CHANGE
CENTER FOR HEALTH AND GENDER EQUITY

OCTOBER 2018

Building an Advocacy Agenda
for Integrated Sexual and Reproductive Health and Rights for Women and Girls:
A three-country landscape

INTRODUCTION

Suppose you are a 16-year-old girl. The school day has ended, and you head over with your friends to the local youth hub. There, you find study spaces, a library, career assistance, and services alongside a television and some snacks. There is also a friendly nurse to advise you on family planning and contraception; STI screening, diagnosis, and treatment; HIV prevention, treatment, and care; safe abortion; and gender-based violence prevention and care. The space is free of discrimination and stigma, financial burdens, and difficult technical and bureaucratic processes. You can make decisions about yourself and your body without fear and undue influence. Suppose this is possible.[1]

HIV and AIDS treatment and prevention strategies have long been the focus of global health interventions. From 2010 to 2015, increased funding and programming decreased new HIV infections across sub-Saharan Africa by 29 percent.[2] But in 2017, adolescent girls and young women (AGYW) ages 15-24 accounted for a quarter of new HIV infections.[3] As a group, these women and girls represent 59 percent of the 19.4 million people living with HIV in East and Southern Africa.[4]

The risk of HIV infection for women and girls is a biological predisposition and rooted in the overlapping and reinforcing layers of gender inequality that span and give shape to the economic, social, and political dynamics of women and girls' lives.[5] Therefore, effective HIV prevention programming for women and girls must account for the structural, individual, and community factors that increase their HIV risk. Such programming must pursue holistic, layered approaches to prevention, rather than single-session and exclusively medical interventions.[6]

This report builds on previous work by women to define for themselves what an integrated prevention agenda looks like, and to provide concrete, national, next steps. These documents can be found here and here.

COMPASS Africa — the Coalition to build Momentum, Power, Activism, Strategy & Solidarity in Africa — is an innovative, savvy, data-informed, and audacious North-South coalition with a goal to advocate for and implement comprehensive HIV prevention programming in Malawi, Tanzania, and Zimbabwe. With a range of skills and expertise that facilitate differentiated service delivery, COMPASS Partners aim to implement programming that increases:

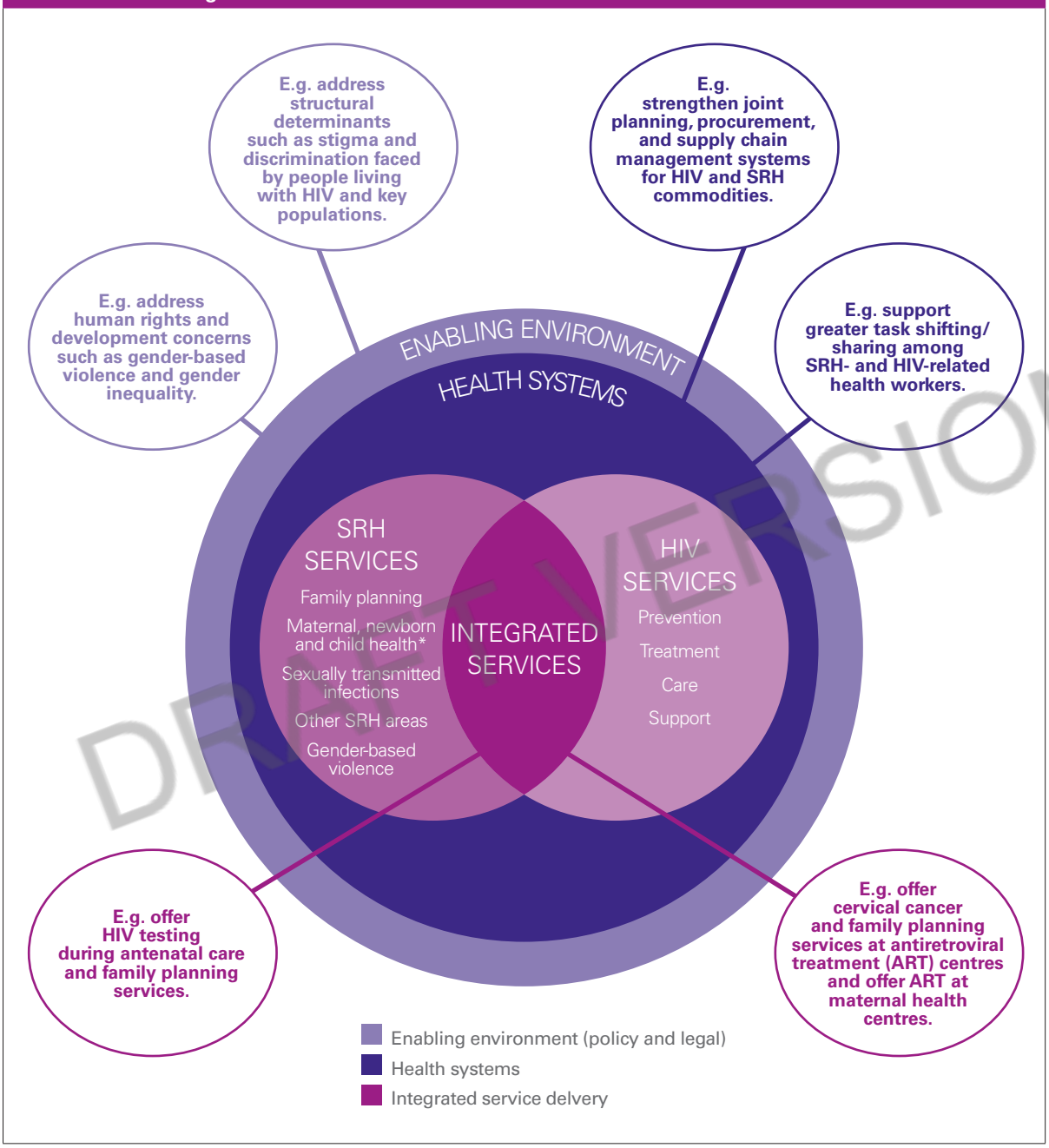
- Combination prevention
- Data literacy and the use of data for advocacy
- Analyses of power dynamics shaping the epidemic response at institutional and individual levels — and of strategies for improving accountability
- Community development and the inclusion of issues concerning men who have sex with men and transwomen
- Support for HIV prevention for women and girls, including female sex workers

The coalition's shared understanding of the multifactorial causes of HIV — and the multilayered prevention and treatment programming they necessitate — grounds this convergence of broad skill sets and areas of expertise. While some of the resultant work plans involved specific programming for AGYW, this report aims to outline a roadmap for collective skill-sharing and action on effective advocacy for integrated HIV and sexual and reproductive health and rights (SRHR) services for women and girls.

This report details what is required to build an integrative HIV prevention agenda that centers the health and lives of women and girls in Malawi, Tanzania, and Zimbabwe. It draws on interviews with COMPASS Partners, state and civil society interventions, and landscape analyses of national and global policies that impact the health and rights of women and girls in the three countries.

This report is divided into three sections that unpack challenges, outline ongoing interventions, and identify future advocacy opportunities for HIV prevention and SRHR for women and girls. The first section highlights some of the major sociocultural, structural, and institutional barriers inhibiting the full and effective inclusion of and access to services and health products by women and girls. The second section details some of the advocacy work COMPASS Partners have conducted in response to specific contextual barriers. The final section concludes with key takeaways and recommendations for further integrating the SRHR needs of women and girls into HIV prevention programming and advocacy efforts.

HIV and SRHR Linkages



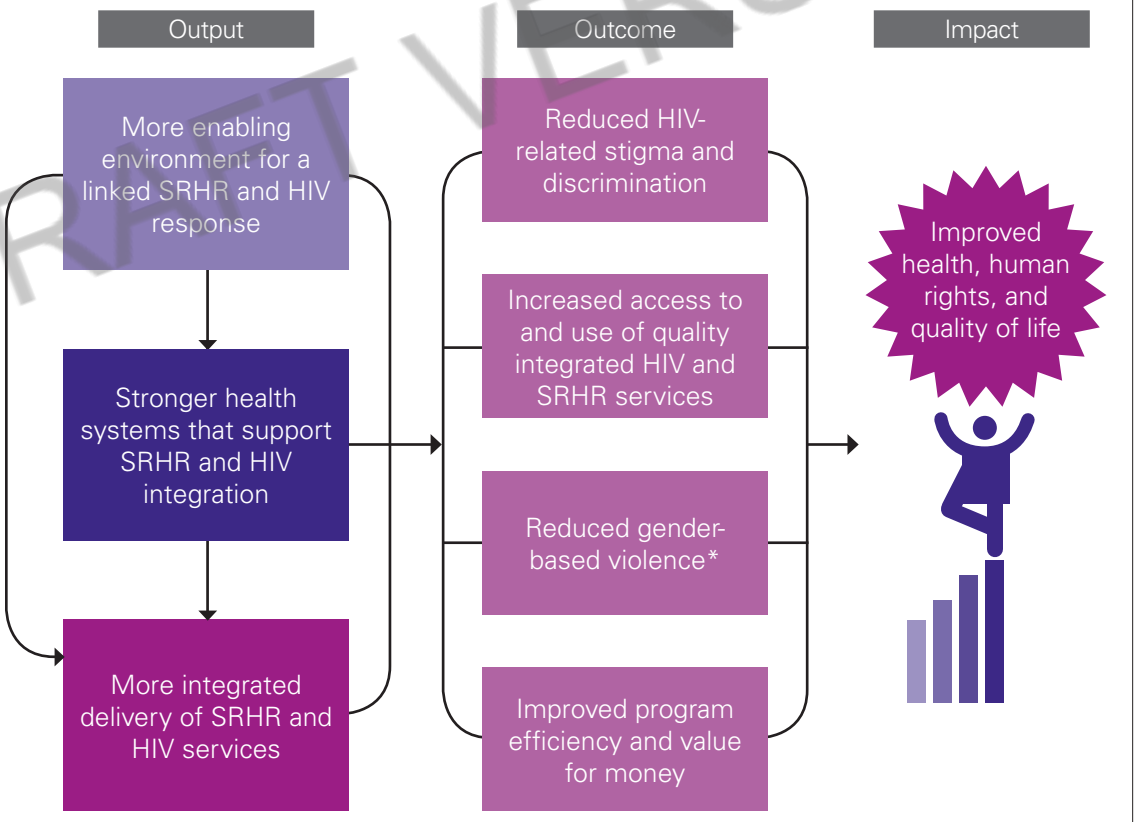
Source: Adapted from WHO, UNFPA, UNAIDS, IPPF (2005) Sexual and reproductive health and HIV/AIDS: A framework for priority linkages. http://srhhivlinkages.org/wp-content/uploads/2013/04/frameworkforprioritylinkages_2005_en.pdf
*Maternal health is an SRH service, which is often clustered with newborn and child health services.

1. CHALLENGES

Disparate power relations and gender biases have combined to form patriarchal societies the world over, wherein men, or what is considered masculine, is accorded more importance than women, or what is considered feminine.[7] Gender inequality is the impetus for each of the barriers women and girls experience in accessing comprehensive SRHR and HIV prevention services. Though this report will subdivide these barriers into separate categories — "sociocultural," "structural," and "institutional" — the challenges experienced at each of these levels are often interrelated, additive, and mutually compounding. An understanding of the reciprocity of these factors underlies the commitment of COMPASS Partners to differentiated service delivery and holistic HIV treatment and prevention strategies for women and girls in Malawi, Tanzania, and Zimbabwe.

Theory of Change for SRHR and HIV Linkages

Linking HIV and SRHR responses is critical for reaching full human rights, gender equality, and health targets for the sustainable development goals.



Source: Adapted from IPPF, UNFPA, WHO (2014) SRH and HIV Linkages Compendium: Indicators and Related Assessment Tools. Available at: http://bit.ly/1KVaET1f

*It is recognized that reducing stigma, discrimination and gender-based violence are also impact-level measures and the outcome measures influence each other.

1.1 SOCIOCULTURAL BARRIERS

Men in positions of power constrain much of the control women have within societal structures like their family unit, community, and health care system.[8] A continuum of stigma and taboo, often reinforced by religious beliefs and cultural practices, restricts the societal standing of women and girls and narrows the range of behaviors and expectations deemed appropriate for them.

"You people of Meatu keep livestock. You are good farmers. You can feed your children. Why would you opt for birth control? These are my views, but I don't see any need for birth control in Tanzania. People who use birth control do so because they do not want to work hard and feed a large family."

President Magufuli, Tanzania, Sept. 9, 2018

Pervasive negative attitudes towards women and girls accessing SRH services are rooted in, and perpetuate, gender biases and unequal access to comprehensive health care.[9]

A COMPASS partner in Zimbabwe noted that some families in rural communities "do not consider it important for a girl to go to school because at the end of the day she is going to get married."[10] This limited expectation creates a "barrier between parents and the child to discussing … sex, sexuality, or just sexual reproductive health in general."[11] A broad expectation for girls and women to marry and bear children leads to wider community stigma, and yet another barrier, for women and girls wanting to access sexual and reproductive health (SRH) and family planning (FP) services. AGYW remain at a disproportionately high risk of contracting HIV. As girls mature to adulthood, they face efforts to keep them ignorant about their own reproductive health, and cultural practices that force them into early marriage or subject them to sexual violence.[12]

A COMPASS partner shared that in Malawi, "with the uptake of SRH, like family planning, there is a lot of stigma that has prevented young girls and adolescents from accessing services."[13] A Zimbabwean COMPASS partner similarly noted that, "if someone sees [a woman or girl] enter a youth-friendly center, just like entering a clinic, they will think that [they] are sick."[14] This widespread stigma and negative association of FP and SRH for women and girls affect the care they receive if they make it to a clinic to access services. Even among providers in the three COMPASS countries, "not all health care people are trained to have that youth-friendly approach."[15]

If women and girls manage to acquire HIV prevention and FP products, like female or male condoms, their lower societal standing in comparison with men once again undercuts their control and ability to negotiate the parameters of their sexual activity. In Malawi, according to a COMPASS partner, "the man still decides the number of children in the family. Not many women have that leverage to tell her husband or to tell her boyfriend to use a condom."[16] Partners in Zimbabwe also commented on the high rates of gender-based violence (GBV) that pose a detriment to HIV prevention and SRHR for AGYW.[17] Thirty-eight percent of girls in Malawi, 33 percent of girls in Tanzania, and 41 percent of girls in Zimbabwe

Thirty-eight percent of girls in Malawi, 33 percent of girls in Tanzania, and 41 percent of girls in Zimbabwe experienced forced sex as their first sexual encounter between the ages of 13-24.

experienced forced sex as their first sexual encounter between the ages of 13-24.[18] There is a strong link between intimate partner violence (IPV) and HIV incidence, and in Eastern and Southern Africa, 12 to 22 percent of new HIV infections among women are due to IPV.[19]

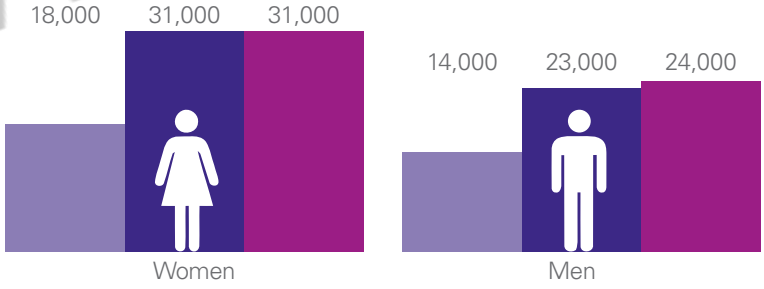
Unequal gender dynamics further impose increased retaliation and censure on women and girls who access services and then test positive for HIV. Rather than pursue antiretroviral therapy (ART) regimens, a Malawi partner reported that, "because of the backlash that other women have had, women tended to shut down and keep quiet for fear of loss of marriage and...being physically abused and ridiculed."[20] Women and girls' limited educational opportunities leaves them with limited economic opportunities. Their financial reliance on the maintenance of their marriage, coupled with the potential for backlash for seeking SRH services, is a deterrent for women and girls seeking HIV testing and treatment.[21]

Key Data

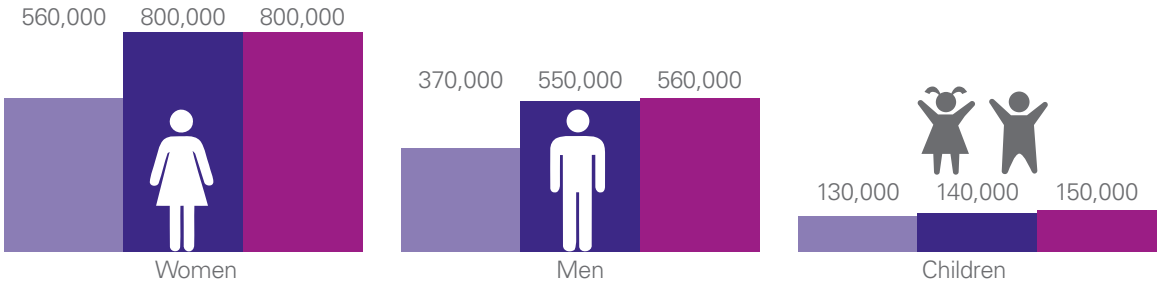
Population size

Malawi	Tanzania	Zimbabwe
16.7 million	15.0 million	15.2 million

New adult HIV infections



People living with HIV



Malawi[22] Tanzania[23] Zimbabwe[24]

For women living with disabilities, stigma even further compounds these socio-cultural barriers. Partners across the three COMPASS countries noted that organizations have difficulty engaging with women living with disabilities.[25] A Zimbabwean partner attributes this to societal stigma against people living with disabilities, whose families have been known to shun or severely limit their engagement with their community.[26]

1.2 STRUCTURAL/RESOURCE BARRIERS

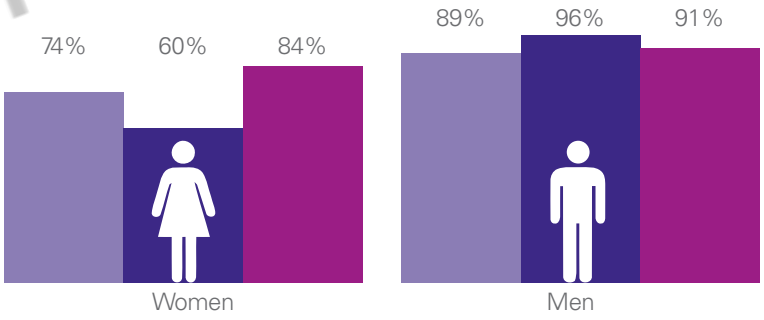
Women and girls experience socio-cultural barriers in accessing comprehensive SRHR and HIV prevention services that manifest into – and are worsened by — additional economic, geographic, and infrastructural challenges.

A lack of financial resources for the health care systems of Malawi, Tanzania, and Zimbabwe

Enabling Environment

Girls married before 18

Ability to participate in decisions regarding their own health



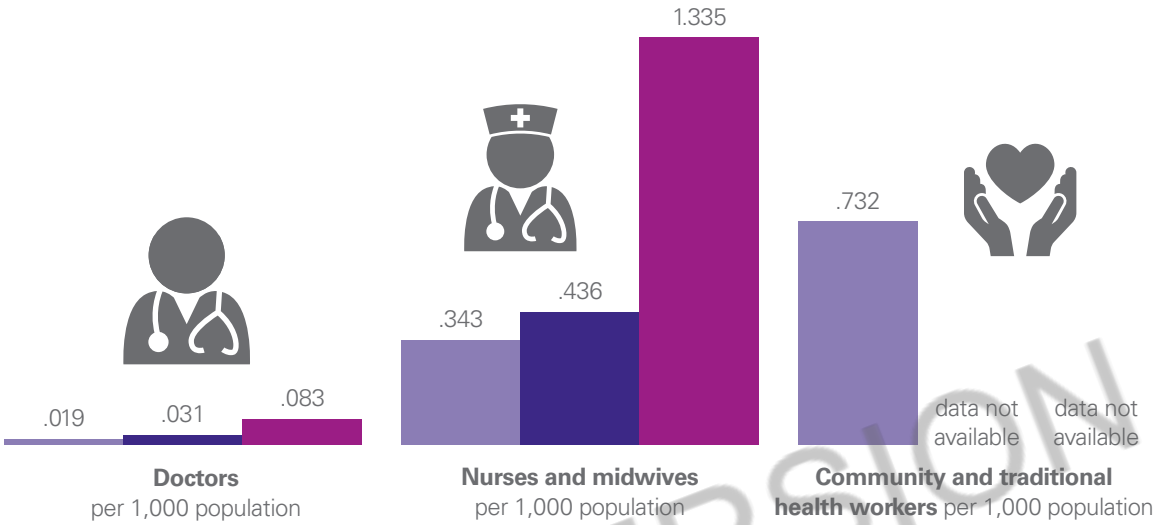
Intimate partner violence prevention programs

	Malawi	Tanzania	Zimbabwe
In-school education on preventing dating violence	Larger scale	Limited	None
Microfinance and gender equity training	Limited	Limited	None
Changing social and cultural norms that support violence	Larger scale	Larger scale	Larger scale

Malawi[22] Tanzania[23] Zimbabwe[24]

Health Systems

Human resources



Doctors per 1,000 population

Nurses and midwives per 1,000 population

Community and traditional health workers per 1,000 population

Logistics and supplies

HIV and SRHR commodities	Malawi	Tanzania	Zimbabwe
Are there integrated supply systems?	Data not available	Yes	Partially integrated
Are there integrated ordering systems?	Data not available	Yes	Partially integrated
Are there integrated monitoring systems?	Data not available	Yes	Partially integrated

Coordination, planning, and budgeting

	Malawi	Tanzania	Zimbabwe
Is there joint planning of HIV and SRHR programs?	Some	No	No
Is there any collaboration between SRHR and HIV for program management/implementation?	No	No	No

SRHR and HIV service coverage

HIV testing and counseling facilities per 100,000 adult population

Malawi[22] Tanzania[23] Zimbabwe[24]

restricts women and girls' access to effective HIV treatment and prevention resources.[27] Bias and stigma among providers persist when there is not enough funding for adequate youth sensitivity and SRH training for staff in health care facilities. A Malawi COMPASS partner noted that youth living with HIV "have issues of access to services in the hospitals, in the clinics, in the setups…not all health care people are trained to have that youth-friendly approach. Some health care workers aren't trained, and it has made girls and young women stay away and not access services at times."[28]

Partners in Zimbabwe, where the government's domestic investments in health stood at just eight percent in 2017,[29] confirmed "there is a lot of work that needs to be put into strengthening health care workers themselves to understand and appreciate the dynamic of working with adolescent girls as it relates to SRH, in terms of understanding and accepting their choices, and that they should be given all options and not be judged for making decisions that relate to their health and to protecting themselves from contracting HIV and other sexually related illnesses."[30]

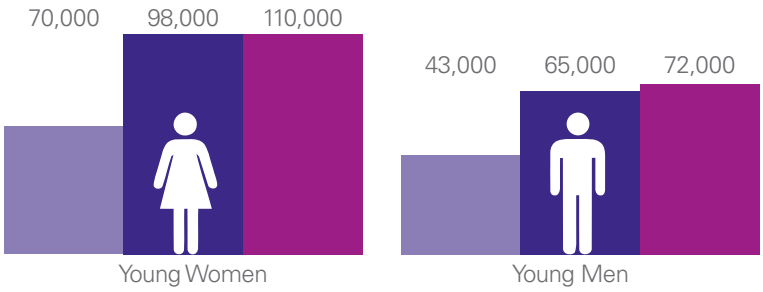
In Tanzania, there is a "lack of financial resources to support regular outreach services, including mobile services for prevention and care and treatment,"[31] let alone specialized youth-friendly prevention programming. And in Zimbabwe, scarcity of health facilities adds a geographical barrier, requiring women and girls to walk long distances to reach providers who may not trained to be receptive to their needs.[32]

Partners in the three countries reported that the lack of parent-child communication about SRH issues and HIV prevention, a product of the taboo around women and girls engaging in sexual activity, left women and girls with a "general lack of knowledge around SRH and the law around SRH, or even the development in [their] body."[33] Partners in Zimbabwe observed that this lack of education "actually predisposes the girl to HIV and becomes a barrier to them accessing services."[34] Inadequate testing and treatment literacy also inhibits proper medication regimens, as many adolescents receiving HIV treatment in Zimbabwe struggle with "adherence and defaulting" because they feel that "other ways of preventing HIV may not necessarily apply to them."[35]

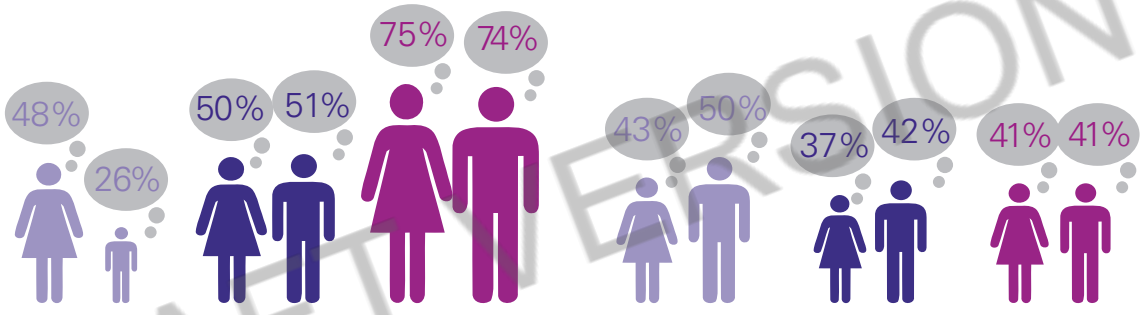
Insufficient SRH education and HIV prevention and treatment programs are matched by the scarce availability of SRH tools and medications. As it stands, in Tanzania "many women and girls do not have the choice of different methods" or "access to female condoms, which can help AGYW be sure they are protecting themselves from HIV."[36] COMPASS Partners in Tanzania are also working to improve access to pre-exposure prophylaxis (PreP), which reduces early virus vulnerabilities and prevents the onset of infection.[37] In Tanzania, a pilot study conducted by the Tanzanian government, Population Council, National AIDS Control Program, Tanzania Sauti, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and CSK Research Solutions on PrEP implementation found that women and girls were open to using PrEP for various reasons, including their elevated risk of contracting HIV and the discretion it afforded them in taking prevention measures.[38] This research showed that women and girls are eager to engage in HIV prevention methods appropriate for their specific realities, yet PrEP remains available in Tanzania only at a "pilot project site where other partners are doing activities to complement the government effort."[39] COMPASS partners are conducting advocacy efforts in Malawi to increase

Young People

Young people living with HIV aged 15-24



Knowledge and comprehensive sexuality education



Young people aged 15-19 who have heard of family planning on any of the three sources (radio, TV or newspapers)

Adolescents aged 15-19 who have comprehensive knowledge of HIV

Malawi[22] Tanzania[23] Zimbabwe[24]

Key Populations

Key populations are often not reached with health services, including for SRHR and HIV, and frequently experience violations of their human rights.

	People who inject drugs			Sex workers		
	Malawi[22]	Tanzania[23]	Zimbabwe[24]	Malawi[22]	Tanzania[23]	Zimbabwe[24]
Population size estimate	*	30,000	*	9,338	155,450	*
HIV prevalence	*	15.5%	*	24.9%	28.0%	46.2%
HIV testing	*	21.9%	*	94.4%	43.1%	45.4%
Condom use	*	29.4%	*	85%	70.0%	71.2%

*Data not available

condom availability by providing them through schools, but this approach has prompted objections from parents and faith organizations who assert that increased availability of condoms would "trigger immorality."[40] Many women and girls in Zimbabwe also experience barriers to accessing menstrual sanitation products. Women and girls often cannot afford these products, which can result in them dropping out of school and engaging in risky sexual behavior — like transactional sex — rather than continuing their education.[41]

Structural barriers also affect advocacy work for increased SRHR and HIV prevention programs for women and girls. A COMPASS partner in Zimbabwe noted the lack of a "strong network of women and girls at the local level in terms of enhancing learning and participation."[42] Major gaps for implementers in HIV prevention work in Tanzania also derive from community members not being involved or participating in campaigns for increased information and testing services.[43] The financial cost of advocacy, in terms of transportation and lodging for advocates, as well as potential foregone wages, poses another barrier to grassroots representation of communities that are already disproportionately affected by inequality, such as AGYW.[44]

1.3 INSTITUTIONAL BARRIERS

Laws and policies, or a lack thereof, can serve as both impediments to and catalysts for securing SRHR and effective HIV treatment and prevention for women and girls. COMPASS Partners across Malawi, Tanzania, and Zimbabwe identified laws that are barriers to their work, laws they hope to see codified to improve their ability to provide services to women and girls, and existing laws and policies they believe could be better enforced.

Laws criminalizing sex work in Tanzania[45] and Zimbabwe[46] prevent health providers and organizations from effectively meeting the SRH

Strategies and Policies

Is there a national HIV strategy?

If yes, have these SRHR components been included as a measurable target:	Malawi[22]	Tanzania[23]	Zimbabwe[24]
Condoms (with reference to STI prevention / contraceptive method)?	YES	NO	YES
Prevention / elimination of mother-to-child transmission of HIV?	YES	YES	*
SRHR of people living with HIV?	NO	Mentioned	NO
Sexually transmitted infections?	YES	YES	YES
Gender- based violence?	Mentioned	YES	Mentioned

Is there a national SRHR strategy?

If yes, have these HIV components been included as a measurable target:	Malawi	Tanzania	Zimbabwe
Condoms (with reference to HIV prevention)?	Mentioned	Mentioned	YES
Prevention / elimination of mother-to-child transmission of HIV?	YES	YES	YES
SRHR of people living with HIV?	Mentioned	NO	Mentioned
Sexually transmitted infections?	Mentioned	Mentioned	Mentioned
HIV counselling and testing?	YES	Mentioned	YES

and HIV prevention needs of all members of society. Sex work criminalization in Tanzania means organizations are deprived of the opportunity to "work with groups like sex workers because they cannot be open for their work in Tanzanian communities and government."[47] COMPASS partners in Tanzania remarked that "on the one hand, the government is giving. On the other hand, the government is taking. It is still criminalizing sex work," and is even investigating one of their partners organizations who works with sex workers.[48] Zimbabwean COMPASS Partners are similarly restricted in their ability to meet the SRH and HIV prevention needs of sex workers, even while HIV prevalence among sex workers varies between 50 percent and 70 percent in several countries in southern Africa.[49]

In Malawi and Zimbabwe, laws restricting the age of consent for HIV testing also impose barriers to accessing services for AGYW. In Malawi, adolescents below 13 years of age "cannot go and have an HIV test without a guardian," while in Zimbabwe the age of consent for HIV testing is 18 years old. Given the stigma around AGYW engaging in sexual activity and the lack of communication between children and adults, the age of consent requirement to receive HIV testing presents a "big barrier to accessing services."[50]

In Tanzania and Zimbabwe, the lack of formal guidelines or clearly established roles for civil society organizations (CSOs) was a barrier to SRH and HIV prevention programming. COMPASS partners in Tanzania reported training and relying on the work of competent volunteers, but the lack of recognition of those volunteers "when we try to connect them to local health facilities…becomes challenging. Currently as a nation we don't have a policy or a law which governs or recognizes community action in prevention services."[51]

Comparably, Zimbabwean COMPASS Partners had to navigate bureaucratic challenges and establish a Memorandum of Understanding (MoU) with the Ministry of Primary and Secondary Education of Zimbabwe to be able to ask a group of AGYW students about what kinds of HIV prevention programming would best meet the needs of their age group.[52] And "even with the MoU, we still often have to go back to the ministry and the relevant department of whatever services is responsible for such kinds of projects."[53]

The middling commitment to and lukewarm enforcement of important laws and best practices by national governing bodies further undermines the work of COMPASS Partners in Malawi, Tanzania, and Zimbabwe.[54] Jointed Hands Welfare Organisation in Zimbabwe lobbied for the inclusion of civil society organisations to engage more meaningfully in formal policy processes by changing the national operational guidelines for PEPFAR HIV grants.[55] This narrow avenue for the inclusion of key populations deprives policy makers, and ultimately programming beneficiaries, of the opportunity to create target-population-informed HIV treatment and prevention strategies in other capacities. COMPASS Partners in Zimbabwe also reported that the government's lack of enforcement of laws prohibiting child marriage perpetuates the practice rather than following their original intent of "ensuring anyone that is to break the law is exposed somehow."[56]

Laws

Support to SRHR and HIV linkages: Inhibitive Partial Condusive

People living with HIV

Are there laws that:	Malawi[22]	Tanzania[23]	Zimbabwe[24]
Criminalize HIV transmission or exposure?	NO	YES	YES
Impose HIV specific restrictions on entry, stay or residence?	NO	NO	NO
Address HIV-related discrimination and protect people living with HIV?	YES	YES	YES

Key populations

Are there laws that:	Malawi	Tanzania	Zimbabwe
Criminalize same-sex sexual activities?	YES	YES	YES
Deem sex work as illegal?	NO	YES	YES
Mandate the death penalty for drug offenses?	NO	NO	NO
Demand compulsory detention for people who use drugs?	NO	NO	NO
Recognize a third, neutral and non-specific gender besides male and female?	NO	NO	NO

Gender-based violence

Are there laws that:	Malawi	Tanzania	Zimbabwe
Address gender-based violence?	YES	YES limited enforcement	YES
Penalize rape in marriage?	NO	NO	YES partial implementation
Allow free entry into marriage and divorce?	YES full enforcement	data not available	YES partial implementation
Allow the removal of violent spouses?	YES full enforcement	data not available	YES partial implementation

Other laws

Are there laws that:	Malawi	Tanzania	Zimbabwe
Make sexuality education mandatory?	YES	data not available	data not available
Allow legal abortion?	YES to save a woman's life	YES to save a woman's life; preserve a woman's physical health; preserve a woman's mental health	YES to save a woman's life; preserve her physical health; in case of rape or incest; because of foetal impairment
Prohibit female genital mutiliation?	NO	YES limited enforcement	YES partial enforcement

Age of consent	Malawi	Tanzania	Zimbabwe
What is the minimum legal age for marriage without parental consent?	18 years	18 years	18 years
What is the legal age for HIV testing without parental consent?	13 years	16 years	16 years
What is the legal age for consent to sexual intercourse?	16 years	16 years	12 years, girls 16 years, boys

2. ENVISIONING SUCCESS

The barriers blocking women and girls from accessing comprehensive SRHR and HIV prevention services are interrelated, additive, and mutually compounding — so their solutions must be as well. COMPASS Africa's diverse array of partner organizations is well positioned to learn from one another and from the broader global health community to create innovative and uniquely effective solutions for women and girls in Malawi, Tanzania, and Zimbabwe.

Work done by CHANGE and other COMPASS Partners highlights a critical need to center HIV policies and programs around the entirety of women's health needs and human rights, and integrating family planning, STI, and maternal health considerations into HIV prevention and treatment initiatives. Ideally, a woman or girl could walk into a "one-stop-shop" clinic and have all of her health needs met, with respect for her sexual, reproductive, and human rights. To achieve this goal, funding streams, public policies, and advocacy strategies must also be integrated.

Integrated services can include the following:

- Contraception
- STI prevention, diagnosis, and treatment
- HIV prevention (including PrEP, male and female condoms, future effective microbicides and multipurpose prevention technologies)
- HIV treatment and care
- Screening, counseling, referral, and treatment for GBV
- Youth-friendly and accessible SRHR services
- Emergency contraception
- Post-exposure prophylaxis
- Safe abortion and post-abortion care
- Respectful maternity care
- Comprehensive sexuality education
- Economic livelihoods and basic skills

There is no single model for integrating these services. Rather, there are multiple ways to think about and frame integration within the varying contexts of women and girls' lives. However integration is defined or modeled in varying contexts, it needs to be as inclusive and as accessible as possible, attentive to the holistic needs and human rights of women and girls, and aware of the different entry points of women and girls who require SRHR services. Advocacy efforts must be coordinated to build a foundation for a world in which integrated health is championed at all levels of decision-making, and the self-identified needs of women and girls are reflected and prioritized in the design, study, and funding of effective HIV and SRHR interventions.

COMPASS Partners can subvert the barriers to SRHR and HIV prevention for women and girls in the three target countries by advocating for and implementing integrated programming across individual, community, and national levels.

2.1 EMPOWER WOMEN AND GIRLS

- **To Stay in School:** Education can be a protective factor against HIV for AGYW, helping them to establish financial security, decrease transactional sex, reduce unplanned pregnancies, and have positive effects on overall health.[57] Programs that integrate school-based HIV and violence prevention interventions have demonstrated success in curbing risk behaviors.

– One DREAMS implementing organization in Lusaka, Zambia uses local libraries to reach a targeted 20,000 in-school and out-of-school AGYW ages 15-24 years with a mentorship program that fosters self-esteem, empowerment, and resilience.[58]

– COMPASS Partners in Zimbabwe detailed their in-school engagement activities. See Annex, page 24.

- **Through Comprehensive Sexuality Education (CSE):** CSE is a life-skills and evidence-based sexuality education curriculum that covers all aspects of sexuality.[59] CSE programs provide information on the entirety of available sexual and reproductive health care options. Topics covered include the promotion and provision of condoms, HIV testing and counseling (HTC), PrEP counseling and provision for high-risk populations, contraceptive mix, factual information on abortion, post-violence care, and abstinence as one of many methods for prevention of STIs and unintended pregnancy.[60]

  – A study conducted by the United Nations Educational, Scientific, and Cultural Organization (UNESCO) found that school-based CSE programs increased knowledge on pregnancy, HIV, STIs, risk behaviors and sexuality, and more open attitudes towards SRH.[61]

  – A COMPASS partner in Malawi provided a first-hand example of empowering programming for women to combat provider bias and stigma. See Annex, page 19.

- **Through Economic Empowerment**: Financial security decreases HIV risk behavior among AGYW.[62] Economic vulnerability can lead to financial dependency on men, which can restrict the ability of AGYW to negotiate condom use, discuss fidelity, or refuse sex.[63]

  – Studies exploring the effects of the South African Child Support Grant (CSG), an unconditional cash transfer program for economically vulnerable children and adolescents, played a vital role in reducing the likelihood of early sexual activity among female adolescents.[64] Girls in households receiving CSG were less likely to have transactional and age-disparate sex, compared to their non-beneficiary peers.[65]

  – In Malawi, a cash transfer program to keep girls in school increased school attendance, reduced risk behaviors, and lowered HIV and herpes prevalence.[66]

2.2 PARTNER AND WORK WITHIN COMMUNITIES

- **To Address Wider Gender Inequality and Biases:** Unequal social norms create and reinforce the inequalities women experience in vulnerability to HIV and access to prevention and treatment services. Broad public messaging, through widely available mediums like radio and television, can increase women and girls' self-esteem and desire to redefine and subvert limited gender norms.[67] This messaging has also shown to decrease both women and men's belief in negative gender biases.[68]

  – In India, cable television programming led to increases in women's sense of autonomy, decreases in the opinion that spousal abuse is acceptable, and a decrease in a preference for sons over daughters. Girls' school attendance improved, and birth spacing increased. Reported attitude changes were greater in areas with more traditional attitudes. Airing a television program in South Africa on domestic

violence was associated with an uptick in help-seeking and support-giving behaviors. In Nicaragua, a similar program led to a 62 percent greater probability of talking to someone about HIV, experiences of domestic violence, homosexuality, or the rights of youth.[69]

– In locations where television is not accessible, radio programs can also spur shifts in social norms and catalyze the spread of information. In Uganda, a radio program centered on the lives and aspirations of AGYW was hosted by the Wizarts Foundation, a nonprofit media organization that produces radio and television programming on social issues.[70] Girls shared their own perspectives of how gender biases limit their personal aspirations, and the program helped to increase the support of girls' parents and community leaders.

– A COMPASS partner details their success with media programs. See Annex, pages 19 and 24.

- **To Reduce GBV:** GBV increases the risk of AGYW for HIV infection.[71] One in three women experiences GBV in her lifetime,[72] and because girls are at a high risk of sexual violence and GBV, they are three times more likely to get an STI or HIV.[73] IPV and sexual violence should be addressed through school-based programs and community-based interventions to curb HIV infection and increase gender-equitable attitudes.[74]

  – A six-week self-defense program for adolescent girls in Nairobi, Kenya helped to reduce sexual assault among participating girls.[75] Fifty percent of the girls reported using the self-defense they learned to prevent sexual assault within one year of the training. [76]

  – In Chile, Brazil, Rwanda, and India, an intervention study found that engaging men in efforts to reduce GBV led to increased discussion about gender equality among men and a drop in tolerance for support of IPV.[77]

  – For COMPASS Partner examples on effectively running programming through schools, see Annex, page 24.

- **To Reduce Provider Bias:** Specialized youth sensitivity training for health providers is critical to young people accessing and accepting health services. Integrated "one-stop shop" services help women and girls receive and reinforce the importance of HIV prevention messaging and services.

  – In Zimbabwe, A Médecins Sans Frontières' (MSF) youth-friendly clinic offers adolescent peer-to-peer mentoring, an area for clients to relax, play games, and talk with trained peer educators about HIV and sexual health issues, and is staffed by providers in casual clothes to facilitate a more comfortable environment.[78]

  – In Lesotho, an organization called Phelisanang Bophelong (PB) partnered with Avert to work with youth ages 15-24 and provide HIV testing and referrals, youth meetings, youth meetings specifically for those in the LGBT community and people in prison, intergenerational talks between parents and youth, and community and school-based health talks.[79] In the first year of this partnership, 5,600 youth participants received information about SRH; 3,600 participants received counseling and testing, 2,500 of whom were tested for the first time; and about 2,500 participants attended youth clubs.[80,81]

To Improve Program Designs: HIV prevention and treatment programs are more effective when based on the feedback and perspectives of target populations. COMPASS Partners found numerous examples of youth and key populations sharing how their specific needs are not met by existing solutions, and laid out examples of service provision that would more realistically meet their needs.

– A COMPASS partner in Zimbabwe collected information from youth on what they need from HIV education programming. See Annex, page 24.

– COMPASS Partners in Zimbabwe and Tanzania also shared insights on program design in consultation with key and vulnerable populations. See Annex, pages 21 and 24.

2.3 ADVOCATE NATIONALLY

- **For Integrated Services:** Increases in funding and the inclusion of a budget line for integrated SRHR, HIV, and GBV work are necessary. COMPASS Partners should continue and expand their engagement with key government ministries and policymakers.

  – Organize a technical working group with HIV and SRHR stakeholders to plan, coordinate activities, and monitor progress together on the integration of HIV and SRHR.[82]

  – Facilitate the merging of actors and networks to maximize financial and human resources.[83.]

  – Advocate through coalitions for the introduction and expansion of access to PrEP, male and female condoms, emergency contraception, abortion, maternal health care services, all provided in tandem, at one location, as needed.

    ◦ Partners in Tanzania and Zimbabwe detailed examples of this. See Annex, pages 21 and 24.

- **For Increased Inclusion of CSOs in Policy Formation:**

  – Continue demanding and monitoring meaningful civil society engagement in PEPFAR's DREAMS initiative and Country Operation Plans (COPS) process, emphasizing the inclusion of human rights-based organizations led by or serving young women and girls.[84]

  – Formal recognition and codification of the role of CSOs and their volunteers is necessary, as the lack of clear dynamics currently inhibits outreach and data collection activities of COMPASS Partners.

    ◦ COMPASS Tanzania partners provide examples of advocacy for formal CSO recognition. See Annex, page 21.

- **For Policy Change to Facilitate Provision and Integration of Services:** National laws, like those criminalizing sex work and restricting minors from receiving HIV testing without parental consent, hinder the ability of health practitioners to engage with key and vulnerable populations who are at higher risk of HIV infection.

  – Partners in Malawi provided examples of national level policy advocacy to create more enabling environments for provision and integration of HIV and SRHR services. See Annex, page 21.

3. CONCLUSION

Women and girls experience different contexts and challenges across Malawi, Tanzania, and Zimbabwe, and so too do the perspectives and experiences of each COMPASS Partner differ. The COMPASS coalition's array of diverse organizations is well positioned to learn from one another to create unique and effective HIV prevention and treatment solutions for women and girls.

Suppose you are a 16-year-old girl. The school day has ended, and you head over with your friends to the local youth hub. There, you find study spaces, a library, career assistance, and services alongside a television and some snacks. There is also a friendly nurse to advise you on family planning and contraception; STI screening, diagnosis, and treatment; HIV prevention, treatment, and care; safe abortion; and gender-based violence prevention and care. The space is free of discrimination and stigma, financial burdens, and difficult technical and bureaucratic processes. You can make decisions about yourself and your body without fear and undue influence. Suppose this is possible.[85]

4. ANNEX

LINKS TO SOURCE PUBLICATIONS

Malawi HIV SRHR integration snapshot
Tanzania HIV SRHR integration snapshot
Zimbabwe HIV SRHR integration snapshot

Prescribing Chaos in Global Health:
The Global Gag Rule from 1984-2018, Page 24-59

PARTNER INTERVIEWS

Partner Interview – Malawi	
Issue	**Comment**
Patriarchy	"We noted that in some instances, when a woman has been diagnosed with HIV she would go to the family and sometimes when the husband is there, it would lead to the dispossession of property." "In Malawi, fertility rate is quite high and the uptake of family planning is quite low. Why though, it's because it has a number of sides attached to it. One of them is the cultural aspect where perhaps women, she doesn't have a say in terms of the number of children because of the patriarchal society — the man still decides the number of children in the family. Not many women have that leverage to tell her husbnad, to tell her boyfriend to use a condom." "One of the barriers women are currently facing with regards to HIV prevention and SRHR is the cultural issue, the patriarchal society. Men still hold a lot of power…we had instances where a woman would go to a health facility and diagnosed with HIV and in such circumstances a woman would go and inform the spouse. And because of the backlash that other women have had, women tended to shut down and keep quiet for fear of loss of marriage and for fear of bein physically abused and so on, for fear of being ridiculed. In Africa these are quite huge issues because of the patriarchal society. You have women, in terms of financial capacity, they do not have that financial capacity so they would sit and say, if my family breaks I will not be able to take care of myself, I will not be able to lose support and I will not be able to take care of the children. So such issues tend to have a burden on the uptake of — not only HIV but even family planning services.
Provider Bias/ Stigma	"What we were doing is that we were empowering them before supporting them as a group to speak for their rights…how to reach out in terms of discrimination and getting medical assistance because some of the nurses would discriminate against them and stigma around that."
Patriarchy/Stigma	"We would have some chiefs that would discriminate against women and we would mobilise women to engage the chief and inform the chief that whatsoever he is doing is against the law, people that are living with HIV are not supposed to be treated this way."
HIV Education	"Our community in Malawi, especially the women folks, they are engaged in a number of — we have people that join women groups and other groups, be it religious groups or where they teach each other how to prepare nutritious food. They also pass on information on HIV, these are the avenues. Because we are coming from an era where it was a national crisis — HIV at one point 13 years ago was declared a national crisis — and because of that our communities rose and realised it is something that has to be passed on using any avenue available so it was good information that was being passed on, be it religiously, whereever women are congregated there is information on HIV and even on health in general that is passed on."

Partner Interview – Malawi *continued*	
Issue	**Comment**
Women living with disabilities	"So one thing that we noted was that not many organizations were working, or had programs or projects that focused on people with disabilities. Some of them had no experience to communicate, lets say with people with hearing impairments, and not many CSOs were versed on how to communicate in sign language. Not many organizations had the know-how to put that very same information which was passed around into a format that could be accessed by people with different categories of disabilities to share the project."
Sex Work	"Two to three years ago, we had laws that did not recognize sex work. It criminalized sex work. When that law was repealed, it brought a window of opportunity to the CSOs working in HIV that began to develop programs targeting female sex workers. So we now have a number of organizations that are now working specifically for female sex workers."
Young Women	"Statistically, for the last five to six years, the prevalence of HIV in adolescent girls is almost double that of men, especially between the age range 17-24. It's a national issue, even the governement of Malawi is now designing programs that are targeting AGYW. The DREAMS program was initiated and based on statistics that showed alarming figures among AGYW. Because AGYW have less economic empowerment, issues of illiteracy, issues of poverty, that have made AGYW prone to the HIV epidemic."
Age of HIV testing	"If you are below 13 our guidelines set that you cannot go and have an HIV test without a guardian, so you need to have consent. At that age, that has been a hinderance."
Stigma	"With the uptake of SRH, like family planning, there is a lot of stigma that has prevented young girls and adolescents from accessing services."
School Programs, Religion, Stigma	"Right now, we are contending with the government to allow condoms in school, but parents and faith organizations object to that idea. Let's say condoms are introduced to secondary schools, then it will trigger immorality."
Religion	"Malawi is a Christian nation. So anything that comes along, like providing condoms in schools, is weighed and seen through the lens of faith, so right now there is a bone of contention. You cannot just walk into a health facility if you are a young girl because some people will tell on you for seeking family planning. Some people will ask you why you are looking for such a kind of thing."
Youth-friendly Services	"I have had interactions with youth living with HIV, and they have issues of access to services in the hospitals, in the clinics, in the setups, it is still a challenge. Not all health care people are trained to have that youth-friendly approach that remains a barrier. Some health care workers aren't trained and it has made girls and young women stay away and not access services at times. So that is a national issue. A solution to that is to train health workers."
Lack of resources for health facilities	"Unfortunately because of a lack of resources, not many health facilities have youth-friendly services — the kind where one can easily walk in, not be stigmatised, and access SRHR services. Ninety percent of our work is supported by donors and the most of our resources go towards procurment of drugs and so forth. But it's an area of dire need. Not only in terms of human resources but in terms of the capacity of infrastructure."
Economic Challenges	"Statistically, for the last five to six years, the prevalence of HIV in adolescent girls is almost double that of men, especially between the age range 17-24. It's a national issue, even the governement of Malawi is now designing programs that are targeting AGYW. The DREAMS program was initiated and based on statistics that showed alarming figures among AGYW. Because AGYW have less economic empowerment, issues of illiteracy, issues of poverty, that have made AGYW prone to the HIV epidemic."

Partner Interview – Tanzania	
Issue	**Comment**
HIV Education	"PrEP advocacy for us is to create a demand among AGYW, tell them how it works, what are the side effects, how they can be able to use it and access it. So far it is not available at health facilities. It's only available at the pilot project where other partners are doing activities to complement the government effort."
Women living with disabilities	"Advocacy plan priorities should be investing in LGBTQ communities, sex workers, and women living with disabilities, especially to work on having policy change to enable them to access HIV prevention services easily and without any barriers."
Sex Work	"Because of our new Tanzanian policies, this group is not moving freely like past days. So we are missing contributions and to work with groups like sex workers because they cannot be open for their work in Tanzanian communities and governement." "Advocacy plan priorities should be investing in LGBTQ communities, sex workers, and women living with disabilities, especially to work on having policy change to enable them to access HIV prevention services easily and without any barriers." "On the one hand the government is giving and on the other hand the government is taking. It is still criminalizing sex work — we have some other partner organizations who are under investigation. One is for sex workers and the other is for MSM…they are talking about access to health services for key and vulnerable populations, but it seems they are reluctant to work with them. They want to have the services throughout the government setting. For us we feel that the government setting is not that friendly. "
Young Women	"PrEP advocacy for us is to create a demand among AGYW, tell them how it works, what are the side effects, how they can be able to use it and access it. So far it is not available at health facilities. It's only available at the pilot project where other partners are doing activities to compliment the government effort."
Lack of resources for health facilities	"A challenge that is not only ours but also within the government is the lack of enough outreach services for prevention and the biggest excuse is the lack of financial resources to support regular outreach services, including mobile services for prevention and care and treatment. "PrEP advocacy for us is to create a demand among AGYW, tell them how it works, what are the side effects, how they can be able to use it and access it. So far it is not available at health facilities. It's only available at the pilot project where other partners are doing activities to complement the government effort."
Cervical Cancer	successfully advocated for comprehensive, youth-friendly services that combines ARV and cervical cancer screening when attending the HIV Drugs clinic called Care and Treatment Center (CTC) "We have done capacty building on SRHR and issues of cervical cancer targeting WLHIV in ten districts. We are very good on treatment literacy to make sure that WLHIV and PLHIV are accessing quality service and adhere to the treatment and their viral load suppression. We have also created demand to make sure that those who are on treatment are accessing viral load tests, and we are still pushing on making sure that the government is assuring that treatment is monitored."
Coalition Work	"Major gaps for implementers in HIV prevention work in Tanzania comes from community members not being involved or participating in campaigns for increased information and testing services."

Partner Interview – Tanzania *continued*	
Issue	**Comment**
Coalition Work (continued)	"We are developing some learning materials to support the PLHIV with the necessary information, and these informational materials are actually emanating from our five point strategic plan related to advocacy. So we deliver these materials to the PLHIV but also to the target audience, whom we want to change policies and strategies for the benefit of PLHIV. We are also networking with another partner organization at the national level and working closely with JEPAIGO, HP+, and FHI 360. We also work with local organizations like Tanzania Network of Women Living with HIV and Tanzania National Youth who are living with HIV, and a number of other organizations including those like people who use drugs, and in this way we are actually forming a team. It is called ESUD, and it is a sort of Tanzanian network of organizations working jointly to advocate for HIV prevention, care and treatment. So the combination of those approaches is what we are pushing for, with the priority given to PLHIV themselves to come front and speak on their own."
Lack of information	"Some of the barriers AGYW face in Tanzania when it comes to HIV prevention and SRHR is a lack of information on family planning generally and family planning methods. Many women and girls do not have the choice of different methods." "A challenge for AGYW and HIV prevention in Tanzania is that PrEP is not known. It's still a new thing."
Female Condoms	"Many women and girls do not have a the choice of different family planning methods. We also do not have free female condoms, which can help AGYW be sure they protect themselves from HIV." "In terms of collection and distribution of commodities like male and female condoms, we are doing well because we are working with some of the organizations who are supporters of non-commercial female and male condoms which we distribute to the community through our clusters and the appointed PLHIV representative at ward level."
LGBTQ	"Advocacy plan priorities should be investing in LGBTQ communities, sex workers, and women living with disabilities, especially to work on having policy change to enable them to access HIV prevention services easily and without any barriers."
Population-informed programming	"I would ensure the increased participation of AGYW in advocacy work, from planning to implementation." "We mostly engage with PLHIV by actually providing education on the strategic issues which relate to their basic needs or requirements as PLHIV. In doing so, we are encouraging the formation of PLHIV support groups, which are used for their own discussion but of course partly supported by some information from our organization. So they sit down and discuss on their issues and then through representation in some of the technical working groups, they manage to deliver their advocacy messages. But also, nationally we are engaging with the parliament, especially with the parliamentary committee for HIV/AIDS to ensure that the policies under the national processes are inclusive of the PLHIV prevention and other services as required by PLHIV, which information we are getting from the PLHIV support groups themselves." "We are developing some learning materials to support the PLHIV with the necessary information, and these informational materials are actually emanating from our five point strategic plan related to advocacy. So we deliver these materials to the PLHIV but also to the target audience, whom we want to change policies and strategies for the benefit of PLHIV. We are also networking with another partner organization at the national level and working closely with JEPAIGO, HP+, and FHI 360. We also work with local organizations like Tanzania Network of Women Living with HIV and Tanzania National Youth who are living wiht HIV, and a number of other organizations including those like people who use drugs, and in this way we are actually forming a team. It is called ESUD, and it is a sort of Tanzanian network of organizations working jointly to advocate for HIV prevention,

Partner Interview – Tanzania *continued*	
Issue	**Comment**
Population-informed programming (continued)	care and treatment. So the combination of those approaches is what we are pushing for, with the priority given to PLHIV themselves to come front and speak on their own." "There is a lack of a strong network of women and girls at the local level in terms of enhancing learning and participation. Most of the organizations working with women and girls are largely nationally focusing, and we see it necessary that throughout clusters at the district level, we encourage the formation of these specific platforms that are bringing together women and bringing together girls." "Through different platforms at the community level, we are actually gaining a lot in terms of knowing what are the key, or specific issues to do with women and girls, and then we sit together and strategize on how to address them. These structures are about support for an advocacy strategy from the ground up to the national level to feed up the necessary information so that the campaign becomes well-informed with specific issues."
Economic Challenges	"Another big challenge specific to AGYW is the lack of financial assistance to address some of the economic challenges they are facing which are related to advocacy. For example, when they need to participate in particular campaigns the representatives of PLHIV who have been appoint at local level, they need to move from one place to another, they need to have time to translate the information they are sharing to their own settings. So lack of financial suport is a bit challenging because some of the advocacy methods require financial support." "Financial support in terms of economic empowerment is another challenge to AGYW specific HIV prevention programming. Economic empowerment contributes to psychosocial issues which relate to PLHIV." "Recently there was a meeting for key and vulnerable population estimation size where we participated and requested additional slots to make sure more people could participate. The MoH provided us with three slots, one for PLHIV, one for MSM, and another for a person using and injecting drugs. But they told us that because we were not in their budget, we had to pay for ourselves and AVAC facilitated the logistics to make sure that the three people attended the meeting."
Lack of recognition of volunteers/CSOs	"There are people we trained as volunteers where we have a project. But the biggest challenge is the recognition of the volunteer treatment advocates in some of the local health care facilities, whereby they are working as volunteers but when they try to connect or when we try to connect them to local health facilities, it becomes challenging because currently as a nation we don't have a policy or a law which governs or recognizes community action in prevention services. With that lack of recognition, its actually demoralizing the volunteering spirit of the PLHIV that are trained in the sense that they become reluctant sometimes to go to the facilities and look for some of the necessary information." "So now we are pushing the self-test, the PrEP, the combined HIV prevention for WLHIV, sex workers, and AGYW. This is at the national level of advocacy, because if there are no national guidelines in place, there is no way you can go into the community. "
People who inject drugs	"There are some key population issues which are not largely supported by the government processes and policies so it becomes challenging for the — unless you work with the organizations, you hardly get some of these KP voicing through the clusters that 'I'm a PLHIV and a sex worker, or MSM,' and it becomes a bit challenging because of the policy environment in the country so far."
Media	"We are also networking and working well with the media and programs on a weekly basis. We have programs with radio, and if we miss a program with radio then we have a program with print media to cover some of the key issues of HIV prevention, care, and treatment. We have a number of media institutions we are working with, including the Tanzania broadcasting coroporation. We also network with the two major newspapers in Tanzania, including the Guardian and the Mwananchi — it's a Swahili newspaper."

Partner Interview – Zimbabwe	
Issue	**Comment**
Patriarchy/Stigma	"Take for example, a girl in the rural areas. They do not consider it important for a girl to go to school because at the end of the day she is going to gt married. So that exposes the girl to dropping out of school at the end of primary level which exposes her to either risky behavior or she gets into early child marriange, so that is a cultural barrier. And also, it's also taboo. There's a barrier at the community level — there is a bearrier between the parent and the child to communicate about these issues. It could be sex, sexuality, or just sexual reproductive health in general — there is not that parent-child communication."
HIV Education	"We had a closed-door session with junior parliamentarians — they are young people in school but there is the Zimbabwe Youth Council that then works with the junior parliament. And so we were talking to them to say what are the major challenges that you are facing and how would you want to be taught — or how would you appreciate teaching around SRHR issues as young people. They highlighted that 'we do not want to be in a classroom setup and have knowledge about HIV taught to us where what is HIV and what does it stand for, what are the transmission methods and things like that.' They felt that this information was not very necessary, they had other critical things that could be taught. They had other questions and things that probably they could not talk to their parents about. ...So they were saying that there's a need to really strenghten the capacity of teachers in terms of how they can deliver the pedagogy of SRHR. So we don't want them to bring books as if it's another geography lesson or a physics lesson. Let them be innovative. Let teachers show videos and movies and the TV. Use things that engage us so that we really appreciate it. Use role models and celebrities to empower us around that. Edutainment. Things like that." "We managed to identify the issue that we need to involve young people to access the services, so the thing we have learned is that the young people need things that interest them. So HIV prevention through sports, that has been one of the ways that we have looked forward to helping our young people. It's more like edutainment as they are learning they are also playing and they are accessing information and in that set up we can actually bring service providers to them while they are doing their sports and they can actually access HIV testing onsite." "Then we also have the issue of the girl herself and her general lack of knowledge around SRH and the law around SRH, even the development in her body — what does it mean to say that you are now menstruating, how does it come about, what does it mean that you need to do when you are menstruating. The lack of knowledge actually predisposes the girl to HIV and becomes a barrier to them accessing services." "Treatment and testing literacy should be prioritised for adolescents because already we have many adolescents who are living with HIV and are on treatment and most are struggling with adherence and are defaulting. We are introducing all these other ways of preventing HIV that they may not necessarily feel apply to them because socially and culturally, they should not be having sex and yet they are."
Women living with disabilities	"Young women and girls with disabilities, it was a bit difficult to reach them because some of them may not be in schools. They are disabled, and there is stigma and the parents are probably not there. They are reluctant to bring them out in open spaces, so its not very easy to reach out to them. There is a lot of work that may need to be done before you actually are able to reach out and engage with those with disabilities." "We have been fighting to get a mapping study to get a sense of how many people living with disabilities are affected and infected by HIV in the country."

Partner Interview – Zimbabwe *continued*	
Issue	**Comment**
Women living with disabilities (continued)	"We have seen a challenge around women with disabilities. It has been a hard, hard key population to reach because they are being shunned by the family specifically or reaching out in terms of information — how are we going to communicate? Not being able to communicate with them so much that they are not able to access the information that is required because of maybe, sign language or they are deaf. Women living with disabilities are a hard-to-reach population. "
Sex Work	"Those young girls that drop out of school may end up engaging in…for us we decided that we cannot call it promiscuity or child prostitituion, for us it is child exploitation. Because when someone is 9 or 10 and is said to be engaging in those practices with a very old person, its child exploitation. You find these girls, but to really break through to them you need a holistic approach to be able for you to really rescue them from those situations. It's not easy work. You go there, they have a need for information. Information is not what they want, they also want food on the table. 'What are you able to bring for me to eat before talking to me about accessing a service here?' So you see, there's need for a lot of collaborations and partnerships in terms of really helping those girls."
Age of HIV testing	"We continue to push the element around the age of consent versus age of being able to receive services, where in the country age of consent is 18 years and you the majority is 18. But when it comes to age of receiving services, any person should be able to receive services without a caregiver or a guardian signing for and on their behalf because that's a big barrier to accessess services. We continue to battle for testing because if there is no consent from a caregiver, we cannot test an under 18. So we need policy reform."
Stigma	"Lack of communication and discussions on HIV within the family and home setting were challenges."
School Programs, Religion, Stigma	"What we found to be helpful was strengthening the capacity of teachers to handle these issues. Because as much as they teach out of books, they also teach guidance and provide counselling to these children."
Religion	"We have a pentecostal movement that comes in and tells you you are treated, so you no longer take your meds. So you stop taking your ARVs because you are cured."
Youth-friendly Services	"They were also saying make those centers user friendly, youth-friendly. They are called youth-friendly but they are not youth-friendly for us because if someone sees you enter a youth-friendly center, just like entering a clinic, they will think that you are sick. So how can you improve on such centers to make them youth-friendly and popularise them so that everyone — make them centers that youth can visit without reservation." "For vulnerable young girls, there is a need for support for menstrual hygiene because a number are dropping out of school because of menstrual hygiene-related interventions. Girls cannot afford sanitary wear, then that becomes a challenge, but they are located far away from services. The health facilities, some of them are not youth-friendly so you'll find that you are in a community and the aunt is the one that's manning the health center and the girls then tend to shy away to look for SRHR-related services so it becomes a challenge because they end up having unsafe abortions. It's not only the distance of health services, but also the youth-friendly services." "There is a lot of work that needs to be put into strengthening health care workers themselves to understand and appreciate the dynamic of working with adolescent girls in particular as it relates to SRH in terms of understanding and accepting their choices, sexual-related choices that they should be given all options and that they should not be judged for making decisions that relate to their health in particular protecting themselves from contracting HIV and other sexually related illnesses."

Partner Interview – Zimbabwe *continued*	
Issue	**Comment**
Coalition Work	"A lot of community involvement is critical for this work. Ensuring that the communities are on board. By communities I'm not only talking about their parents, but even some people in leadership within those communities, the decision makers. They are critical for this work. For a holistic approach you have to ensure that there is community engagement because that is how to get direct service for these AGYW."
Population-informed programming	"A key issue for prioritising AGYW in HIV prevention and SRH is to have youth engagement to champion the rights of girls, so that they at least have a voice with regards to issues affecting them. Getting the issues from the youth themselves, not assuming that they are facing these challenges but actually hearing the issues from them and then coordinating to improve the situation with these issues from the specfic beneficiaries, in this case AGYW." "It's more than critical now to involve AGYW in decision making processes around health. So much is discussed and decided on without necessarily hearing from them and they are the most affected in the sense that they are the ones that struggle to face health care services. The are the ones who face stigma at health care facilities, who may not necessarily have the infomation that they require, so decision making around health should deliberately involve AGYW. ..This needs to start from the very bottom upwards to say, as we talk about AGYW we must also ensure that we hear from them, we must include them and involve them and actually hear them when it comes to decisions relating to their health and relating to service provision within their communities and health facilites."
Economic Challenges	"While giving AGYW comprehensive SRHR information is crticial, there need also to prioritize economic empowerment…we still feel that even for them to access education whether formally or informally, it will be good to provide them some form of economic empowerment that would take them away from some of these risky decisions that they make becasue they want to make money." "A lack of finances hinders girls from either going to school or it hinders them from acquiring specific equipment they require, for example sanitary wear for the menstruation, so that becomes a challenge. When they do not have the finances, we are saying they are going to engage in sexual activities that will predispose them to being HIV positive a the end of the day." Donor/funding challenges. One program favored over another, etc.
Lack of recognition of volunteers/CSOs	"You are able to appreciate that we are able to go directly to the child and talk to them, but for you to do that you should be, according to the laws of the land, in the right standing in terms of your clearance processes and processes required by the country through various ministries, through local government otherwise it is then not easy to enter schools and do anything."
Education	"There are girls that are in school that are at risk of dropping out because of lack of knowledge around SRHR, and there are girls that are out of school because they had fallen pregnant along the way and dropped out of school or they are just out of school because they lack comprehensive information around SRHR." "Part of the work we did in that project was to carry out a desk review and mapping of allies in SRHR within the comunities that we are operating, and we also did provide comprehensive bursary support to girls that we thought might drop out of school. A lack of school fees and dropping out would maybe lead them to look for sources of money in other places, like in uninformed sexual activities."

Partner Interview – Zimbabwe *continued*	
Issue	**Comment**
GBV	"We did a number of consultations with these young people, junior parliamentarians from both communities and they gave us a number of challenges they were facing as young people. It was noted that GBV was very prevalent within the communities and risky sexual behaviors, lack of leadership and role modelling, and issues of girls just engaging in sexual activity for the sake of engaging in it." "GBV is a barrier for HIV prevention and SRHR for AGYW. GBV is related to societal norms and economic empowerment or disempowerment. It's also related to patriarchy, to a big extent."
Child marriage	"Policy advocacy is critical. Alignment of policies — child marriages, etc., and ensuring that they are enforced and that anyone that is to break the law is exposed somehow. For example, for a man who is 40-something coming to these young girls that are just nine years old, what critical actions are being done to curb such practices?"

5. ENDNOTES

1. Center for Health and Gender Equity (CHANGE) & AIDS Vaccine Advocacy Coalition (AVAC), Prevention Now: An Integration Agenda for Women, by Women (2015), available at http://www.genderhealth.org/files/uploads/change/publications/CHANGE_AVAC_2015_Report_Final.pdf [hereinafter CHANGE, Prevention Now].
2. UNAIDS, Global AIDS Update 2016 (2016), available at http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf
3. Id.
4. UNAIDS, Fact Sheet July 2017 (2017), available at https://www.compassion.com/multimedia/unaids-fact-sheet.pdf
5. Abigail Harrison et al., Sustained High HIV Incidence in Young Women in Southern Africa: Social, Behavioral and Structural Factors and Emerging Intervention Approaches, 12 CURRENT HIV/AIDS REPORT 207-215 (2015); See also UNAIDS, HIV Prevention Among Adolescent Girls and Young Women: Putting HIV Prevention HIV Among Adolescent Girls and Young Women on the Fast Track and Engaging Men and Boys 12-16 (2016), available at http://www.unaids.org/sites/default/files/media_asset/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women.pdf [hereinafter UNAIDS, HIV Prevention Among Adolescent Girls and Young Women].
6. UNAIDS, HIV Prevention Among Adolescent Girls and Young Women, supra note 5.
7. UNWomen defines "Patriarchy" as a traditional form of society "where men, or what is considered masculine, are accorded more importance than women, or what is considered feminine". UNWomen, Gender Equality Glossary, available at https://trainingcentre.unwomen.org/mod/glossary/view.hp?id=36&mode=letter&hook=P&sortkey=&sortorder=asc
8. Matthew R. Dudgeon & Marcia C. Inhorn, Men's influences on women's reproductive health: medical anthropological perspectives, 59 SOCIAL SCIENCES & MEDICINE 1379-1395 (2004).
9. The Citizen Reporter, Magufuli advises against birth control, available at http://www.thecitizen.co.tz/News/Magufuli-advises-against-birth-control/1840340-4751990-4h8fqpz/index.html
10. Interview with Michelle, Project Health Officer, Chiadze Child Care Centre, in Harare, Zimbabwe [hereinafter Interview with Michelle in Zimbabwe].
11. Id
12. CHANGE, The U.S. DREAMS Partnership: Breaking Barriers to HIV Prevention for Adolescent Girls and Young Women w25 (2016), available at http://www.genderhealth.org/files/uploads/change/publications/2017__DREAMS_web_final.pdf [hereinafter CHANGE, The U.S. Dreams Partnership].
13. Interview with Eric, Project Coordinator, MANET+ & COMPASS, in Malawi [hereinafter Interview with Eric in Malawi].
14. Interview with Lydia, National Coordinator in the Curriculum development Unit, Forum for African Women Educationalists Zimbabwe Chapter, in Harare, Zimbabwe [hereinafter Interview with Lydia in Zimbabwe].
15. Id
16. Interview with Eric in Malawi, supra note 13.
17. Interview with Lydia in Zimbabwe, supra note 14; Interview with Donald, Executive Director, Jointed Hands, in Harare, Zimbabwe [hereinafter Interview with Donald in Zimbabwe].
18. Charlotte Watts, Violence against women and HIV (2018), available at https://www.pepfar.gov/documents/organization/285561.pdf
19. Id.
20. Interview with Eric in Malawi, supra note 13.
21. Ida Susser & Zena Stein, Culture, sexuality, and women's agency in the prevention of HIV/AIDS in southern Africa, 90 AMERICAN JOURNAL OF PUBLIC HEALTH 1042-1048 (2000).
22. World Health Organization (WHO) et al., HIV and SRHR Linkages Infographic Snapshot: Malawi 2016 (2016), available at http://srhhivlinkages.org/wp-content/uploads/Malawi_HIVSRHR_infographic_snapshot_en.pdf
23. World Health Organization (WHO) et al., HIV and SRHR Linkages Infographic Snapshot: Tanzania 2016, available at http://srhhivlinkages.org/wp-content/uploads/Tanzania_HIVSRHR_infographic_snapshot_en.pdf
24. World Health Organization (WHO) et al., HIV and SRHR Linkages Infographic Snapshot: Zimbabwe 2016, available at http://srhhivlinkages.org/wp-content/uploads/Zimbabwe_HIVSRHRLinkagesInfographicSnapshot_EN_final.pdf
25. Interview with Eric in Malawi, supra note 13; Interview with Mpendwa Abinery, Executive Chairperson, National Network of Girls and Young Women with HIV/AIDS, in Tanzania [hereinafter Interview with Mpendwa in Tanzania]; Interview with Lydia in Zimbabwe, supra note 14; Interview with Michelle in Zimbabwe, supra note 10.

26. Interview with Michelle in Zimbabwe, supra note 10.

27. Rene Loewenson & David McCoy, Access to antiretroviral treatment in Africa: New resources and sustainable health systems are needed, 328 BRITISH MEDICAL JOURNAL 241 (2004).

28. Interview with Eric in Malawi, supra note 13.

29. HEARD, Zimbabwe: Sexual and Reproductive Health and Rights (2015), available at https://www.heard.org.za/wp-content/uploads/2015/11/Zimbabwe-country-fact-sheet.pdf

30. Interview with Definate & Barbara, PZAT & COMPASS, in Harare, Zimbabwe [hereinafter Interview with Definate & Barbara in Zimbabwe].

31. Interview with Matthew, Manager of Community Mobilization and Engagement, National Council for People Living with HIV/AIDS, in Tanzania [hereinafter Interview with Matthew in Tanzania].

32. Interview with Donald in Zimbabwe, supra note 17.

33. Interview with Michelle in Zimbabwe, supra note 10.

34. Id.

35. Interview with Definate & Barbara in Zimbabwe, supra note 27.

36. Interview with Mpendwa in Tanzania, supra note 22.

37. J. Gerardo Garcia-Lerma et al., Oral pre-exposure prophylaxis for HIV prevention, 31 TRENDS IN PHARMACOLOGICAL SCIENCES 74-81 (2010).

38. Population Council, Introducing oral pre-exposure prophylaxis to adolescent girls and young women in Tanzania: Overview of findings from implementation science research (2017), available at https://www.popcouncil.org/uploads/pdfs/2017HIV_DREAMS_PrEP-Tanzania_summary.pdf [hereinafter Population Council Oral Pre-Exposure Prophylaxis AGYW in Tanzania].

39. Interview with Joan, Network of Women Living with HIV, in Tanzania [hereinafter Interview with Joan in Tanzania].

40. Interview with Eric in Malawi, supra note 13.

41. Interview with Donald in Zimbabwe, supra note 17; Interview with Michelle in Zimbabwe, supra note 10.

42. Interview with Donald in Zimbabwe, supra note 17; Interview with Michelle in Zimbabwe, supra note 10.

43. Interview with Donald in Zimbabwe, supra note 17.

44. Interview with Mpendwa in Tanzania, supra note 22; Interview with Joan in Tanzania, supra note 36.

45. Interview with Matthew in Tanzania, supra note 28; Interview with Joan in Tanzania, supra note 36.

46. CAMPAIGN 3 – To contribute to increased access to comprehensive Health services for KPs including PWD, Landscape Analysis, (2018).

47. Interview with Mpendwa in Tanzania, supra note 22.

48. Interview with Joan in Tanzania, supra note 36.

49. UNAIDS, HIV Prevention among key populations (2016), available at http://www.unaids.org/en/resources/presscentre/featurestories/2016/november/20161121_keypops

50. Interview with Donald in Zimbabwe, supra note 17.

51. Interview with Matthew in Tanzania, supra note 28.

52. Interview with Lydia in Zimbabwe, supra note 14.

53. Id.

54. Interview with Joan in Tanzania, supra note 36.

55. The National Council of People Living with HIV in Tanzania (NACOPHA), Landscape Analysis, (2018).

56. Interview with Lydia in Zimbabwe, supra note 14.

57. Center for Health and Gender Equity (CHANGE), HIV Prevention with Adolescent Girls and Young Women (2018), available at http://www.genderhealth.org/files/uploads/change/publications/CHANGE_AGYW_data_brief.pdf [hereinafter CHANGE, HIV Prevention with AGYW].

58. Lubuto, receives DREAMS Innovation Challenge grant to keep girls in school, prevent AIDS (2016), available at https://www.lubuto.org/november-2016/; See also Lubuto Library Partners, Keeping Girls in Secondary School and AIDS-Free, available at https://www.lubuto.org/dreams/#dreamsprograms

59. United Nations Educational, Scientific and Cultural Organization (UNESCO), International technical guidance on sexuality education: An evidence-informed approach (2018), available at http://unesdoc.unesco.org/images/0026/002607/260770e.pdf

60. CHANGE, HIV Prevention with AGYW, supra note 54.

61. United Nations Educational, Scientific and Cultural Organization (UNESCO), Review of the Evidence on Sexuality Education: Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education (2018), available at http://unesdoc.unesco.org/images/0026/002646/264649e.pdf

62. Stefani A. Butts et al., Let us fight and support one another: adolescent girls and young women on contributors and solutions to HIV risk in Zambia, 9 INTERNATIONAL JOURNAL OF WOMEN'S HEALTH 727-737 (2017).

63. Geeta Rao Gupta, How men's power over women fuels the HIV epidemic, 324 BRITISH MEDICAL JOURNAL 183 (2002).

64. Carolyn J. Heinrich, John Hoddinott & Michael Samson, Reducing Adolescent Risky Behaviors in a High-Risk Context: The Effects of Unconditional Cash Transfers in South Africa, 65 ECONOMIC DEVELOPMENT AND CULTURAL CHANGE 619-652 (2017).

65. Lucie Cluver et al., Child-focused state cash transfers and adolescent risk of HIV infection in South Africa: A propensity-score-matched case-control study, 1 THE LANCET GLOBAL HEALTH E362-E370 (2013).

66. Baird et al., Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomized trial, 379 THE LANCET P1320-1329 (2012); HIV Prevention Trials Network, Study Summary: Effects of cash transfer for the prevention of HIV in young South African women (2012), available at https://www.hptn.org/research/studies/88

67. Elizaveta Perova & Renos Vakis, Improving Gender and Development Outcomes through Agency (2013), available at https://openknowledge.worldbank.org/bitstream/e/10986/16259/797130WP0Impro0Box0377384B00PUBLIC0.pdf?sequence=1&isAllowed=y

68. Id.

69. Klugman et al., Voice & Agency: Empowering Women, supra note 18.

70. CHANGE, The U.S. Dreams Partnership, supra note 12.

71. Kristin L. Dunkle et al., Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa, 363 THE LANCET P1415-1421 (2004); Rachel K. Jewkes at al., Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study, 376 THE LANCET P41-48 (2010).

72. World Health Organization (WHO), London School of Hygiene & Tropical Medicine & South African Medical Research Council, Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (2013), available at http://apps.who.int/iris/bitstream/handle/10665/85239/9789241564625_eng.id=0BA0479121DF4A0263C3006CA7F37D2D?sequence=1

73. The President's Emergency Plan for AIDS Relief (PEPFAR), Fourteenth Annual Report to Congress (2018), available at https://www.pepfar.gov/press/2018annualreport/index.htm

74. Rebecka Lundgren & Avni Amin, Addressing Intimate Partner Violence and Sexual Violence Among Adolescents: Emerging evidence of Effectiveness, 56 JOURNAL OF ADOLESCENT HEALTH S42-50 (2015).

75. Jake Sinclair et al., A self-defense Program Reduces the Incidence of Sexual Assault in Kenyan Adolescent Girls, 53 JOURNAL OF ADOLESCENT HEALTH 374 (2013).

76. Id.

77. Instituto Promundo et al., Engaging Men to Prevent Gender-Based Violence; A Multi-country Intervention and Impact Evaluation Study, available at http://menengage.org/resources/engaging-men-to-prevent-gender-based-violence-a-multi-country-intervention-and-impact-evaluation-study/

78. Doctors Without Borders SA, Zimbabwe: Providing sexual and reproductive services to adolescents in Mbare (2018), available at https://doctorswithoutborderssa.exposure.co/zimbabwe?slow=1

79. Avert, Phelisanang Bophelong (PB) in Lesotho, available at https://www.avert.org/what-we-do/where-we-work/pb

80. Avert, Young People, HIV, and AIDS, available at https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/young-people; Avert, Effective Civil Society, available at https://www.avert.org/effective-civil-society

81. CHANGE, HIV Prevention with AGYW, supra note 54.

82. World Health Organization (WHO) et al., HIV and SRHR Linkages Infographic Snapshot: Malawi 2016 (2016), available at http://srhhivlinkages.org/wp-content/uploads/Malawi_HIVSRHR_infographic_snapshot_en.pdf

83. CHANGE, Prevention Now, supra note 1.

84. Id.

85. Id.

About CHANGE

The Center for Health and Gender Equity (CHANGE) is a U.S.-based nongovernmental organization that promotes sexual and reproductive health and rights as a means to achieve gender equality and empowerment of all women and girls, by shaping public discourse, elevating women's voices, and influencing U.S. and global policies. We are guided by our vision of a world that respects, protects, and honors sexual and reproductive rights for all. Our four-pronged impact model—advocacy, research, partnerships, and communications—is grounded in and driven by a human rights framework at the intersection of multiple sectors including women's rights, human rights, family planning, maternal health, HIV/AIDS, and gender-based violence.

CENTER FOR HEALTH AND GENDER EQUITY
1317 F ST. NW, SUITE 400
WASHINGTON, DC 20004
TEL: (202) 393-5930
FAX: (202) 393-5937
EMAIL: CHANGE@GENDERHEALTH.ORG
WWW.GENDERHEALTH.ORG
@GENDERHEALTH FACEBOOK.COM/GENDERHEALTH