gender-based violence into HIV services, such as through addressing violence during HIV testing and counselling.
- Promoting and implementing laws and policies related to violence against women, gender equality and HIV, including developing and implementing national plans and policies to address violence against women as a component of the HIV response.

Comprehensive sexual and reproductive health and HIV services must be integrated. This requires significantly expanding access to quality services, including HIV testing, and integrating HIV counselling within sexual and reproductive health services for adolescents and young people. The contraceptive needs of all people, including people living with HIV, must be addressed. Equally, evidence-informed policies must be vigorously pursued, adequately financed and implemented. And all forms of forced or coerced sterilization of adolescent girls and young women living with HIV should be eliminated.

HOW TO CLOSE THE GAP

01

End all forms of gender-based violence

02

Ensure access to quality health services

03

Keep girls in school

04

Empower young women and girls and challenge and change social norms

Adolescent girls and young women bear a disproportionate burden related to HIV, mainly in sub-Saharan Africa and in the Caribbean in particular in countries with generalized epidemics and with hyperendemic levels. Additional comprehensive assessments are needed to determine the causes of this high burden. This includes understanding the multiple dimensions of gender inequalities and power imbalances. We must improve our understanding of the vulnerabilities of adolescent girls and young women who have lost one or both parents to an AIDS-related illness or who have lived with HIV through infancy and childhood.

Completion of secondary education contributes to protection against HIV. Efforts must be doubled to keep adolescents girls and young women in school, free of HIV, able to plan their pregnancies and safe from all forms of stigma, discrimination and violence. Education should also enable the development of skills and knowledge to live better with HIV. Indeed, during the post-2015 debate, young women have highlighted access to a good education, better health care and an honest and responsive government as the top three priority areas to be included in the post-2015 development framework *(31)*.

Given the overwhelming burden of HIV on adolescent girls and young women in eastern and southern Africa, there is a need for a geographically targeted approach that comprehensively addresses their needs and rights.

Young women are powerful drivers for social change and the achievement of global targets for health and development. Participatory, people-centred approaches to adolescent girls and young women's health and rights must be scaled up.

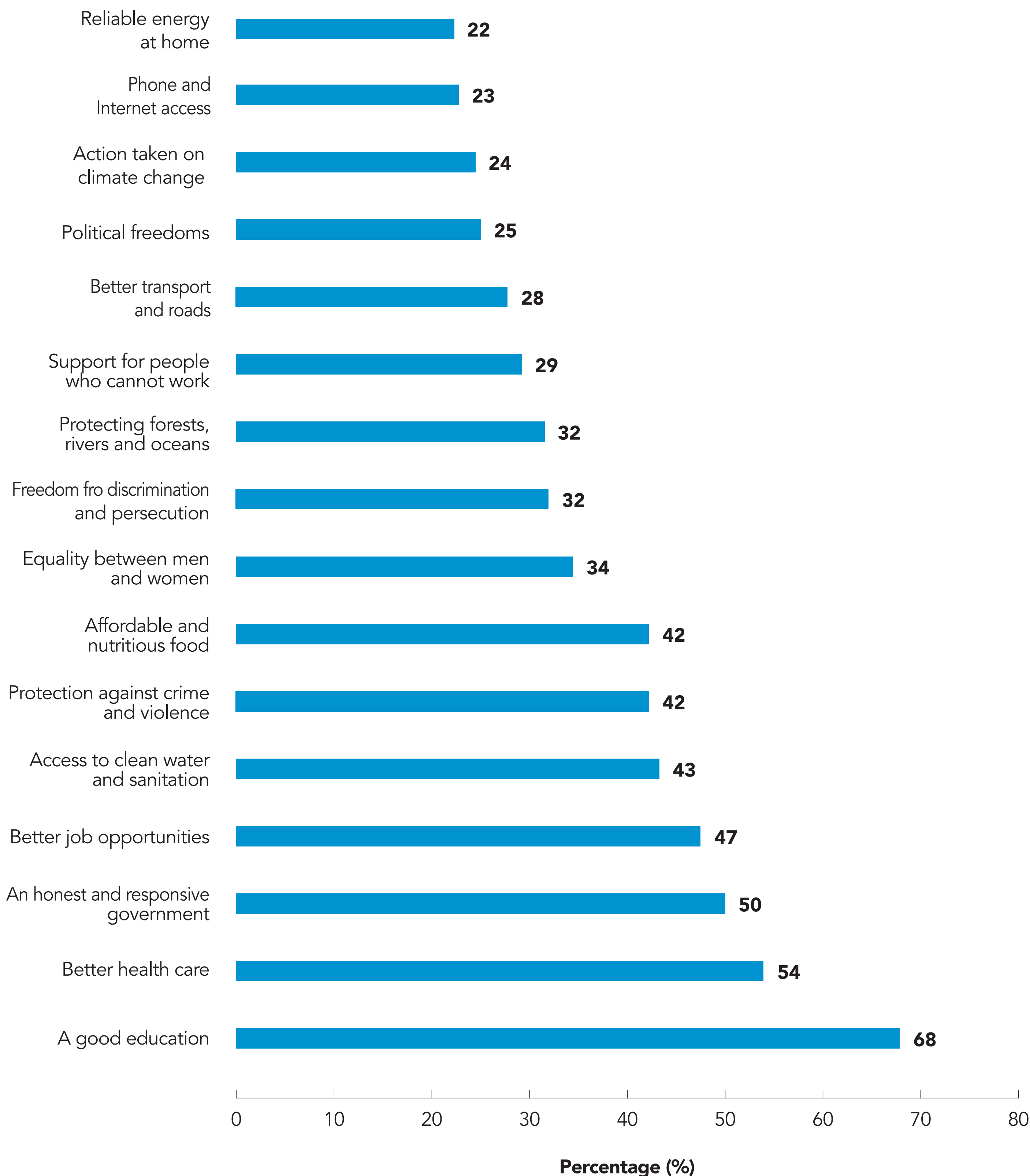
Removing social and legal barriers that prevent young people—in particular young women and girls from key populations (including young people who use drugs, young people who sell sex and young transgender people)—from accessing comprehensive, integrated sexual and reproductive health and HIV prevention, treatment, care and support services has been shown to be important.

Increasing investments in integrated programmes, including the use of social benefits or cash transfers and skills development to prevent negative HIV and sexual and reproductive health outcomes, has been shown to work. A study in the United Republic of Tanzania found that the prevalence of sexually transmitted infections was 25% lower among young people who benefited from conditional cash transfers than among those in the control group *(32)*. Furthermore, although cash transfers did not reduce all risks related to HIV, child-focused cash transfers in South Africa have proven to reduce the risk of transactional sex and age-disparate sex among teenage girls *(33)*.

What do adolescent girls and young women want?

- **68% want a good education**
- **54% want better health care**
- **47% want better job opportunities**
- **42% want protection from violence**

Percentage of votes by topic among women 16–30 years old at all education levels from all countries on their priorities for the post-2015 development framework



Source: MYWorld Analytics. New York: United Nations; 2014.

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