African Union

UN WOMEN

Gender Equality, Women's Empowerment (GEWE) and HIV in Africa: The impact of intersecting issues and key continental priorities

FOREWORD

The complex interplay of social, economic and structural drivers, including poverty, gender inequality, unequal power relationship , gender-based violence, social isolation and limited access to schooling increase the HIV vulnerability of women and girls. Furthermore these factors deprive them of voice and the ability to make decisions regarding their lives, reduce their ability to access services that meet their needs, increase their risks of violence or other harmful practices, and hamper their ability to mitigate the impact of AIDS.

Adolescent girls and young women are more than twice as likely to acquire HIV as their male peers. AIDS-related illnesses remain one of the leading causes of death for women of reproductive age (aged 15 to 44 years) in Africa. In sub-Saharan Africa, young women and adolescent girls accounted for one in four new infections in 2019, despite making up about 10% of the total population. In addition, only about one third of young women in sub-Saharan Africa have accurate, comprehensive knowledge about HIV. Nearly 30% of women aged 15 years and above have experienced gender-based violence with intimate partner violence ranging from 13% - 97%. During displacement and times of crisis, the risk of gender-based violence significantly increases for women and girls.

Forty years of responding to HIV has taught the global community that a human rights-based approach is essential to create enabling environments for successful HIV responses and to affirm the dignity of people living with, or vulnerable to HIV. This study is timely and is set against the backdrop of several global and regional commitments that address systemic inequalities and those that respond to HIV including Africa's Agenda 2063, Beijing Declaration and Platform for Action, Maputo Plan of Action, and the 2021 Political declaration on AIDS. It highlight how gender intersects with other drivers of inequalities such as income, age, gender-based violence, stigma, discrimination and child marriage to exacerbate the vulnerability and susceptibility of women to HIV infection and also influence the health outcomes.

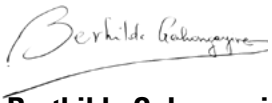
Demands for social and gender transformative approaches are building as the HIV response reaches an important milestone and is moving towards the last mile. Countries have implemented several comprehensive best practice programmes focused on increasing the agency, economic empowerment and improving access to HIV and sexual and reproductive health and reproductive rights (SRH&RR)services for adolescent girls and young women such as the DREAMS, SASA, HER programme and She Conquers with positive outcomes reported. Greater investments in these proven innovations is required to sustain and accelerate progress towards the 2030 goals. Member States have demonstrated political will and leadership to address HIV. Eastern and Southern Africa has provided leadership by increasing their domestic resource allocation to HIV programs by 26% between 2010 and 2019.

While progress in reducing HIV infection and placing people living with HIV on treatment has been commendable in most countries, the COVID-19 pandemic has compounded the situation. It has revealed deeply entrenched societal inequalities and threatened to blow away the gains made towards the 2020 targets, which were already off-course.

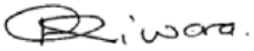
Achieving the African Union (AU) Catalytic Framework goals of ending AIDS by 2030 will require transforming harmful social norms, reducing gender-based discrimination and inequalities, advancing women's empowerment, and fulfilling women's SRH & RR.

Through this partnership, the AUC, UNAIDS and UN Women aim to promote coherent and coordinated action across the AU and UN for a human rights-based and gender responsive approach to addressing the AIDS pandemic through policies, processes and initiatives at national, regional and continental levels. Furthermore, the collaboration underlines the importance of investing in the creation and strengthening of multi-sectoral partnerships and generation of sex disaggregated data as key enablers and accelerators of durable solutions and for successful HIV responses. We thus call on all stakeholders to rally behind the bold recommendations in this study to seal the fault lines of gender inequalities and intersecting issues that keep women and girls vulnerable to HIV and prevent them from their right to health. Let us all commit to collectively invest sufficient resources and accelerate effort towards ending AIDS by 2030.

Victoria Lehau Maloka
Ag Director of the Women
Gender and Youth Directorate



Berthilde Gahongayire
UNAIDS Country Director for Ethiopia and
Acting Director Liaison Office to AU and UNECA



Letty Chiwara
UN Women Representative to Ethiopia, AU and UNECA

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AFRICAN UNION COMMISSION – WGYD

Victoria Lehau Maloka, Tapiwa Uchizi Nyasulu Rweyemamu (PhD),
Hilina Wassihun and Inas Mubarak Yahia Abbas (AUC-Department of Health, Humanitarian Affairs and Social Development of Social Affairs (DHHAS))

UNAIDS

Netseht Tadeseh, Irene Maina and Kreeneshni Govender

UN WOMEN

Marie Goretti Nduwayo, Tikikel Tadele Alemu, Amen Deneke and Dukaye Amare Mergia (UN Women Liaison to the AU and ECA), Jacqueline Utamuriza-Nzisabira (UN Women South Africa Multi-Country Office), Addisalem Befekadu (UN Women Ethiopia Country Office) Jack Onyisi Abebe (UN Women ESARO), Nazneen Damji and Elena Kudravtseva (UN Women HQ)

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ABBREVIATIONS

ABYM	Adolescent Boys and Young Men
ACHPR	The African Commission on Human and Peoples' Rights
AEC	The East African Community (EAC)
AU	African Union
AUC	African Union Commission
AfDB	African Development Bank
AGYW	Adolescent Girls and Young Women
AMA	Africa Medicines Agency
ACRWC	African Charter on Rights and Welfare of the Child
APHRC	African Population and Health Research Centre
ARVS	Anti-Retroviral drugs
AWA	AIDS Watch Africa
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CEDOVIP	Centre for Domestic Violence Prevention
CECM	Campaigns on Ending Child Marriage
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSW	Commission on the Status of Women
CSO	Civil society organisations
ECOWAS	The Economic Community of West African States
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
ESA	East and Southern Africa
FGM	Female Genital Mutilation
TGF	The Global Fund
GBV	Gender-Based Violence
GVAW	Gender-Based Violence Against Women
GEWE	Gender Equality and Women Empowerment
GIMAC	Gender Is My Agenda Campaign
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
MPoA	Maputo Plan of Action
NEPAD	New Partnership for Africa's Development
PMP	Pharmaceutical Master Plan
PrEP	Pre-Exposure Prophylaxis
OAFLA	Organisation of African First Ladies
OAU	Organisation of African Unity

REC	Regional Economic Communities
SADC	Southern African Development Community
SRH&RR	Sexual and Reproductive Health and Reproductive Rights
TASAF	Tanzania Social Action Fund
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNSRC	United Nations Security Council Resolution
UN WOMEN	The United Nations Entity for Gender Equality and the Empowerment of Women
UNECA	The United Nations Economic Commission for Africa
UNICEF	United Nations Children's Fund
UNFPA	The United Nations Population Fund
VMMC	Voluntary Medical Male Circumcision
WCA	West and Central Africa
WGYD	Women, Gender and Youth Directorate
WLHIV	Women Living with HIV

"Empowering women and girls…with the agency to claim their rights, receive a quality education, enjoy healthy lives and take measures to protect themselves from HIV is a requisite component of combination HIV prevention—structural change that reflects the interconnected nature of the Sustainable Development Goals."

Phumzile Mlambo-Ngcuka, Executive Director, UN Women

KEY CONCEPTS AND DEFINITIONS USED IN THE STUDY

Gender: Refers to the socially and culturally constructed differences between men and women, boys and girls, which give them unequal value, opportunities, and life chances. It also refers to typically masculine and feminine characteristics, abilities, and expectations about how women and men should behave in society. These characters are time-bound and changeable.[1]

Gender inequality: refers to unequal opportunities connected to gender, gender roles, and expectation to obtain and control social, economic, and political resources, including protection under the law (such as health services, education, and voting rights). Importantly, gender inequality often specifically determines differential, unequal and negative development and health outcomes for women and men and for girls and boys[2],[3].

Gender equality: This refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born male or female.[4]

Gender norms: Gender norms are ideas about how men and women should be and act. We internalise and learn these "rules" early in life. This sets-up a life cycle of gender socialisation and stereotyping.[5]

Gender roles: Gender roles refer to social and behavioural norms that, within a specific culture, are widely considered to be socially appropriate for men, women, boys and girls.[6]

Gender-based Violence (GBV): GBV is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed differences between females and males. The nature and extent of specific types of GBV vary across cultures, countries and regions. Examples include sexual violence, early marriage and female genital mutilation.[7]

Gender Transformative: Transforming unequal gender relations to promote shared power, control of resources, decision-making, and support for women's empowerment.[8] Addresses the causes of gender-based inequalities and works to transform harmful gender norms, roles, behaviours, practices and power relations.[9]

Sexual and Reproductive Health and Reproductive Rights (SRH&RR): Sexual and Reproductive Health and Reproductive Rights is in the context of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), which ensures that the right to health of women is respected and promoted, including women's right to control their fertility; the right to decide whether to have children, the number of children and the spacing of children; the right to choose any method of contraception; the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internally recognised standards and best practices; and the right to have family planning education. Accordingly, State Parties are required to take all appropriate measures to provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas; establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding; and protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.[10]

Reproductive Health: As defined by the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) "is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".[11]

Social determinants and HIV: Addressing the determinants of vulnerability and responding to the holistic needs of people living with and at higher risk of HIV infection are critical to ending the AIDS epidemic as a public health threat.[12]

EXECUTIVE SUMMARY

INTRODUCTION

African girls and women bear a disproportionate global disease burden of the HIV/AIDS pandemic. Women account for more than half of people living with HIV (63%) and 60% of new infections among adults (15 years and older) in Africa. Young women are disproportionately burdened, accounting for over double the number of people living with HIV (1.9m versus 0.85m) and for over 70% of new HIV infections in their age group. This translates to over 4,600 new HIV infections per week among adolescent girls and young women in Africa. Adolescent girls and young women are more than twice as likely to acquire HIV as their male peers. AIDS-related illnesses remain one of the leading causes of death for women of reproductive age (aged 15 to 44 years) in Africa.

HIV among African girls and women is fuelled by multiple gender inequalities that intersect at the individual, sociocultural, economic, and systemic levels. These gender inequalities, including gender-based and intimate partner violence, exacerbate women and girls' physiological vulnerability to HIV and block their access to HIV services, testing, treatment, and care. While HIV is driven by gender inequality, it also entrenches gender inequality, leaving women more vulnerable to its impact. The power imbalance between men and women means that many young women cannot make decisions about their health. These inequalities are more severe for marginalised, migrant and women with disabilities due to their heightened risk of discrimination and violence. Some of the gender inequalities that drive the HIV epidemic are; Gender Based Violence including child marriage and Female Genital Mutilation, Inequalities in power and decision making, women's lack of economic empowerment, girls' lack of access to education, Legal and political factors such as discriminatory legal frameworks, Stigma and discrimination, Humanitarian crisis and COVID 19 as a cross cutting factor.

This policy paper comes at a significant time globally and continentally. The year 2020 marks a watershed moment for the African Union (AU) Gender Equality Calendar – It is the 10th anniversary and the end of the first African Women's Decade (AWD) on Grassroots Approach to Gender Equality and Women's Empowerment 2010-2020. It also marks the 20th anniversary celebrations of the United Nations Security Council Resolution (UNSRC) 1325 and the 25th anniversary of the Beijing Declaration and Platform for Action. 2020 also marks the start of the SDG decade of decisive action. It also marks the first 5 years since the AU adopted the Catalytic Framework to End AIDS, TB and eliminate Malaria by 2030 to monitor progress towards ending HIV/AIDS by 2030.

OBJECTIVE

Against this backdrop, the study aims at, first, providing insights on how gender and other intersecting inequalities impact the risk and vulnerability to HIV for women and girls in Africa. Secondly, the review is to provide key recommendations to the AU and partners on integrating gender equality, women's empowerment and SRH&RR into the existing AU architecture, through strategic, planning, budgeting and implementing processes to address the gender-related barriers and challenges in the HIV response. Thirdly, to provide evidence that can serve as an advocacy tool for policy makers, AU organs, funders, civil society and community organisations in the design of national and continental programmes.

METHODOLOGY

A gender equality, SRH&RR and human rights-based approach was used to review AU instruments, policies, and frameworks to identify gaps and move towards ensuring that the HIV response in Africa is gender-transformative and addresses the multiple, intersecting, and shifting needs of women and girls. Data were collected from secondary sources through desk review conducted by two international consultants working under the guidance of the African Union Commission (AUC)-WGYD, UNAIDS, and UN Women – in accordance with the principles of respect and the protection of the human rights of women and girls – through an evidence-informed approach.

FINDINGS

The review shows that continentally, the AU has shown exceptional leadership in uniting Africa's leaders to leverage the power of policies and accountability mechanisms as efficacious tools to fight AIDS on the continent. Some of the commitments and their specific focus on HIV and GEWE are.

1. Agenda 2063 serves as Africa's blueprint and master plan for transforming the continent into the global powerhouse of the future. Adopted in 2013 as a fifty-year vision, this framework seeks to accelerate the realisation of sustainable development and growth, peace and security, governance, democracy, respect for human rights, justice, and the rule of law in Africa.

2. The Africa Health strategy (2016-2030)'s goal is to ensure healthy lives and promote the well-being for all in Africa in the context of "Agenda 2063". Strategic Objective 2 of the AHS highlights 'Ending AIDS, TB, and Malaria, as part of reducing morbidity and ending preventable mortality.

3. The AU Catalytic Framework to End AIDS, TB, and Malaria sets a target for ending AIDS as a public health threat by 2030. The framework identified gaps, challenges and opportunities that have existed on the African continent with the view to ending AIDS, TB and malaria in the context of the Abuja +12 targets. Specific to HIV, the Catalytic Framework 2016-2030 was adopted with the vision to create an "Africa free of AIDS, tuberculosis and malaria". It is expected that the African continent through the catalytical framework which is consistent with Agenda 2063 and Agenda 2030 will end these three diseases by 2030.

4. In 2018, the AU adopted its first Gender Equality and Women's Empowerment Strategy (2018–2028) to reaffirm its commitment to advancing gender equality. The Gender Strategy is instrumental in strengthening/ catalysing gender mainstreaming in the AU in line with Agenda 2063, the Maputo Protocol and the Sustainable Development Goals (SDGs). Specifically, the Gender Strategy contributes to the realisation of Aspiration 6 of Agenda 2063 through the achievement of 'full gender equality in all spheres of life'. It requires, among others, the ratification, domestication and full implementation of the Maputo Protocol.

5. The African Charter on Human and Peoples' Rights (ACHPR) has developed General Comments as well as Guidelines on specific topics, to provide interpretative guidance to Member States on the Maputo Protocol provisions and the required state response on women and girls' rights. It recognises that people living with HIV and those at risk as one of the most vulnerable groups are exposed to serious violations of human rights in Africa.

6. The African Youth Charter was adopted in 2006 in response to the need to prioritise youth development and empowerment. It reiterates the need to protect and realise the fundamental rights of young people and for girls to education, information, communication and awareness on HIV and reproductive health. The charter calls for the elimination of all forms of discrimination, harmful cultural practices and violence against girls and young women and protection of their rights by ensuring equal access to healthcare, education, and economic opportunities. It calls Member States to provide timely access to treatment for young people infected with HIV/AIDS including the prevention of mother-to-child transmission, post-rape prophylaxis, and anti-retroviral therapy and creation of health services specific for young people.

7. The African Women Decade (AWD) a grass root approach to gender equality and women's empowerment advances the accelerated implementation of global and regional GEWE commitments through top-down and bottom-up approaches, inclusive of grassroots participation.

8. The ground-breaking Maputo Protocol on women and girls' rights was adopted in 2003 and came into force in 2005. In July 2004, the AU Member States adopted the Solemn Declaration on Gender Equality in Africa as the reaffirmation of their commitment to gender equality, gender parity and women and girls' human rights – as enshrined in Art. 4(L) of the Constitutive Act of the AU as well as other international, regional and national commitments.

9. The Maputo Plan of Action (MPoA) emphasized integration of sexual and reproductive health and reproductive rights (SRH&RR) with STI/HIV/AIDS programmes during of service delivery.

10. The African Children's Charter is an important normative framework regarding children which was adopted in 1990 and came into force in 1999. It is the most significant regional legal instrument on the rights of children. The Plan of Action emphasises resource allocation for the full implementation of children's programmes; enhancing the life chances of children; prevention of HIV and AIDS to ensure children's development and survival, developing the potential of children by realising their right to education, and ensuring the participation of children.

Over the last two decades, the AU has launched campaigns and accountability mechanisms on GEWE and HIV, which include;

1. The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA): This campaign is in line with AU's vision to eliminate new HIV infections in children and keeping their mothers alive. In 2009, CARMMA was adopted by the AU as a response to the crisis of high maternal deaths; placing maternal deaths firmly on the continental agenda. CARMMA's main objective is to expand the availability and use of universally accessible quality health services, including those related to SRH.
2. The Free to Shine campaign: the main objective of this campaign is to end childhood AIDS by raising awareness of the HIV epidemic in children and by highlighting the importance of removing barriers that prevent women and mothers from accessing with HIV and AIDS-related health services for themselves and their children.
3. The African Union Campaign to End Child Marriage: The main purpose of this Campaign is to accelerate the end of child marriage in Africa by enhancing continental awareness of the effects of child marriage. The Campaign aims at promoting, protecting, and advocating for the rights of women and girls in Africa.
4. AIDS Watch Africa (AWA): AIDS Watch Africa was established to lead advocacy, resource mobilisation and accountability efforts to advance a robust and harmonised continental response to end AIDS, TB and malaria by 2030.

Other initiatives/programmes that have been implemented across Africa and have recorded tremendous results include;

1. the Training of national AIDS coordinating bodies in Gender Equality in 2018-2019. Seventeen national AIDS coordinating bodies and other governmental institutions responsible for the coordination of the national HIV response increased their knowledge, skills, and capacities to address gender inequality in HIV policies and programmes, with UN Women's support.
2. Engaging of Women living with HIV across 30 countries in decision-making processes around the HIV response resulting in increased advocacy and leadership skills, expanded participation in decision-making spaces in the HIV response, and increased access to HIV services.
3. In Operationalisation of Resolution 60/2; recognising that the underlying structural gender inequalities that drive and increase the vulnerability of women and girls are inadequately addressed, the Southern African Development Community (SADC) has developed a programme of action to implement the Commission on the Status of Women Resolution 60/2. This Plan of Action (POA) has helped Member States to track their progress as well as regularly report to the Secretary-General on gaps and plans to close them.
4. National governments, in collaboration with their UN and other partners, have exhibited strong multisectoral commitment and momentum in engaging a broad range of stakeholders through participatory and decentralised processes. In addition to donor commitments to multisectoral interventions, innovative management, and funding arrangements, such as contracted services, pooled funding, and community funding channels designed to strengthen the multisectoral response have also sprung up. For instance, in Uganda, the creation of the Uganda AIDS Commission with support from the international and bilateral donor agencies; and the implementation of HIV interventions at the national, district, institutional, and community levels – has seen a decline in HIV incidence. The Uganda AIDS Commission established a central dashboard with gender-responsive indicators to track the progress of key gender equality priorities in the implementation of the National HIV and AIDS Strategic Plan.

5. Adolescent girls and young women-specific programmes include the Malawi programme for girls; Tanzania's HER programme; the PEPFAR-DREAMS programme; South Africa's She Conquers campaign and the SASA Project!

Although tremendous progress has been made by Member States in reducing the number of new infections, and HIV related deaths in the last decade, the review shows that this progress has not been consistently achieved across all the regions and countries in Africa. Stigma and discrimination remain major barriers to ending AIDS. There is limited research in North Africa that hampers the efforts being made in the continent to address gender inequalities and HIV in the region. Additionally, the lack of gender-disaggregated data on the HIV response is a notable gap across Member States.

Although laws, policies, and frameworks exist, they fail to enable rights, services, or equitable access in practice because of poor and fragmented implementation. There is limited funding and political commitment for the implementation of national programmes: for instance, the progress review of the first MPoA carried out in 2015 pointed to limited political commitment and leadership, inadequate domestic financing for health, and high donor dependency. The Gender Assessments in Tanzania and Ethiopia point to a heavy reliance on donor funding and the danger of unsustainability should the donor funding decline. Retention of girls in higher education remains a challenge and the COVID-19 pandemic has and continues to exacerbate women and girls' vulnerabilities.

RECOMMENDATIONS

The AU, the AUC, and member states should leverage the current global and continental momentum and synergies to promote a gender-transformative HIV agenda. In line with paragraphs 1 and 12 of the Solemn Declaration on Gender Equality in Africa (SDGEA), Member States are committed to accelerating the implementation of gender-specific economic, social, and legal measures aimed at combating the HIV/AIDS pandemic; to effectively implementing both Abuja and Maputo Declarations on HIV/AIDS; to reporting annually on progress made in gender mainstreaming; and to address all issues (including HIV/AIDS) raised within the Declaration.

WGYD, other AU organs and partners should work with AIDS Watch Africa and the AUC-Department of Health, Humanitarian Affairs and Social Development (DHHASD) to routinely collect and present continental sex disaggregated annual figure on HIV/AIDS to the Africa Centres for Disease Control and Prevention (Africa CDC). These data are important to galvanise political commitment at the highest levels as they demonstrate a deeper picture of progress toward gender equity.

The AUC and her organs should be involved in the development and review of national, regional and continental Universal Health Coverage (UHC) policies to ensure the needs of girls and women are fully addressed in their design and delivery. In this regard, WGYD with support from UNAIDS can engage the services of health system specialists in this exercise. Addressing gender equality in health systems' design, financing, and delivery and in the health workforce, will drive the success of UHC. Furthermore, Member States should conduct national gender-assessments of their HIV/AIDS response in order to make their response gender-transformative, equitable and rights-based and, as such, more effective.

Member states in collaboration with relevant partners such as UNAIDS and UN Women should commission further research to better understand the intersections of HIV/AIDS and GEWE for African girls and women; and to assess the extent to which girls and women are being impacted by these intersecting factors. There should be a strong focus on North Africa Member States where there is currently limited data from the region.

The growing number of humanitarian crises in Africa – which are often linked to displacement, disruption in health and social services, food insecurity and poverty, increase vulnerability to HIV and negatively affects the lives of people living with HIV. Member states, CSOs, and HIV advocates should work on ensuring that HIV services (prevention, treatment, care, and support services) are effectively integrated into all stages of the humanitarian response (rapid assessment, programmes etc.), especially for victims of gender-based violence and conflict-related-sexual-violence.

The importance of education to HIV prevention cannot be underestimated. Therefore, CSOs should work with community-based organisations to hold National governments accountable in improving access to and retention

in quality education for adolescent girls and young women across Africa and promote the integration of HIV/AIDS education into school curriculums.

COVID-19 has revealed the gendered nature of the health crisis and the critical need for gender-transformative responses. Development partners and the media should work with other AU organs and partners to certify that all COVID-19 responses are gender-sensitive and transformative to ensure the needs of girls and women are effectively addressed.

HIV funding across Africa is losing momentum. Between 2017 and 2019, domestic funding for the HIV/AIDS response has decreased in Eastern and Southern Africa (14% decrease) and Western and Central Africa (12% decrease) – both high HIV burden regions. Member States need to reaffirm their commitment to the HIV response and scale-up their investments in the HIV response, with special focus on programmes for girls and women who are disproportionately affected.

1 INTRODUCTION AND OVERVIEW

1.1 WOMEN BEAR THE BRUNT OF HIV/AIDS IN AFRICA

African girls and women bear a disproportionate global disease burden from the HIV/AIDS epidemic. Women account for more than half the number of people living with HIV in Africa. In Eastern and Southern Africa, the region with the largest burden of HIV/AIDS, women and girls account for over 12 million of the 20.7 million people living with HIV. In West and Central Africa, an estimated 4.9 million adults and children are living with HIV; of which 2.8 million are women aged 15 and over. Although the number of men living with HIV in the North Africa region is larger than the number of women, new infections are increasing among women.

1.2 ADOLESCENT GIRLS AND YOUNG WOMEN ARE PARTICULARLY VULNERABLE

Adolescent girls and young women (aged 15-24 years) face a heightened vulnerability to HIV. They are twice as likely to acquire HIV as young men the same age. UNAIDS has underlined in 2019 that HIV infections among young women aged 15-24 years are 60% higher globally than among young men of the same age.[13] HIV infections among the 15-24-year olds averages 5,500 new infections every week in Africa. Most of these weekly new infections occur among girls and young women in Sub-Saharan Africa. In 2019, they constituted 72% of new HIV infections among young people aged 15-24 in East and South Africa (ESA) and 70% in West and Central Africa (WCA). 46% of new HIV infections among young people aged 15-24 in North Africa occurred among adolescent girls and young women.

1.3 FACTORS DRIVING THE HIV EPIDEMIC

Women and girls often face multiple and intersecting individual, social, cultural, economic and health challenges. It has been hypothesised that HIV and gender inequality have a bidirectional connection, most especially through pathways of harmful norms, beliefs and practices. Gender inequalities, including gender-based and intimate partner violence, exacerbate women and girls' physiological vulnerability to HIV and block their access to HIV services, testing, treatment and care. HIV is not only driven by gender inequality, but it also entrenches gender inequality, leaving women more vulnerable to its impact.[14] The power imbalance between genders also means that many young women are not able to make decisions about their own lives. These inequalities are more severe for marginalised women, including migrant women and women with disabilities who are also at a heightened risk of discrimination and violence.

HIV and Gender inequality intersect in the harmful and malignant practice of gender-based violence (GBV). HIV and GBV which mutually reinforce one another, are like two sides of the same coin, yet rarely analysed, planned, and programmed around jointly. HIV is also fuelled by vulnerabilities such as poverty, socio-cultural and demographic characteristics. Gender inequalities and GBV are among the key factors in sexual and reproductive health and reproductive rights (SRH&RR) vulnerabilities for women and girls[15]; at the same time, SRH&RR issues such as HIV infection or unwanted pregnancies can increase GBV risks and serve to compound the effects of other aspects of gender discrimination.[16]

Adolescent girls' and young women's (AGYW) vulnerability to HIV is multifaceted shaped by a range of proximal biological and behavioural factors, as well as more distal social and structural factors like gender norms.[17] For instance, HIV incidence is higher when young women also have sexually transmitted infections (STIs).[18] Behaviourally, engaging in transactional sex, having multiple partnerships, engaging in substance abuse, and limited condom use also contribute to HIV risk among AGYW.[19],[20] Further, structural factors, like parental loss and being out-of-school, are associated with HIV acquisition.[21]

Sustainable and comprehensive responses to HIV and GEWE depend on multilevel policies and programmes that address gender inequalities along with other social stratifiers such as race/ethnicity, age, location, socioeconomic status as well as larger structures of systemic discriminations that shape societies.[22] Understanding the underlying intersecting factors that contribute to both Gender inequalities and HIV in diverse communities is critical for addressing differential risks, outcomes and barriers in accessing services and exercising human rights. Integrated responses are moving toward a more people-centred analysis of GBV and HIV, looking for common elements and determinants to move closer to common causes and solutions.[23],[24]

Integration also involves moving research and programming to an approach that identifies and capitalises on those women affected with HIV and community assets that promote equality, social justice and human rights.[25] The political declaration on the twenty-fifth anniversary of the Fourth World Conference on Women (Beijing Declaration and Platform for Action) expressed concern that, many women and girls experience multiple and intersecting forms of discrimination, vulnerability, and marginalisation throughout their life course. The least progress had been made to address, particularly, barriers faced by women with HIV and AIDS, rural women, women with disabilities, migrant women, and older women.[26] As the Lancet report puts it, for the HIV epidemic to end, gender inequality must end.[27]

> *"We must consider the cultural barriers that strain effective behavioural change implementation and in the AU Member States... It is a strategic time to voicing cultural matters that Africa must address to end AIDS by 2030."*
>
> H.E. Amira Elfadil Mohammed Commissioner for Health, Humanitarian Affairs and Social Development

2 SIGNIFICANCE OF THE ISSUES

Addressing the disproportionate impact of HIV on women and girls is an urgent priority. Gender inequality, and the epidemic levels of GBV, are key social and structural determinants that disproportionately affect women and girls. The empowerment of women through strategies, policies, budgets, institutions, and accountability frameworks is therefore paramount.

It is equally important to empower women in addition to working with communities to address discriminatory social norms so that they can protect themselves from infection, overcome stigma, and gain greater access to and HIV prevention choices, HIV testing, treatment, care, and support. There is a need to implement initiatives to eliminate social barriers even among service providers to ensure access to basic health and social services. Initiatives to amplify the voices of women living with HIV by promoting their leadership and meaningful participation in all decisions and actions to respond to the epidemic need to be evidence-based. These strategies provide the basis for unpacking the question of 'what needs to be done from a gender perspective' to accelerate the gender-responsive implementation of HIV and AIDS responses in line with the milestones and targets set about in the Catalytic Framework.

The following infographics indicate the gender differences in HIV prevalence and in effect the inequalities among adolescent girls and young women and adult men and women continentally.

TABLE 1 - GENDER DIFFERENCES IN KEY HIV METRICS ACROSS AFRICA AMONG ADULTS AND YOUNG PEOPLE – DATA FROM 2019 UNAIDS ESTIMATES[28]

METRIC	ADULT MEN AGED 15+	ADULT WOMEN AGED 15+	YOUNG MEN AGED 15 – 24	YOUNG WOMEN AGED 15 – 24
New HIV infections	340,000 [250,000 – 490,000]	510,000 [380,000 – 700,000]	94,000 [19,000 – 150,000]	240,000 [130,000 – 360,000]
People living with HIV	9,000,000 [7,800,000 – 10,500,000]	15,100,000 [13,300,000 – 17,200,000]	850,000 [430,000 – 1,300,000]	1,900,000 [890,000 – 2,800,000]
AIDS-related deaths	230,000 [170,000 – 310,000]	220,000 [160,000 – 300,000]	180,000 [140,000 – 250,000]	180,000 [130,000 – 240,000]

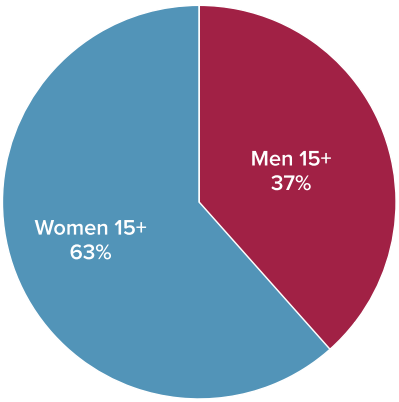
PROGRESS TOWARDS 90-90-90 TARGETS			
	Percentage of people living with HIV who know their status	**Percentage of people living with HIV receiving antiretroviral therapy**	**Percentage of people living with HIV with suppressed viral load**
Adult Men aged 15+	80 [69 – 93]	62 [53 – 72]	54 [47 – 63]
Adult Women aged 15+	88 [77- 100]	76 [67 -86]	67 [59 – 77]

2.1 THE HIV EPIDEMIC AMONG WOMEN AND GIRLS: KEY FACTS AND FIGURES

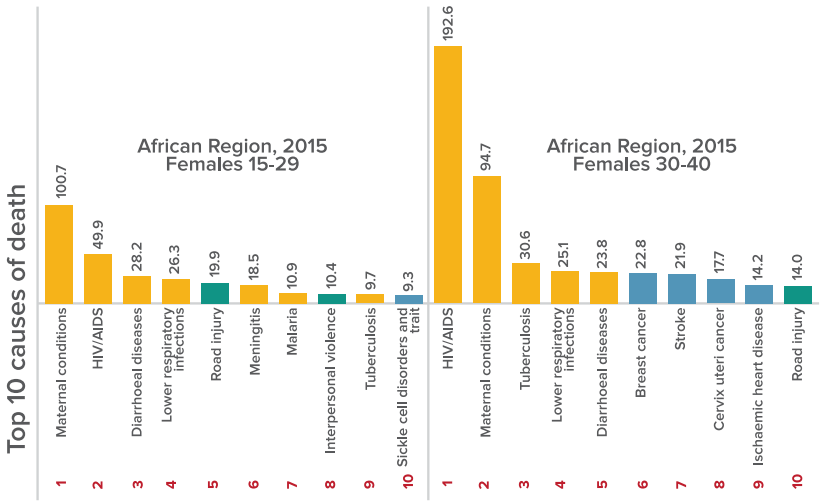
Women and girls carry a disproportionate burden of HIV/AIDS across the African region

TABLE 2 – THE HIV EPIDEMIC AMONG WOMEN AND GIRLS: KEY FACTS AND FIGURES

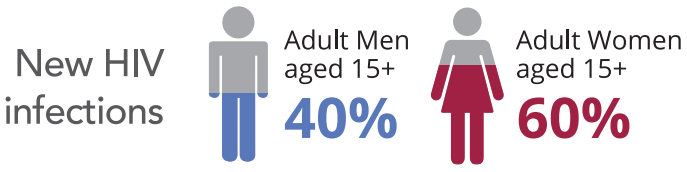
Across Africa, **15.1 million women** are living with HIV compared to **9.0 million men** in 2019[29]



In 2015, **AIDS-related illnesses** were one of the **leading causes of death** for women of reproductive age (aged 15 to 44 years) in Africa[30]



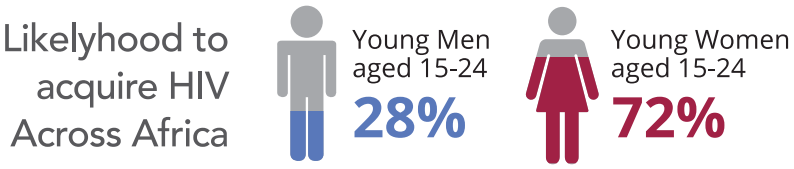
Women account for **60% of new infections among adults** (15 years and older) in the region, a share that has remained largely unchanged since 1995 (2019 data)[29]



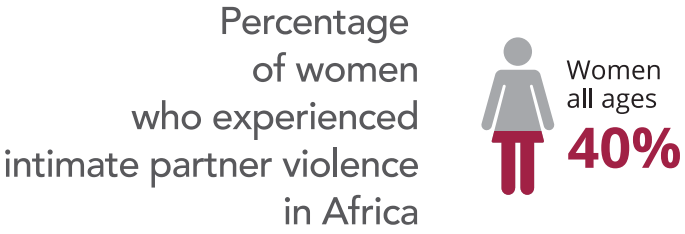
In Africa, young women and adolescent girls accounted for **240,000** new HIV infections in 2019. In sub-Saharan Africa where the epidemic is concentrated, they accounted for **one in four new infections** in 2019, this translates to 5,500 new infection a week among adolescent girls and young women[29]

Eastern and Southern Africa, is the area most affected by HIV, here, adolescent girls and young women accounted for **30% of new infections**[29]

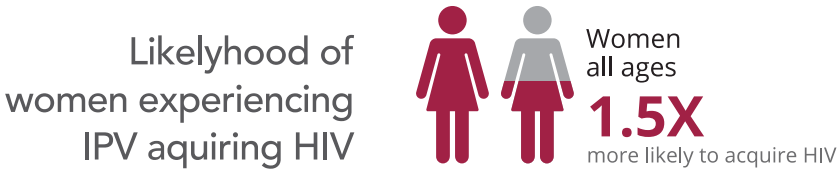
Across Africa, gender-related factors fuelling the epidemic are especially stark: **adolescent girls and young women** were **more than twice as likely to acquire HIV** than **their male peers**[29]



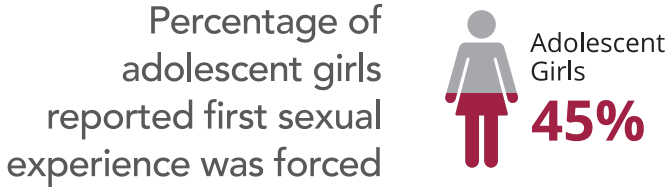
Globally, **almost one third (30%) of women** who have been in a relationship report that they have **experienced some form of physical and/or sexual violence** by their **intimate partner in their lifetime**. Studies report **more than 40% of women** have experienced IPV in Africa[38]



Women who experience sexual and/or physical violence perpetrated by an intimate partner are **1.5 times** more likely to acquire HIV[31]

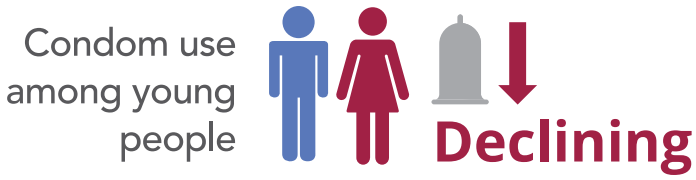


In some settings up to **45%** of adolescent girls report that their first sexual experience was forced[32]

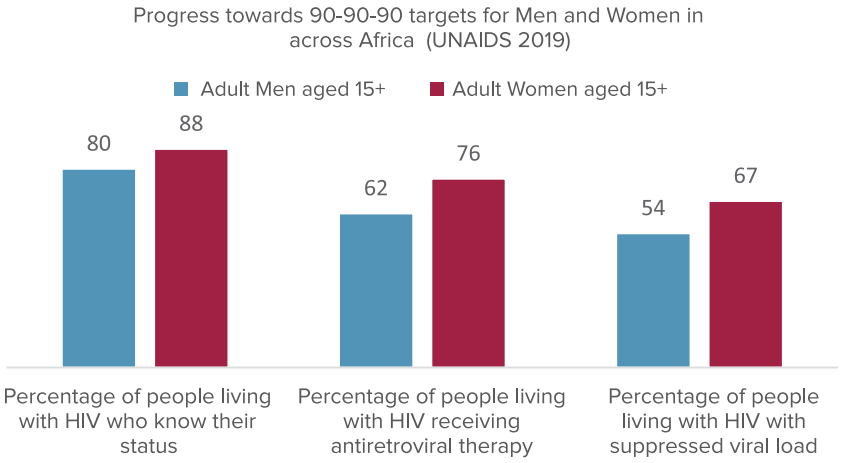


Legal norms directly affect **women's risk of acquiring** HIV. In many countries where women are most at risk, **laws to protect them are weak**. A **lack of legal rights** reinforces the **subordinate status of women**, especially in relation to women's rights to divorce, to own and inherit property, to enter into contracts, to sue and testify in court, to consent to medical treatment and to open a bank account.[33]

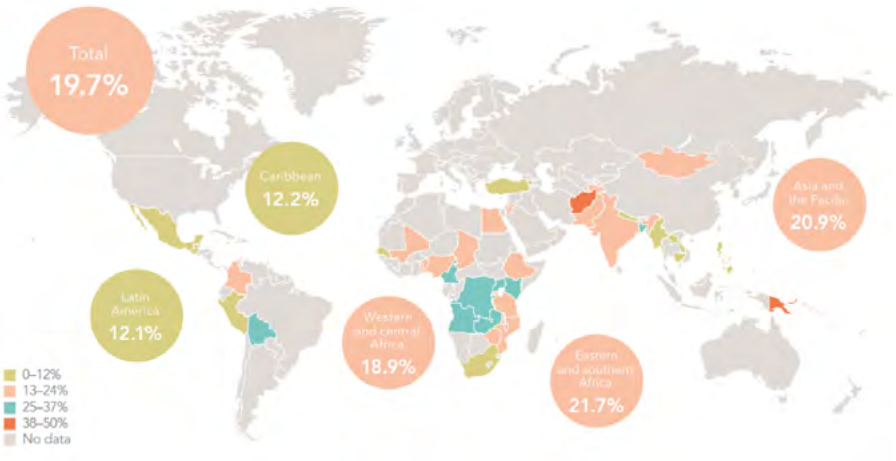
Results from population health surveys show that condom use among young people is declining in countries across the continent.[34]



Across Africa, women living with HIV are more likely to access HIV testing and antiretroviral therapy than men, they are also more likely to be virally suppressed. This treatment gap among men living with HIV contributes to the higher number of new HIV infections among women in sub-Saharan Africa.



Percentage of over-married or partnered women 15 to 49 years who experienced physical and/ or sexual violence by an intimate partner in the past 12 months, 2014 - 2018.



Source: *Population-based surveys, 2014-2018.*

In Africa, as many as **one in five women** have an **unmet need for family planning**[35] In Africa, **among married or in-union women of reproductive age**, the proportion of the **demand for family planning that was satisfied by modern contraceptive methods** (the proportion of women currently using a modern method among all women who have a need for family planning) was **65%**.

As many as **one in three women living with HIV** reported **experiencing** at least one form of **discrimination related to their sexual and reproductive health and reproductive rights** in a **health-care setting** within the past 12 months, abuse documented include unauthorised disclosure of status, being advised to not have children, forced and coerced sterilisation or termination of a pregnancy, denial of sexual and reproductive health and reproductive rights services, and related psychological violence.

On average, **43% of women** aged 15 to 49 years **make their own informed decisions** regarding sexual relations, contraceptive use and their own **health care** (in countries with available data, across Africa)[36].

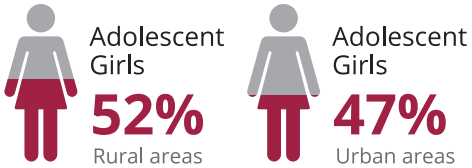
Among population surveys conducted between 2011 and 2018, just **39%** of **young women** (aged 15 to 24 years) in **eastern and southern Africa**—and **28% in western and central Africi**—demonstrated comprehensive knowledge of HIV, compared to **46% and 31% of young men** in the same age group, respectively. Data from North Africa was unavailable.

> *"Education, awareness and prevention are the key, but stigmatisation and exclusion from family is what makes people suffer most"*
>
> Ralph Fiennes

****The following data focus predominately on sub-Saharan Africa. This area is where the HIV epidemic is highly concentrated, as a result there is more research and HIV-related information from this area. Although, HIV prevalence in North Africa is quite low, infection rates are increasing in and there are concentrated epidemics among sub-population. ****

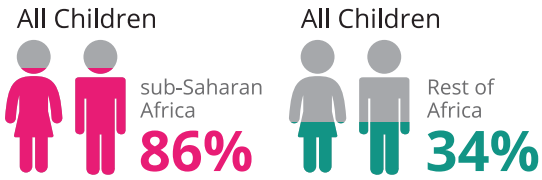
52% of adolescent girls and young women in rural areas are unable to make decisions about their own health, compared with 47% in urban areas[37].

Percentage of adolescent girls unable to make decisions about their own health



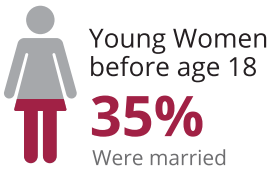
Approximately 86% of all children newly infected with HIV in 2018 were in sub-Saharan Africa, were the HIV epidemic is mostly concentrated.

Percentage of children newly infected with HIV in 2018



Between 2013 an d 2019, **35% of young women** in sub-Saharan Africa were **married before** the age of **18.**

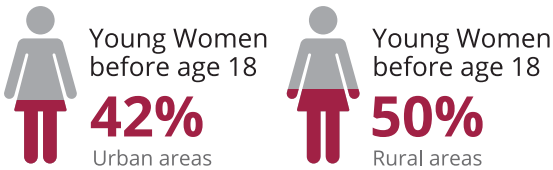
Women married before the age of 18 sub-Saharan Africa 2013 - 2019



In sub-Saharan Africa, **42%** of women living in **urban areas** aged 15–24 had a pregnancy before the age of 18.

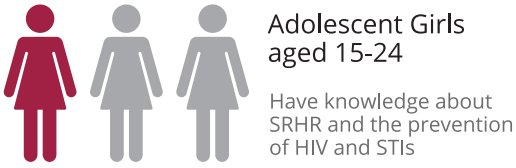
In **rural areas**, more than **50%** of women aged 15–24 had a pregnancy before the age of 18.

Percentage of women pregnant before the age of 18 sub-Saharan Africa



Knowledge about sexual and reproductive health and reproductive rights and the prevention of HIV and STIs among adolescent girls and young women is also low: **only about one third of women** aged 15 to 24 years in sub-Saharan **Africa have adequate knowledge about HIV.**

Young women aged 15-24 have adequate knowledge about HIV sub-Saharan Africa



Cervical cancer is the **most common cancer** among women living with HIV, and the likelihood of a woman living with HIV developing invasive cervical cancer is up to **five times greater than** for a woman who is not living with HIV. Each year approximately 528 000 women are diagnosed with cervical cancer and approximately 311 000 women die from the disease. Close to 90% of the women who die from a highly preventable and curable disease are from LMIC. Most countries with high rates of cervical cancer are in sub-Saharan Africa. A total of **11 countries in sub-Saharan Africa** reporting having **screening programmes** for cervical cancer in 2019, with coverage ranging from 10% to 70%.

3 METHODOLOGY

This study provides insights into how gender and other intersecting inequalities impact the risk and vulnerability of HIV for women and girls in Africa. A gender equality, sexual and reproductive health and reproductive rights (SRH&RR), and human rights-based approach was used to review AU instruments, policies and frameworks to identify gaps and move towards ensuring that the HIV response in Africa is gender-transformative and addresses the multiple, intersecting and shifting needs of women and girls.

The review aimed at;

- Assessing the HIV epidemic and response, as well other inter-related and intersecting gender equality and SRH&RR issues (such as gender-based violence (GBV) –affecting women and girls from a gender equality SRH&RR and human rights perspective, and economic empowerment and women participation in the response as crucial to GEWE and HIV prevention;
- Highlighting the disproportionate burden of HIV/AIDS on women and girls and the challenges they face in accessing HIV and SRH services;
- Reviewing AU instruments, policies, organs, mechanisms, charters, and frameworks for commitments towards GEWE and ending HIV/AIDS as a public health threat;
- Providing key recommendations to AU and member states on integrating gender equality, women's empowerment, and SRH&RR into other strategic, planning, budgeting and implementing processes to address the gender-related barriers and challenges in the HIV response;
- Providing evidence-based recommendations to AU and member states on key priority action points as well as targets for the next women decade;
- Serving as an advocacy tool for policy makers, funders, and civil society and community organisations in the design of the national programmes

Data was collected from secondary sources through desk review guided by the principles of;

- Respect and protecting the human rights of women and girls
- Evidence informed approach

The review was conducted under the guidance of the AUC- WGYD, UNAIDS and UN Women. A list of websites with relevant AU policy and legal frameworks and commitments were reviewed in addition to UN and other databases for the collection of gender disaggregated data on various HIV indicators among different geographical as well socio-economic groups. A literature search using PubMed, JAMA evidence, PopLine, ScienceDirect, Scopus, and Google Scholar for data on Gender inequality and HIV was also made in the process.

Data from the multiple sources indicated above was examined while interpreting it to provide deeper insights into the intersecting gender equality dimensions of the HIV epidemic, context, and response. Effectively responding to gender inequalities and HIV requires addressing the multi-dimensional and complex circumstances of men and women.[80]

FIGURE 1 - DIAGRAM ILLUSTRATING INTERSECTING ISSUES BETWEEN HIV/AIDS AND GENDER

4 THE INTERSECTIONS BETWEEN HIV EPIDEMIC AND GEWE

This section provides the linkage between the HIV epidemic and the various forms of Gender Inequalities. These are Gender Based Violence including child marriage and Female Genital Mutilation, Inequalities in power and decision making, economic empowerment, Girls' access to education, Legal and political factors such as discriminatory legal frameworks, Stigma and discrimination, women with disabilities, refugee women and women who abuse drugs, Humanitarian crisis and COVID 19 as a cross-cutting factor.

4.1 EVIDENCE ON THE LINKAGES BETWEEN HIV AND GBV

Gender-based violence varies in definition but is generally defined as violence perpetrated against an individual based on their gender.[38] The term 'gender-based violence' (GBV) is often used interchangeably with 'violence against women.'[39] It includes physical, sexual, psychological/emotional abuse, and economic or educational deprivation.[40] Violence can be perpetrated by a variety of actors, including intimate partners (referred to as intimate partner violence (IPV)), family members, community members, and representatives of the state (e.g.[41]

GBV is a health and human right concern globally, with estimates suggesting that 1 in 3 women experience some form of GBV in their lifetime, primarily from an intimate partner.[42]

Statistics globally show that:

- 35% of women worldwide have experienced either physical and or sexual intimate partner violence or non-partner sexual violence in their lifetime[43]
- Almost one third (30%) of women who have been in a relationship report that they have experienced some form of physical and or sexual violence by their intimate partner in their lifetime[42]
- Globally, as many as 38% of murders of women are committed by an initmate male partner.[43]

In Africa, GBV, specifically IPV is highly prevalent[38]. Results from a recent comparative analysis across different regions of Africa found an average IPV prevalence of 31%.[44] This figure was consistent with another study conducted in other African countries which reported an IPV prevalence of roughly 30% among adolescent girls and young women.[45] Other studies in countries across the continent have reported IPV prevalence ranging from 13% to as high as 97%[46],[47],[48],[49],[38],[50]. Although the figures for IPV vary, in reality, these figures could be even higher, due to the underreporting associated with GBV,[51] because of factors associated with stigmatisation, victimisation, retaliatory violence, fear of divorce, amongst many other reasons[38],[17],[52],[53],[54].

Summary of GBV statistics and figures for Africa shows that:

- IPV prevalence ranges from 13% to as high as 97% across the continent.[38]
- Only 22 African countries have adopted laws that prohibit GBV.[38],[55]
- According to the Gender Equality Index Report, 27 of the 30 countries in the world that exhibit unequitable gender indices are in Africa.[56]
- Across Africa cultural beliefs and traditions promote men's hierarchical role in sexual relationships and especially in marriage.[57],[58],[59],[60],[61],[62]
- Almost two-thirds (63%) of the African population live in remote rural settings and are disparate from the influence of central government or laws that prohibit GBV.[40],[63]

A large body of evidence has demonstrated an inextricable link between GBV and HIV among women.[64],[65],[66] Studies reveal the strong forward and reverse correlations between GBV and HIV; HIV acquisition is a risk factor for GBV and vice-versa.[67] Women who experience GBV are four times more likely to be at risk of HIV and sexually transmitted infections (STIs).[67],[68] Sexual violence can lead to HIV infection directly, as trauma increases the risk of transmission. More importantly, GBV increases HIV risk indirectly.[65] Victims of childhood sexual abuse are more likely to be HIV positive and to have high-risk behaviours.[69]

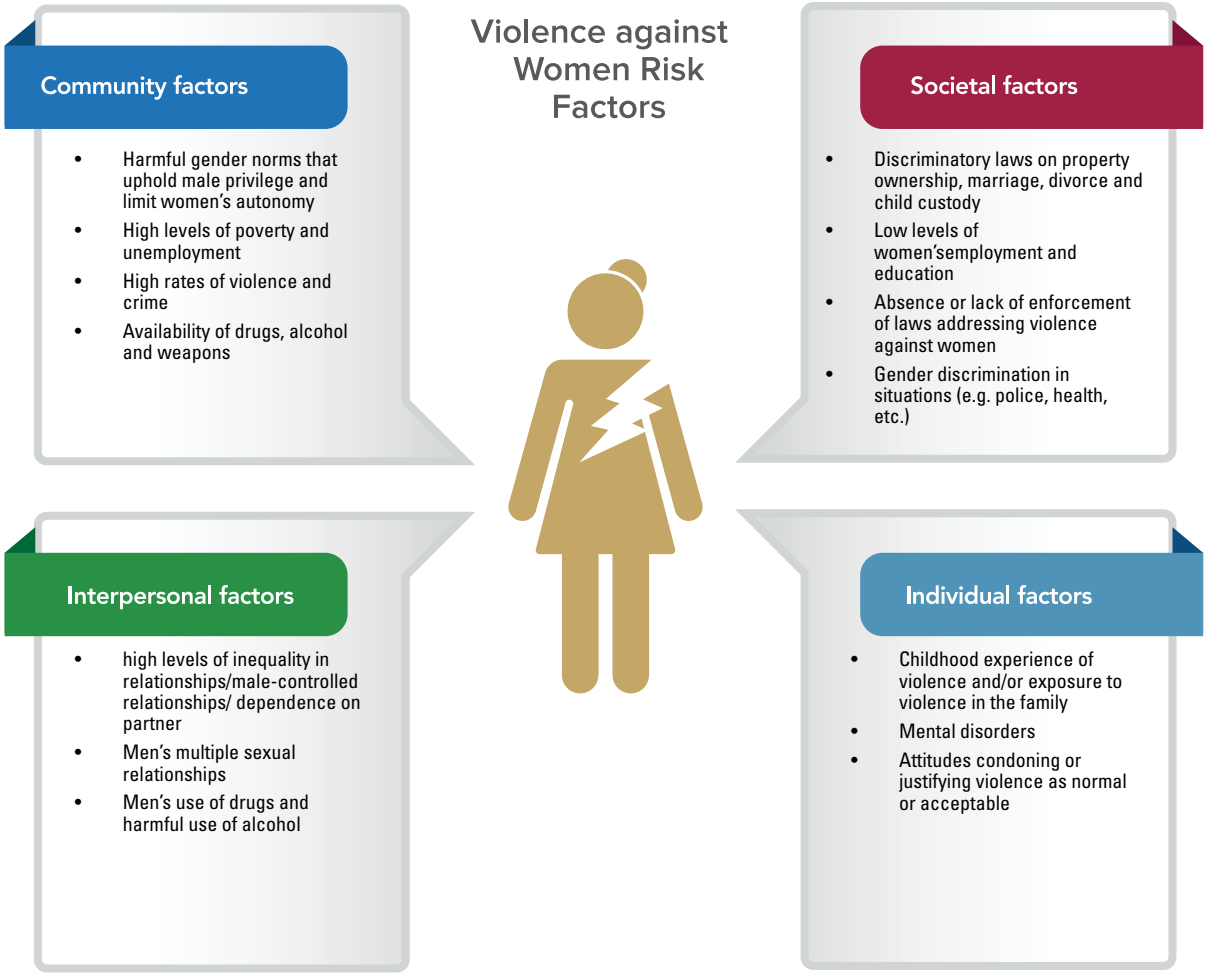
GBV perpetrators are at risk of HIV infection, as their victims have often been victimised before and have a high risk of infection.[69] Social and gender norms—introduced in childhood and consistently reinforced throughout life—drive such violence. In 24 of 43 countries with recent data from population-based surveys, more than 40% of young women (aged 15 to 24 years) stated that a husband is justified in hitting or beating his wife.[70]

GBV has been shown to hinder women's ability to access treatment and care and adhere to ART.[71] Several studies demonstrate that fear of GBV (abuse and abandonment) leads many women to conceal their HIV status, treatment, and care-seeking behaviour from their partners which, in turn, impacts adherence.[72],[45],[73],[74] For example, a study of antiretrovirals access and adherence in five districts of Zambia showed that 66% did not disclose their HIV status to their intimate partners because of "fear of blame, abandonment and losing the economic support of their partner", and 76% of women did not adhere to their ART regimen as prescribed because they were trying to hide their medication.[75]

Further studies show that fear of violent reaction results in women not accessing treatment and care services at all, including those for the prevention of vertical transmission of HIV.[72],[76],[77],[78] A 2012 study in South Africa showed that women may regret accessing health services because of the GBV they subsequently experience.[72],[79] Overall, these findings confirm that GBV remains a critical barrier to accessing and adhering to treatment.[72]

Violence is rooted in discrimination and inequality that are upheld by individual attitudes, beliefs and practices; broader social norms around gender and violence; and systems and structures that replicate and even codify this inequality and discrimination. In addition to these root causes, there are several risk factors that make it more likely to occur, these are summarised in Figure 2.[80]

FIGURE 2 - SUMMARY OF RISK FACTORS FOR VIOLENCE AGAINST WOMEN[81]



The fear of negative consequences among women living with HIV is not unfounded. Several studies show that women may experience high levels of stigma and discrimination, including physical violence and post-disclosure abuse.[72],[54],[82],[83] Experiences of intimate partner violence are associated with negative HIV-related clinical outcomes, possibly due to a decrease in HIV care, adherence and retention, and an increase in depression and anxiety.[72],[79],[84]

The response to the COVID-19 pandemic appears to be magnifying existing gender inequalities and vulnerabilities that contribute to gender-based violence.[36],[85] Extended confinement measures and restrictions on movement—compounded by economic and social stresses brought on by the pandemic—have coincided with reports in many countries of increased numbers of women and girls facing abuse.[36],[85],[86] Across Africa, country-wide school closures implemented to fight the spread of the virus have led to learners being out of school, including millions of girls.[87],[88] The impact of this period of disrupted education will be far-reaching, and it is likely to hit marginalised girls the hardest.[89]

4.2 CHILD MARRIAGE

Child marriage is any formal marriage or informal union where one or both people are under 18 years old.[90] Marriage before the age of 18 is a fundamental violation of human rights. Many factors interact to place a child at risk of marriage, including poverty, the perception that marriage will provide 'protection', family honour, social norms, customary or religious laws that condone the practice, inadequate legislative frameworks and the state of a country's civil registration system.[91] While the practice is more common among girls than boys, it is a violation of rights regardless of gender.

Worldwide, more than 650 million women were married in childhood, and each year 12 million girls become child brides.[92] Across Africa, roughly 1 in 3 girls marry before they are 18. In some countries, the rate is much higher.

- In Western and Central Africa, at least two-thirds of girls are married by age 18 in the Central African Republic (68%), Chad (67%), and Niger (76%); about half of girls are married by 18 in Burkina Faso (52%) and Mali (54%).
- Many countries in Eastern and Southern Africa – the region with the highest burden of HIV – also have a very high prevalence of child marriage. The highest figures are in Malawi 42%; Mozambique 53%, South Sudan 52% and Ethiopia 40%.
- In North Africa, the percentage of women married before age 18 has dropped by about half, from 34% to 13%, over the past three decades. Nevertheless, child marriages are still prevalent. The highest figures in the region are Mauritania 37%; Egypt 17% and Morocco 13%.[93]
- Most child marriages occur between 15 and 18 years of age, but in Chad and Niger, more than a third of 20- to 24-year olds were married before the age of 15.
- It is projected that the number of youths in Africa will double by 2050; due to high population growth rates, the number of girls who are married is increasing in some countries like Burkina Faso and Nigeria.[94]

African child brides are most likely found in rural areas and among the poorest segment of the population.[95] Girls in rural areas are twice as likely to become child brides as girls from urban areas. Similarly, girls from the poorest households are twice as likely to marry before age 18 as girls from the richest households.[95]

Although the global profile of child marriage is changing, a growing child population combined with a slow decline in the practice of child marriage in Africa will put millions of more girls at risk. If current trends continue, almost half of the world's child brides in 2050 will be African.[96]

While the drivers and impacts for child marriage differ for girls in different contexts, studies show that child brides are generally more likely than non-married girls to experience early pregnancy and childbirth, high fertility rates, low educational attainment, IPV, poverty, and lower earnings over their lifetimes.[97],[98] The evidence further indicates that child brides are often restricted in their physical mobility and limited in their ability to make decisions regarding their health and households.[99] More recent evidence suggests that child marriage may negatively impact the mental health and well-being of those married as children.[100],[101]

Even though there is a need for more research to better understand the relationship between Child Marriage and HIV, it is clear that some of the factors which put girls at higher risk of HIV infection are the same as those that expose them to child marriage. Some of these risk factors include gender inequalities, poverty, and low educational attainment, which limit girls' ability to make decisions about their own health.[102] Once married, there are several factors which can make child brides particularly vulnerable to HIV infection. These factors summarised in the figure 3 include: early pregnancy; having older, more experienced, and non-monogamous sexual partners; an imbalance of power and lack of choice within the marital relationship; experience of IPV; limited access to education, information, and services; and a dearth of appropriate prevention strategies designed to meet the needs and priorities of married girls.[103],[104],[105],[106],[107],[108],[109],[110],[111],[112],[113],[114],[115]

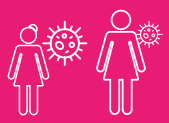
FIGURE 3 - FACTORS IN EARLY CHILD MARRIAGE THAT INCREASE RISK OF HIV INFECTION[97]

In many contexts, early sexual debut, including that which takes place within child marriages, is associated with increased lifetime risk of HIV infection. [102]

Child brides lack power and decision making regarding reproductive choices.[103]

Child brides often marry men who are older than them, which in turn, increases the risk of HIV infection.[104, 105]

Child brides often lack the agency needed to negotiate protective measures or access to vital services such as HIV testing: 80% of married 15-19-year old girls in Burkina Faso, Cameroon, Côte d'Ivoire, Niger and Senegal report that they do not have the final say on their own healthcare.[106]



A solid evidence base indicates that adolescent girls may be more biologically susceptible to HIV infection than older girls and women, and new evidence suggests that the risk of acquiring HIV increases during pregnancy and the postpartum period.[107] Child marriage increases both the number of children a woman has and the number of years she faces this increased risk.

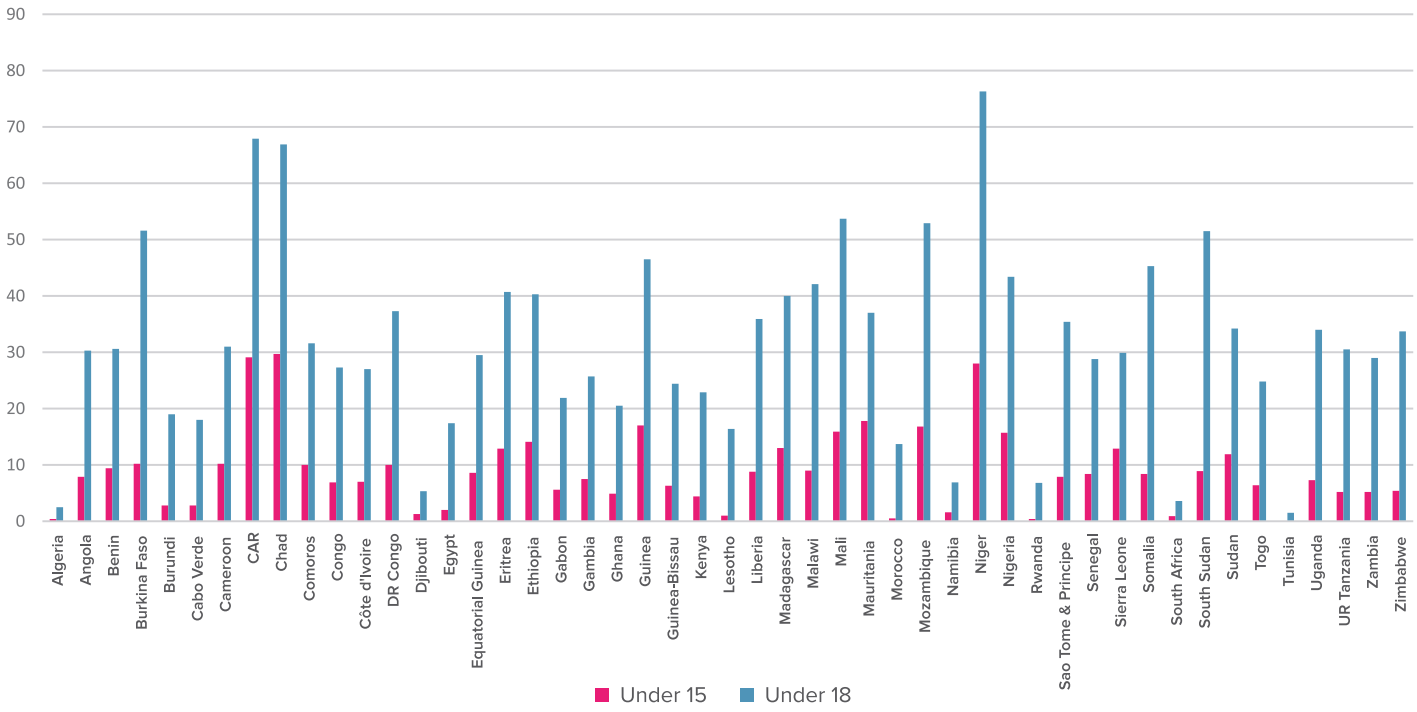
Adolescent girls lack information about HIV and HIV prevention: globally, only 30% of girls aged 15- 24 have accurate knowledge about HIV.[108] Lack of information on HIV prevention undermines young women's ability to negotiate protective measures.[109]

Over 50% of girls married before the age of 18 globally have no more than three years of schooling.[110] Studies demonstrate that higher educational attainment is correlated with reduced likelihood of HIV infection for young women. The lower levels of education of child brides increases their risk of HIV infection.[111]

Globally, girls who were married before the age of 18 report experiencing higher levels of intimate partner violence (IPV) than those married after age 18.[112] In turn, women who experience IPV are at greater risk of HIV:[113] One study in South Africa found that women who experience IPV were 50% more likely to be infected with HIV that those who don't.[114]

Programmes that aim to improve health, education and well-being outcomes for adolescent girls tend to focus on unmarried adolescents. The distinct priorities of married girls, including HIV prevention, are less recognised and attended to.[102]

FIGURE 4 - PERCENTAGE OF WOMEN AGED 20 TO 24 YEARS WHO WERE FIRST MARRIED OR IN A UNION BEFORE AGE 18



The impact of child marriage on the rights and welfare of the child has been well documented,[116] and its elimination has become an international and regional priority.[117] Child marriage is prohibited under the African Children's Charter on the Rights and Welfare of the Child (ACRWC) and the Protocol on the Rights of Women in Africa to the African Charter on Human and Peoples' Rights (Maputo Protocol). Both the ACRWC and the Maputo Protocol specify that "the minimum age of marriage shall be 18 years of age"[118] and stipulate "full and free consent to a marriage that cannot be supplemented or cured with the addition of parental consent given on behalf of a child".[118]

In 2015, AU Member States adopted an African Common Position on Ending Child Marriage, which urges the enactment and implementation of laws that set the legal minimum age for marriage at 18 years old or above, with no exceptions, and applicable under all legal systems, and the implementation of appropriate legislation and policies that effectively prohibit, prevent, punish and redress child marriage including cross border movement of girls for child marriage purposes.

Nevertheless, in 2020, all Member States are yet to fully ratify and implement these commitments. Despite the existing legal standards and guidelines, child marriage continues to be practiced in Africa with serious consequences on the well-being of adolescent girls and young women.

A recent AU-led review of child marriage legislation and laws in all 55 African Union countries reported that child marriage is still legalised in 39 of the 55 African Union Member States. The findings from the AU child marriage compendium identified the following:[118]

- 43 of 55 African Union Member States (78%) have legal frameworks that put the minimum age of marriage at 18 years old or above for both girls and boys, however 27 (63%) of these Member States have exceptions legalising child marriage either with parental/guardian consent, a judge's approval, court/State's approval and other exemptions allowing a child to marriage below the age of 18 legally.
- Eleven Member States (20%) do not have legal frameworks putting the minimum age as 18 years old and above for both boys and girls and 10 Member States (91 per cent) have further exceptions reducing the age of marriage legally to as low as 10 years old for girls.

- Ten Member States (18%) have unequal minimum age of marriage laws for boys and girls ranging from as low as 14 years old for girls and 15 years old for boys, and one Member State (2%) has no minimum age for marriage.
- This brings the total number of States where child marriage is legalised to 39 (71%). (Member States with no minimum age for marriage, States without legal frameworks putting the minimum age as 18 years old and above, and States where frameworks putting the minimum age for marriage at 18 years old and above exist, with exceptions allowing child marriage or with contradictions between customary, religious and civil laws).

To address these gaps, a holistic approach is required coupled with appropriate actions including the enactment of laws, harmonisation of civil, customary and religious laws and enforcement of laws to ensure that child marriage is eliminated in Africa[118].

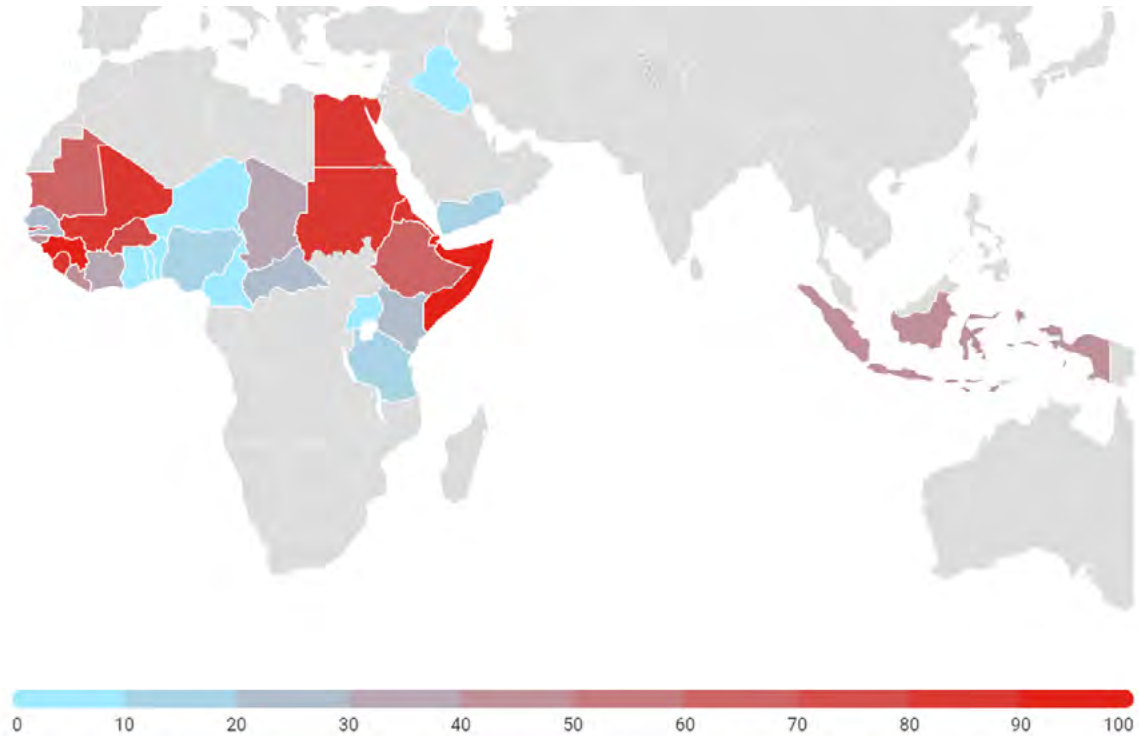
4.3 FEMALE GENITAL MUTILATION AND HIV

Female genital mutilation (FGM) refers to "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons."[119] FGM is recognised internationally as a violation of the human rights of girls and women. It reflects deep-rooted gender inequality and constitutes an extreme form of discrimination against women. FGM is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security, and physical integrity, the right to be free from torture and cruel, inhuman, or degrading treatment, and the right to life when the procedure results in death.[120]

FGM has no health benefits, but it has serious implications for the sexual and reproductive health and reproductive rights of girls and women.[121] Long-term consequences include complications during childbirth, urinary incontinence and increased risk of HIV transmission, as well as psychological effects.

While the exact number of girls and women worldwide who have undergone FGM remains unknown, it is estimated that at least 200 million girls and women alive today have been subjected to the practice in 31 countries with representative data on prevalence. As illustrated by the figure below, the majority of the countries where FGM is prevalent are in Africa.[122] With Africa growing youth population, UNFPA and UNICEF estimate that 50 million girls in Africa risk suffering genital mutilation before 2030 if concerted action is not taken now.[123]

FIGURE 5 - PERCENTAGE OF GIRLS AND WOMEN AGED 15 TO 49 WHO HAVE UNDERGONE FEMALE GENITAL MUTILATION



Although FGM appears to have a negative correlation with HIV infection in Africa when comparing geographic distribution, some studies suggest that FGM may increase the risk of HIV.[124],[125],[126] At the individual level, there are a number of proposed mechanisms through which FGM may influence the risk of HIV acquisition for women.126 In terms of physiology, the use of contaminated cutting instruments or reusing the same instrument continually without sterilisation in group ceremonies increases the risk of HIV transmission.[126]

In contrast, behavioural mechanisms may be protective in some instances while raising HIV risk in others. For example, in some settings, FGM can result in delayed sexual debut,[127] which may be associated with a lower risk of HIV infection. On the other hand, FGM increases girls' marriageability and bride price and may contribute to early marriages to older men who are more likely to have been exposed to HIV.[128]

While the data supporting the link between HIV and FGM is limited, further research is needed to provide better quality evidence of the relationship between FGM and HIV, especially in places where both FGM prevalence and women's risk of HIV acquisition are substantial.[126]

AU Member States have championed the struggle against female genital mutilation at national, regional, and international levels. There are extraordinary examples of leaders – including many women leaders, such as the First Lady of Burkina Faso, Madame Sika Kaboré – who have brought about tremendous change in their countries.[129] In 2019, the AU, in partnership with UNFPA and UNICEF, launched a Continental Initiative to End Female Genital Mutilation (The Saleema Initiative), which marked a strengthened commitment to the elimination of FGM in Africa. The Saleema Initiative aims to galvanise political action to enforce strong legislation, increase the allocation of financial resources and strengthen partnerships to end female genital mutilation, particularly within communities most impacted by the harmful practice.[130]

4.4 HIV, LEADERSHIP AND DECISION MAKING

Women's empowerment generally refers to the recognition that women can and should participate effectively in decision-making processes that shape their own lives and societies. An important aspect of women's empowerment is agency; defined as the ability to set your own goals or make your own choices and act upon them.[132] Women's empowerment entails both the development of women's own agency and the removal of barriers - political, legal, and social - to exercise this agency[131].

Reproductive health and Reproductive rights are central to empowering women and adolescent girls and creating gender-equal societies and economies.[133] In sexual and reproductive health and reproductive rights, women's agency is greatly influenced by their ability to exercise their human rights. In relation to women's empowerment and HIV infection, women must have the ability to and should make informed decisions about their sexual and reproductive health and reproductive rights to reduce their risk of HIV infection[131].

Yet in Africa, a lot of women do not have the ability to make decisions about their own sexual and reproductive health and reproductive rights. In many communities across the continent, unequal power relationships between women and men limit women's sexual decision-making[134],[135],[136],[137] and the ability of women to choose protective measures, which contribute to women's increased risk of HIV infection.[138],[139],[140],[141]

For example, a 2019 study in Mozambique showed that men make most decisions about fertility and family size, with respondents reporting that deeply patriarchal gender norms limit the agency and participation of women in decision-making, including around their own sexual and reproductive health and reproductive rights. Both women and men reported that women must obtain permission from their male partners before seeking health services.

There is a plethora of evidence that demonstrates the ways unequal levels of power between men and women in intimate relationships limit women, including women living with HIV, from making decisions regarding their sexual and reproductive health and reproductive rights.[143],[144],[145],[146].

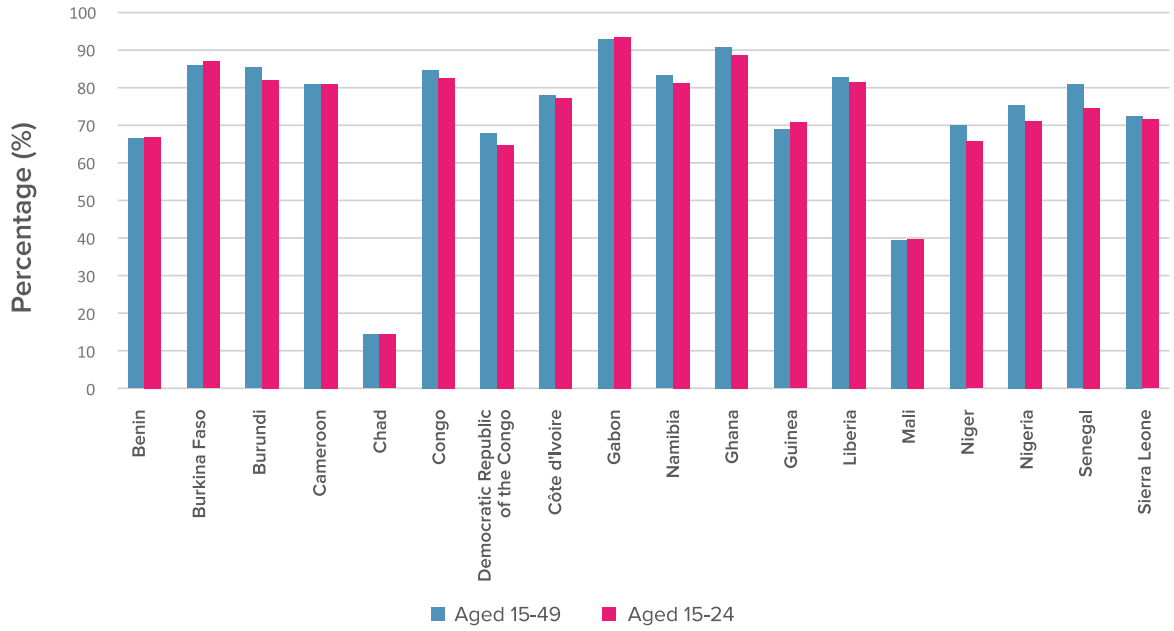
Across Africa, inequalities in education, employment, and access to resources result in a lower socio-economic status for women, which leads to a power imbalance between men and women.[147],[148] This restricts women's access to information about their reproductive health and reproductive rights.[149]

Additionally, in many societies, men tend to be considerably older than women in relationships, reinforcing power imbalance, especially in patriarchal societies, where age and seniority are important in social interactions.[149] As a result, men tend to have higher social status than women and tend to control economic resources. The control of economic resources by men yields more decision-making power in relationships[149].

This limits women from negotiating protective measures, making them more vulnerable to HIV.[150] Figure 6 below shows results from population surveys across West and Central Africa – the results show around 1 in 4 women do not believe that a woman is justified in asking that her husband use a condom even if she knows that he has a sexually transmitted infection.

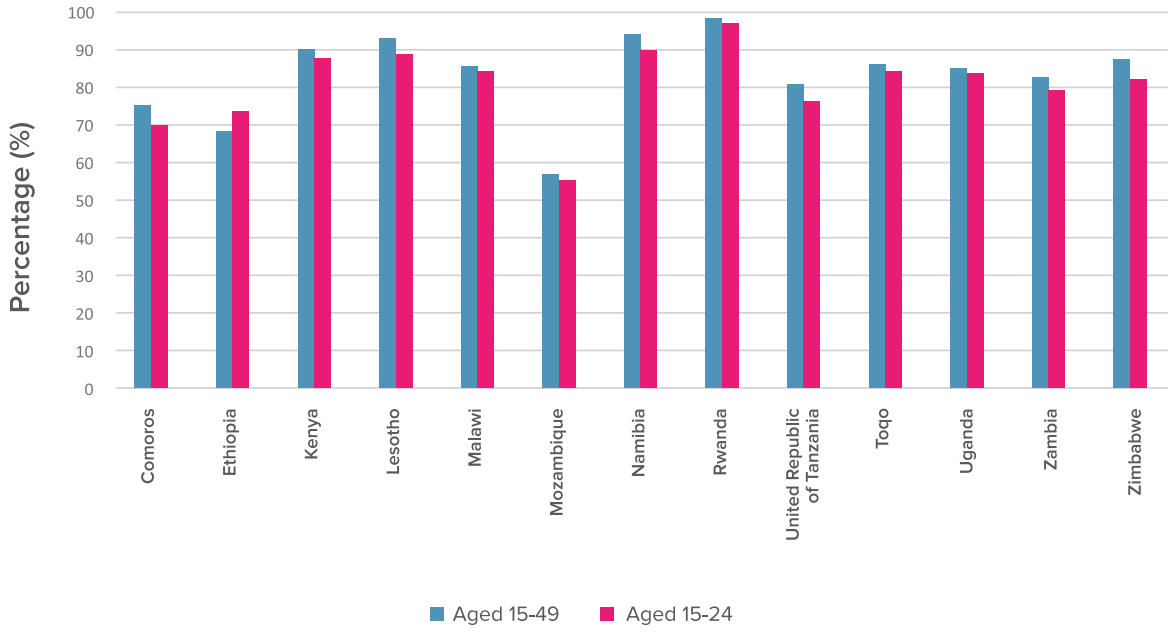
Information measuring young women's agency and power in decision-making about their own health is similarly concerning. Across 11 countries in Eastern and Southern Africa, 62% of currently married young women aged 15-19 years living in urban areas report having the final say in decisions related to their own health care, compared to 53% living in rural areas. Across ten countries in western and central Africa, the result is much lower – the percentage of currently married young women aged 15-19 years who report having the final say in decisions related to their own health care was 29% in urban areas and 25% rural areas.[151],[152]

FIGURE 6 - PERCENTAGE OF WOMEN WHO BELIEVE THAT A WOMAN IS JUSTIFIED IN ASKING THAT THEY USE A CONDOM IF SHE KNOWS THAT HER HUSBAND HAS A SEXUALLY TRANSMITTED INFECTION, 18 WESTERN AND CENTRAL AFRICAN COUNTRIES[157]



Source: *Demographic and Health Surveys, 2010-2015.*

FIGURE 7 - PERCENTAGE OF WOMEN WHO BELIEVE THAT A WOMAN IS JUSTIFIED IN ASKING THAT THEY USE A CONDOM IF SHE KNOWS THAT HER HUSBAND HAS A SEXUALLY TRANSMITTED INFECTION, 13 EASTERN AND SOUTHERN AFRICAN COUNTRIES[153]



Source: *Demographic and Health Surveys, 2010-2015.*

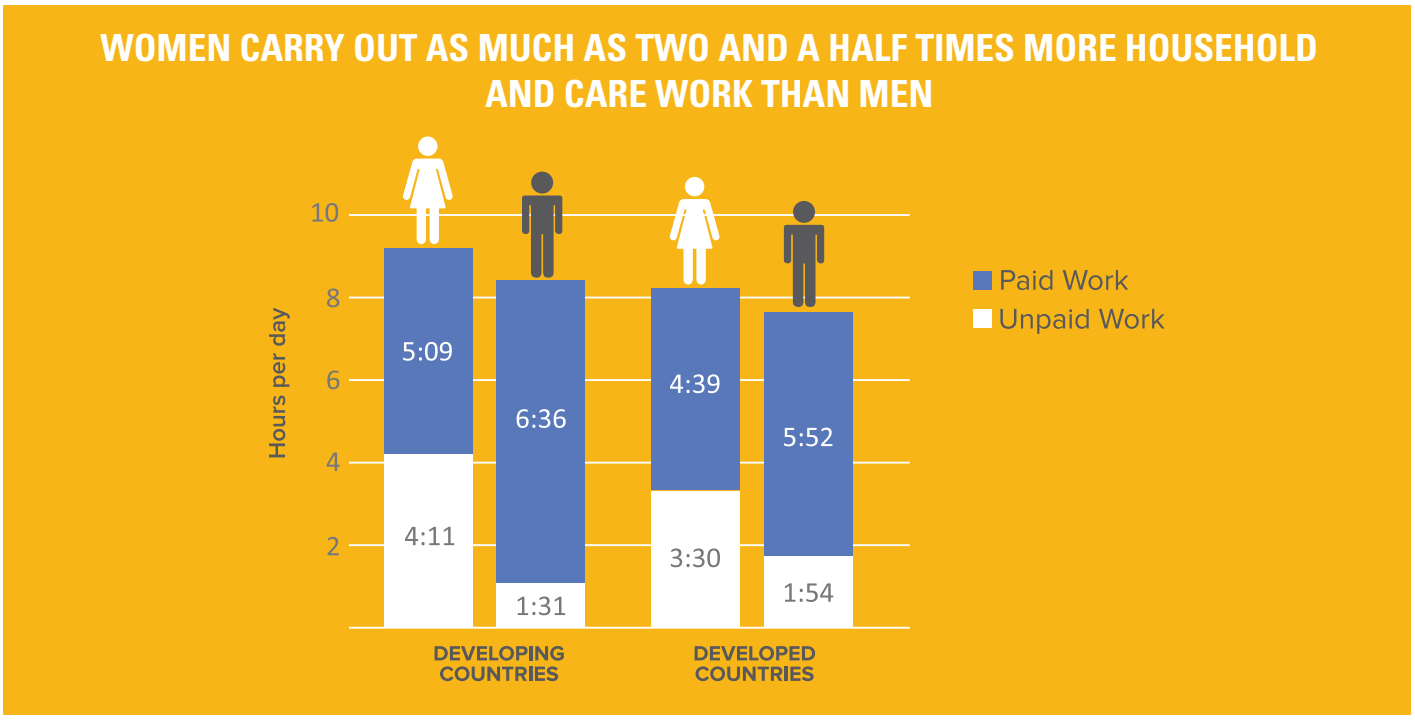
Around the world as well as in Africa, women's leadership and political participation is limited. Women are underrepresented as voters, as well as in leading positions, whether in elected office, the civil service, the private sector or academia.[154] This occurs despite their proven abilities as leaders and agents of change, and their right to participate equally in democratic governance[154].

The underrepresentation of women in leadership is reflected in the HIV response, where women living with HIV and their organisations are not always included in decisions that guide policies and programmes on HIV.[154] The rights of women, particularly women living with HIV, to participate are often overlooked, and their potential contributions of leadership and perspectives on the epidemic are lost. Addressing HIV requires actions on all fronts and will only be effective when women's roles and priorities, as determined by them, are fully integrated in all aspects of decision-making[154].

4.5 HIV AND ECONOMIC EMPOWERMENT

Unequal gender norms dictate the roles of women and girls within households in various contexts around the world – they tend to assign higher levels of domestic work and caregiving responsibilities to girls and women.[155] From cooking and cleaning to fetching water and firewood or taking care of children and the elderly, women carry out at least two and a half times more unpaid household and care work than men.[156] It is estimated that women spend an average of 4.5 hours per day doing unpaid work, as compared with just over two hours for men. As a result, women have less time to engage in paid labour, which ultimately impacts their economic independence, security, and control.[157]

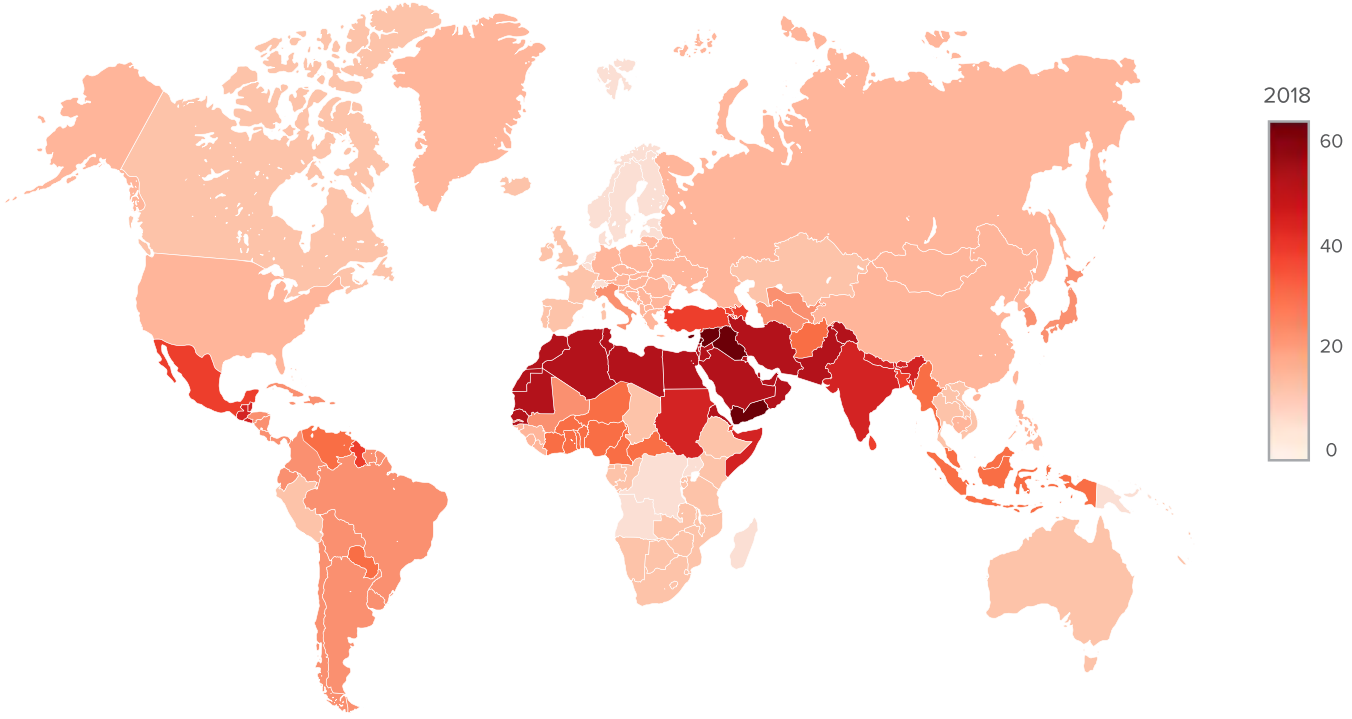
FIGURE 8 - TIME SPENT ON PAID AND UNPAID WORK FOR EMPLOYED PERSON BETWEEN MEN AND WOMEN IN 23 DEVELOPING COUNTRIES (LATEST DATA AVAILABLE)



The burden of unpaid work is felt by women across socioeconomic classes.[158] But it is more severely experienced by the poorest and most disadvantaged women.[159] This is the reality of many women in Africa whose work subsidises the cost of care that sustains families, supports economies and often fills in for the lack of social services. Yet, it is rarely recognised as "work".[160]

There is also a significant gender gap in the global labour force[162]. In 2018, the global gender gap in labour force participation stood at 27%[161]. The global average, however, mask significant variations among regions, the gap is most pronounced in North Africa were fewer than one-third of women of working age participate, whereas, in Sub-Saharan Africa, nearly two-thirds participate, see figure below[161]. Based on data from 84 countries, 95% of men aged 25 to 54 years are in the labour force, compared to just 52% of women. The main reason reported by women for being out of the labour force was unpaid care work[159].

FIGURE 9 - LABOUR FORCE PARTICIPATION ON GENDER GAP, PERCENTAGE POINTS, 2018



Of the women who are in the workforce, more than half are in the informal sector, often in jobs that lack security or rights.[162] As a result of the inequalities in access to income and resources, low-income women are often left economically dependent on male partners.[163]

Women's economic vulnerability and dependence on men increases their vulnerability to HIV.[164] The economic disadvantages women face can start as early as childhood, with girls facing a lack of opportunity and lower levels of investment in their health, nutrition, and education.[165] Throughout their lifetime, African women continue to encounter disadvantages in education, health, and income-generating activities. They tend to have significantly lower human capital endowments than men; worse access to labour markets; lower wages; more limited access or title to productive assets (such as land, credit, and other inputs); fewer political and legal rights; and more stringent constraints on mobility and socially acceptable activities.[166] As a result, gender inequality can trap women in poverty and generate a negative vicious cycle that impacts education and health outcomes for their children.[166]

The lower economic status of women leads to economic dependence on men, making it challenging and sometimes even dangerous for women to negotiate relations. Also, many low-income women have more immediate worries, such as paying rent or having enough food,[167] which may reasonably take precedence over protecting themselves from HIV. Therefore, women's economic dependence greatly limits their decision-making power and increases their vulnerability to HIV.

4.6 HIV AND GIRLS EDUCATION

Equitable access to quality education is a human right. Every child has a right to learn and get a good quality education, regardless of gender, where they live or their circumstances.[168] Yet, despite evidence demonstrating how central girls' education is to development, gender disparities in education persist.[169] Across Africa, large gender gaps exist in access, learning achievement and continuation in education in many settings, most often at the expense of girls.[170]

Educating a girl is one of the best investments her family, community, and country can make. We know that a good quality education can be life-changing for girls, boys, young women, and men, helping them develop to their full potential and putting them on a path for success in their life. We also know that educating a girl, in particular, can kick-start a virtuous circle of development. More educated girls, for example, marry later, have healthier children, earn more money than they invest back into their families and communities, and play more active roles in leading their communities and countries.[171]

Education helps girls and women achieve greater control over their lives and confers them the power to make choices that can prevent HIV infection.[172],[173] Studies show girls who complete primary education are more than twice as likely to adopt protective behaviours; girls who complete secondary education are between four and seven times more likely to adopt protective behaviours, and they are less likely to be infected with HIV, girls educated to secondary and tertiary levels are less likely to be coerced.[173] Higher levels of education also translate into higher earning power in the job market. Every additional year of primary school boosts girls' eventual wages by 10% – 20%, and an extra year of secondary school by 15% – 25%.[174]

Multiple studies have shown that staying in school longer has a protective benefit in reducing the risk of HIV infection.[175],[176],[177],[178] For example, after compulsory and free secondary education was expanded in Botswana, each additional year of secondary schooling led to an 8.1% reduction in the cumulative risk of HIV infection, and a 11.6% reduction in HIV risk among young women in particular.[179] Higher levels of educational attainment among women are also associated with increased control over sexual and reproductive health and reproductive rights.[180] Positive effects of enrolment in secondary school on reduced sexual risk-taking behaviour and rates of HIV infection were also found in Uganda and Zimbabwe, respectively.[181],[182]

Despite evidence for the multiple benefits of remaining in school, girls and young women in Africa face significant barriers to education, driven by poverty, unequal social and cultural norms (such as domestic work and caring for relatives), harmful practices (such as child, early and forced marriage), poor infrastructure, gender-based violence and instability.[183] Across the region, 9 million girls between the ages of about 6 and 11 will never go to school at all, compared to 6 million boys, according to UIS data. Their disadvantage starts early: 23% of girls are

out of primary school compared to 19% of boys. By the time they become adolescents, the exclusion rate for girls is 36% compared to 32% for boys.[184] Patriarchal norms that devalue the education of women and girls also limit their opportunities to access and stay in education. In a study analysing the most difficult countries to get an education around the world, nine of the top 10 most difficult nations for girls to be educated are in Africa.[185] Furthermore, no African country appears in the top 25% quartiles, and only four African countries ranked above the median quartile.[185] Without urgent action, the situation will likely get worse as the region faces a rising demand for education due to a still-growing school-age population.[186]

COVID-19 has a negative impact on girls' health and well-being – and many are at risk of not returning to school once they reopen.[187] Research available shows that the prevalence of violence against girls and women has increased during the pandemic – jeopardising their health, safety, and overall well-being.[188] As school closures and quarantines were enforced during the 2014-2016 Ebola outbreak in West Africa, women and girls experienced more sexual violence, coercion and exploitation. School closures during the Ebola outbreak were associated with an increase in teenage pregnancies.[189] Once schools re-opened, many "visibly pregnant girls" were banned from going back to school. With schools closing throughout the developing world, where stigma around teenage pregnancies prevails, we will probably see an increase in drop-out rates as teenage girls become pregnant or married.

As girls stay at home because of school closures, their household work burdens might increase, resulting in girls spending more time helping out at home instead of studying. This might encourage parents, particularly those putting a lower value on girls' education, to keep their daughters at home even after schools reopen. Moreover, research shows that girls risk dropping out of school when caregivers are missing from the household because they typically have to (partly) replace the work done by the missing caregiver, who might be away due to COVID-19-related work, illness, or death.[190] Therefore, with the current COVID-19 pandemic, we might see more girls than boys helping at home, lagging on their studies, and dropping out of school.

4.7 DISCRIMINATORY LEGAL FRAMEWORKS

Discriminatory laws that restrict the rights of women may inadvertently undermine their health-seeking behaviour. These are seen in plural legal systems; criminalisation of HIV and legal barriers to access to sexual and reproductive health and reproductive rights information and services.

4.7.1 PLURAL LEGAL SYSTEMS

Plural legal systems are jurisdictions in which both formal legal systems and alternative informal justice systems, such as customary, tribal, religious, personal and traditional law, operate in parallel. Although exact figures are difficult to obtain, evidence indicates that a significant number of women in the developing world access informal justice systems, with up to 80% of disputes in some countries resolved through informal justice mechanisms.[191] A UNDP report notes that in some countries in Africa, well over half of all disputes are resolved in customary or religious forums.[192] Social and economic issues significant to women's daily lives are frequently administrated and adjudicated in informal justice systems.[193]

A challenge with plural legal systems is that incoherence in approaches to rights and obligations determined by both formal and informal laws often results in rights being denied rather than protected.[194] Plural legal systems present a challenge to the HIV response for women and girls as legal plurality often legitimises and perpetuates discriminatory laws, harmful traditional practices, violence against women and unequal property and inheritance systems that drive the HIV epidemic in women and girls.[195]

4.7.2 CRIMINALISATION OF HIV

Criminal law significantly affects women and girls living with HIV, often increasing their risk of intimate partner violence, sexual violence and physical abuse.[196] Women and girls are directly and indirectly impacted by criminal law provisions including access to reproductive health services and confidentiality of HIV status. As of 2019, 29 African countries have laws that criminalise HIV either non-disclosure, exposure or transmission, including unintentional transmission.[197]

FIGURE 10 - AFRICAN COUNTRIES WHERE HIV-SPECIFIC LAWS EXIST[198]

Statutes allow the use of HIV status to aggravate criminal charges in some countries. These laws and the prosecutions stemming from them do not always rely on or defer to the best available scientific evidence of HIV-related risks and harms, resulting in unjust prosecutions and convictions.[199]

In contexts with HIV criminalisation, women and girls living with HIV are at significant risk of prosecution. This is because women are often the first to know their HIV-positive status (a prerequisite for most HIV criminalisation prosecutions), due to increased interaction with the healthcare system, including because of provider-initiated testing and counselling programmes during antenatal visits.[200] Women are more likely than men to take an HIV test and to initiate and adhere to HIV treatment.[201] Women living with HIV risk prosecution for HIV exposure and transmission due to childbirth and breastfeeding.[202] Women living with HIV who disclose their status risk domestic violence, abandonment, loss of property and loss of child custody; meanwhile, they risk criminal prosecution and imprisonment for failing to disclose.[203] At the same time, women and girls are least likely to have access to legal services and, thus, a fair trial.[204]

4.7.3 LEGAL BARRIERS TO ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND REPRODUCTIVE RIGHTS SERVICES

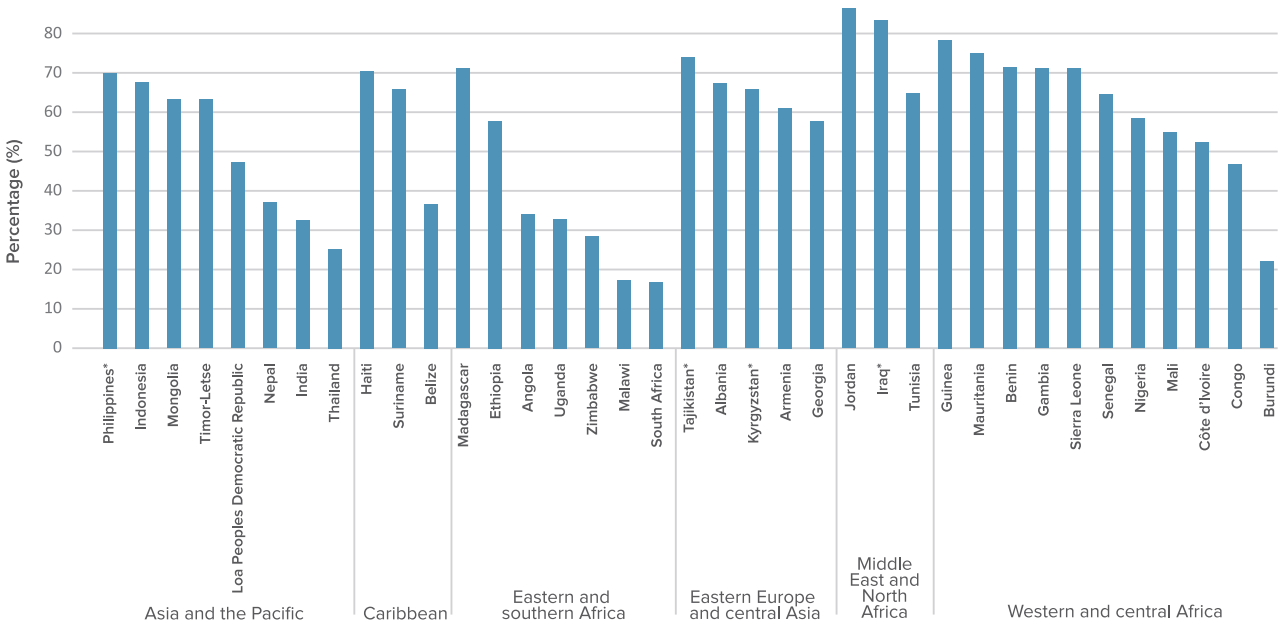
Young people are particularly vulnerable to HIV for physiological and social reasons. However, adolescents face legal and policy barriers to HIV testing and counselling, those related to requirements for parent or guardian consent to access HIV testing and counselling services.[205] Legal barriers to young people's access to sexual reproductive health services impede progress in addressing HIV prevention, treatment and care.[206] In Sub-Saharan Africa, women between the ages 15-24 accounted for almost half of the new infections in 2018 despite being only ten percent of the population.[207]

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) – lauded as one of the most progressive instruments on the rights of women and girls' reproductive health rights enjoins Member States to ensure the rights of women to health including protection from HIV. This includes by taking steps such as abolishing all discriminatory laws, promoting young girls' access to education, ensuring women's legal rights to land, property, and inheritance rights and providing employment and workplace protection. It furthermore requires protection from violence and sexual abuse and the prohibition of customary laws and practices that are harmful to women.[208]

4.8 HIV STIGMA AND DISCRIMINATION

HIV-related discrimination is the unfair and unjust treatment of a person or group of people based on their real or perceived HIV status.[209] Despite decades of scientific advances in prevention and treatment, as well as widespread awareness-raising efforts, irrational fears of HIV infection and negative attitudes towards people living with HIV are a persistent barrier to addressing the epidemic.[209] The impact of stigma can be immense. It can be felt at many different levels – from the mental and physical well-being of an individual to the ability of health systems to reach those most in need and of governments to lead effective and rights-based responses.[210] Results of population surveys show that stigma and discriminatory attitudes are highly prevalent in Africa, see figure.[211]

FIGURE 11 - PERCENTAGE OF PEOPLE AGED 15 TO 49 YEARS WHO REPORT DISCRIMINATORY ATTITUDES TOWARDS PEOPLE LIVING WITH HIV, COUNTRIES WITH AVAILABLE DATA, 2014–2019[212]



Stigma and discrimination can be obvious, for example when a person living with HIV is refused a health service. But it can also be more subtle, for example when a person is not fully included in group activities. Individuals, organisations, institutions, or systems can stigmatise or discriminate, or both, against people based on HIV status. People living with HIV can also stigmatise themselves – 'self-stigma'. For example, someone living with HIV may choose to exclude themselves from a social event because they feel or perceive that they will not be welcome.

Discrimination can become institutionalised in laws, policies, and practices that negatively focus on people living with HIV. HIV-specific laws, such as those criminalising HIV non-disclosure, exposure, and transmission, further entrench stigma and discrimination.[209]

Existing gender-based inequalities are compounded and, in turn, exacerbated by HIV stigma and discrimination. As a result, women and girls living with HIV often experience an interwoven and over-lapping jigsaw of stigma – due to their HIV status and being female.

4.8.1 STIGMA AND DISCRIMINATION – A BARRIER TO ACCESSING HEALTH SERVICES[213]

Health-care settings can be a source of stigma and discrimination, as well as care and treatment, for people living with HIV.[214],[215],[216] Examples include unnecessary delays in treatment, differential care (e.g. avoiding physical contact, inadequate management of pain, separation of prevention of mother-to-child transmission services from other maternal and child health services), conditional care (e.g., granting access to antiretroviral therapy only on the condition of condom or contraception use), neglect (e.g. withholding food, water or hygiene), or refusal of service—all of which directly obstruct access to appropriate health care.[217]

For women living with HIV, HIV-related stigma can be a major barrier to accessing HIV services as well as other health services. This can be observed in the continuum of healthcare services which women use throughout their lives. Within mainstream services – such as government antenatal programmes – women living with HIV may face stigmatising attitudes and inappropriate actions by both staff and other clients.[218]

Stigma may be exhibited through health workers using judgemental language, testing for HIV without consent, taking unnecessary precautions (e.g., double gloving, wearing masks, burning bedsheets), or breaching confidentiality (e.g., gossiping, disclosing to family members without permission). Such displays of stigma and discrimination can impede access to healthcare through discouraging women living with (or who suspect they may be living with) HIV from seeking necessary testing and treatment.[214],[215],[219],[220],[221],[222]

HIV-related stigma can limit women's access to prevention of mother-to-child transmission (PMTCT) services.[223] Each component of PMTCT – from receiving home visits to taking antiretroviral therapy (ART) – risks revealing the woman's status in the health facility, her community and or family.[213] As a result, women may not access relevant services – for fear of revealing their HIV status and experiencing negative consequences such as abandonment and isolation by partners and family.[224],[225]

> *"The fight against HIV/AIDS requires leadership from all parts of government - and it needs to go right to the top. AIDS is far more than a health crisis. It is a threat to development itself."*
>
> Kofi Annan

4.8.2 STIGMA AND DISCRIMINATION IN WORK SETTINGS

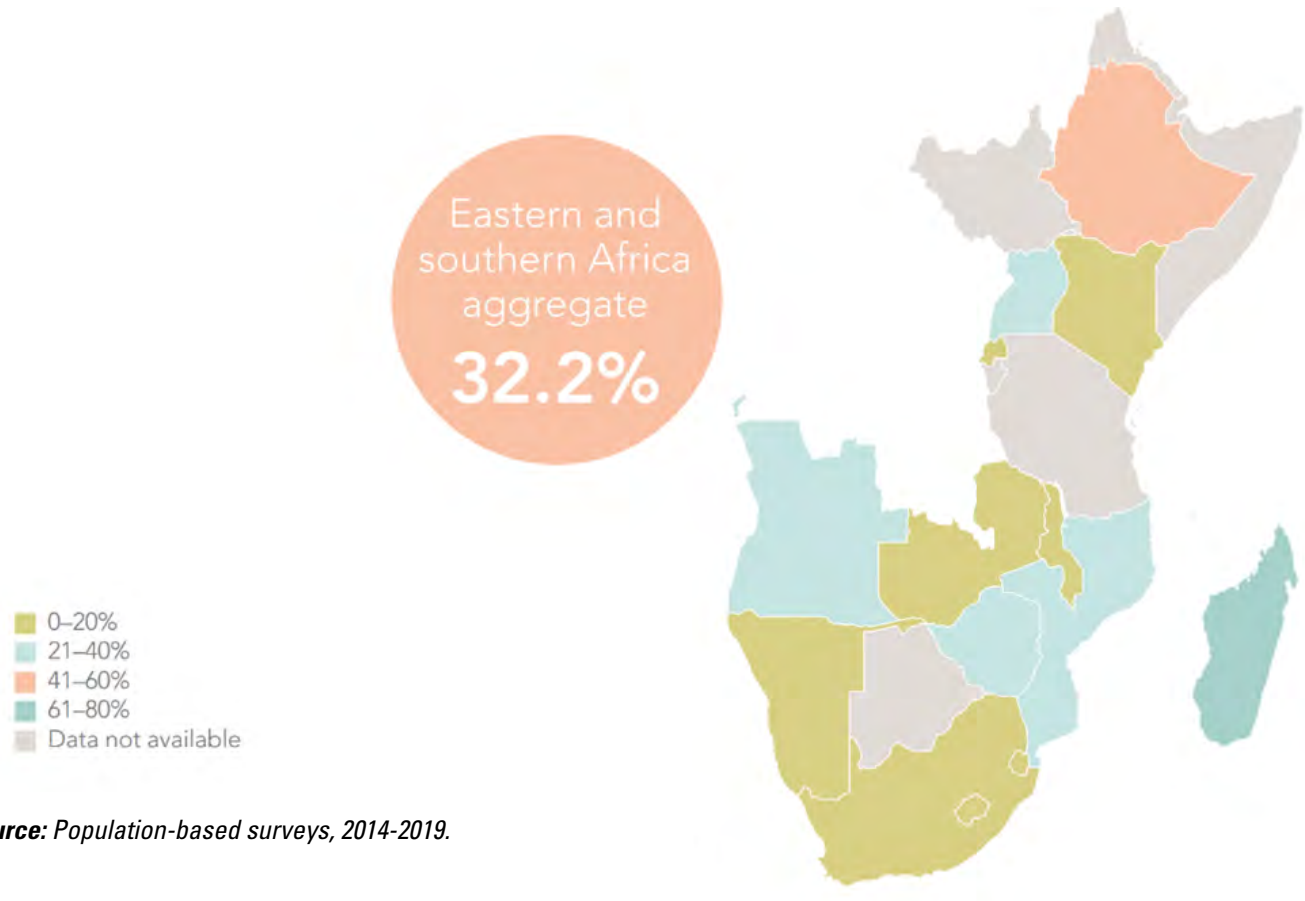
The majority of people living with HIV globally are of working age (15 years and older) and, with proper care and support, have the potential to be valuable members of the workforce.[226],[227] Workplace settings comprise all settings in which workers work, including formal (traditional wage employment) and informal (e.g. street vending, house cleaning) economies. The formal economy includes employment in both the private and public sectors.

People living with HIV are three times as likely to be unemployed as people in the general population.[228] This is partly due to the HIV-related stigma and discrimination they face in workplace settings. Examples of workplace to discriminatory practices include; refusal to hire a person living with HIV; harassment; bullying; forced testing or disclosure; denial of work opportunities or promotion; pressure to resign or wrongful termination of employment.[229],[230],[231]

Gender dimensions persist in many formal workplace settings around the world and in Africa and can exacerbate experiences of HIV-related stigma – which can negatively impact the livelihood and well-being of women living with HIV.

More women than men work in the informal sector in jobs that lack security and regulation and their often-marginal work might be jeopardised by discrimination from the community.[216]. For example, community members may choose to buy fruit and vegetables from different vendors because of their HIV status. On average 32% people in Eastern and Southern Africa and 52% of people in Western and Central Africa would not purchase vegetables from a shopkeeper with HIV. Data from North Africa was unavailable.[232] In more formal employment settings, women may be more vulnerable to discriminatory practices by employers, fellow employees and clients[213].

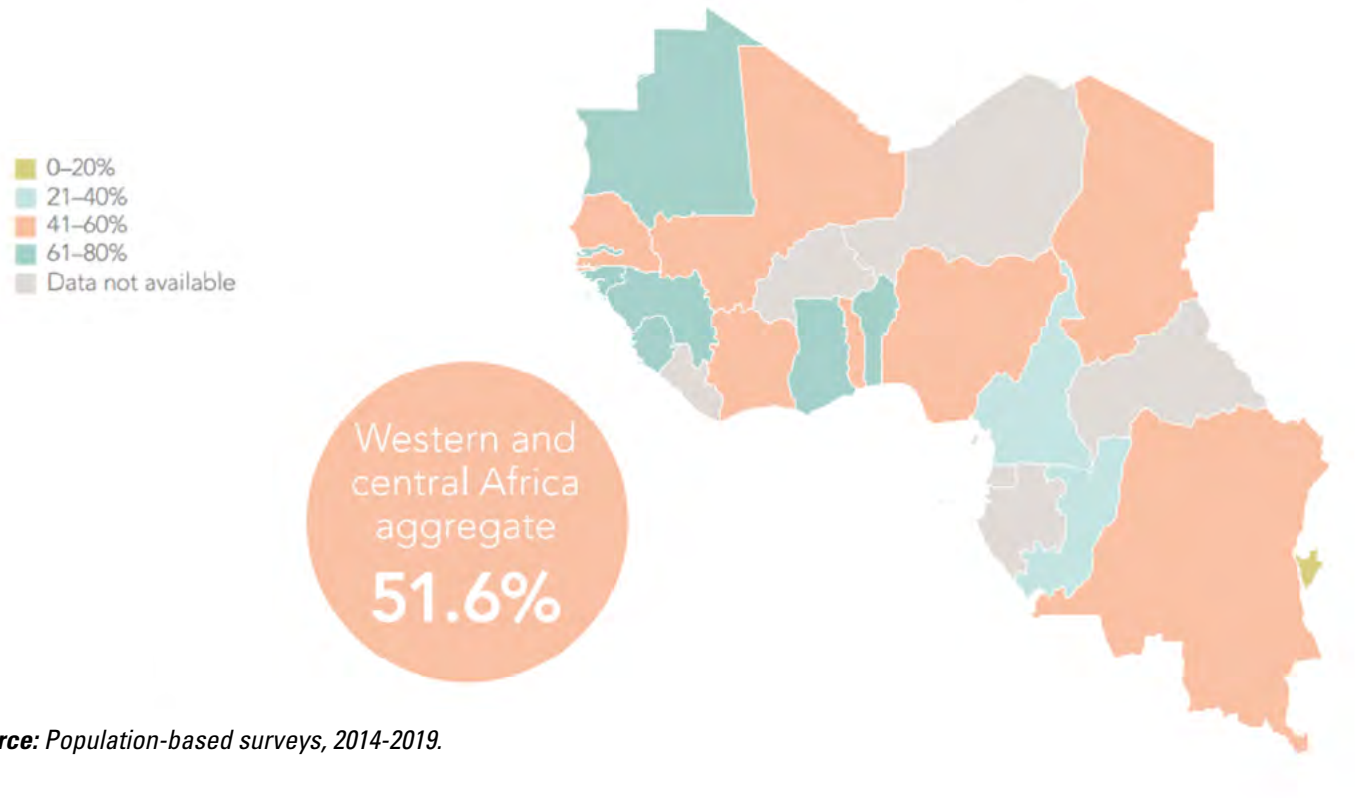
FIGURE 12 - PERCENTAGE OF PEOPLE AGED 15–49 YEARS WHO WOULD NOT PURCHASE VEGETABLES FROM A SHOPKEEPER LIVING WITH HIV, COUNTRIES WITH AVAILABLE DATA, EASTERN AND SOUTHERN AFRICA, 2014–2019



Source: *Population-based surveys, 2014-2019.*

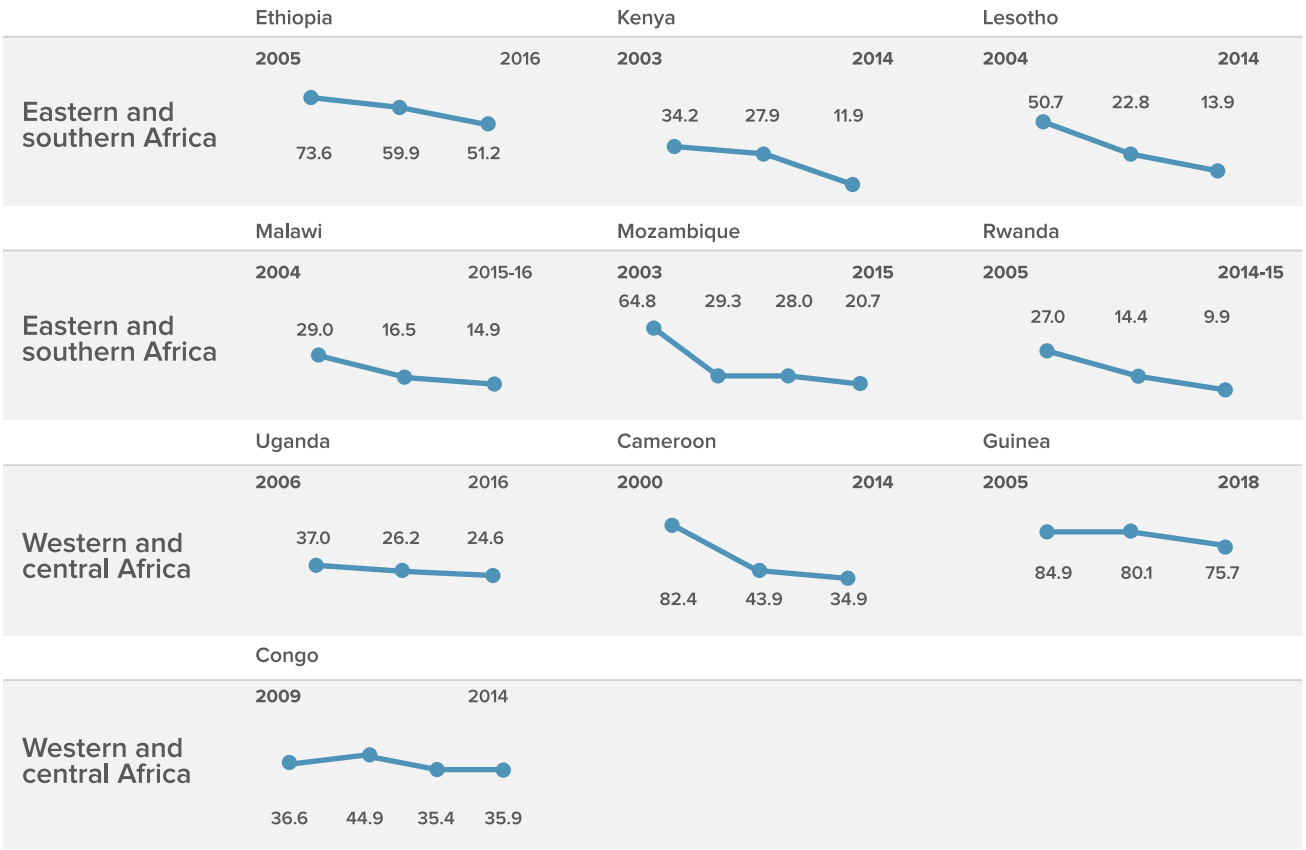
Note: There is a lack of data coming out of North Africa and further research is require to fill in these data gaps

FIGURE 13 - PERCENTAGE OF PEOPLE AGED 15–49 YEARS WHO WOULD NOT PURCHASE VEGETABLES FROM A SHOPKEEPER LIVING WITH HIV, COUNTRIES WITH AVAILABLE DATA, WESTERN AND CENTRAL AFRICA, 2014–2018



Source: *Population-based surveys, 2014-2019.*

FIGURE 14 - PERCENTAGE OF PEOPLE AGED 15 TO 49 YEARS WHO WOULD NOT BUY VEGETABLES FROM A SHOPKEEPER LIVING WITH HIV, COUNTRIES WITH AVAILABLE DATA, 2000–2019



Results from population surveys in African countries where data is available show that discriminatory attitudes are declining.

In order to keep up with regular check-up woman living with HIV may repeatedly need to take considerable time of work to attend hospital and other appointments, particularly when travelling from rural areas. This can mean a loss of income or a poor attendance record. As a result, women living with HIV may decide not to attend the clinic for fear of being penalised or being discovered by their employers.[213]

Although women living with HIV are able to lead full and active working lives, many may decide to reduce or change their employment because of their HIV status. For example, they may prefer to work in the informal sector in jobs that are less scrutinised – to avoid having to disclose their status. On occasion, women living with HIV may be unable to work – because of their own ill health or if they have to take care of other family members – which leads to a loss of income. The result can mean hardship and poverty.[213]

Many women living with HIV are also fully able to access education. However, they may anticipate or experience HIV stigma and discrimination in schools, including bullying and violence; neglect, avoidance and isolation; breaches in confidentiality; and denial of enrolment of students or loss of employment for educators.[233],[234],[235],[236] These manifestations of stigma and discrimination can have serious repercussions on their health and well-being.[217]

4.8.3 STIGMA AND DISCRIMINATION IN COMMUNITY AND SOCIAL SETTINGS

In community settings, HIV-related stigma and discrimination can manifest through subtle gestures (e.g. refusing to share food or utensils with people living with HIV) or more overt actions (e.g. verbal abuse towards, gossip about, rejecting or shunning a person living with HIV). The social judgement of household and community members can result in internalised stigma (self-stigma) among people living with HIV or anticipated stigma among people who think they may be living with HIV. Such experiences may prompt self-isolation and deter disclosure and engagement with HIV testing, care and treatment services, which in turn can result in harm to a person's mental and physical health and well-being.[237],[213]

In different communities across Africa, women's experience of HIV-related stigma and discrimination can vary depending on factors such as marital status and age; nevertheless, it can still immensely impact women's social interactions and behaviour. HIV-related stigma and discrimination can limit women's ability to participate in family and community life, maintain their mental health, adhere to medication, maintain their reproductive health and take care of their children.[213]

Families of women and girls living with them may be subject to HIV-related stigma and discrimination through association. This is particularly relevant in contexts where a family with a member living with HIV is held accountable for the behaviour of its members and is collectively met with HIV-related stigma and discrimination. As such, a family may be less supportive of a member disclosing their HIV-positive status and seeking health-care services.[237],[238]

Stigma can be particularly intense for women living with HIV who live in close-knit communities that play a central role in their lives. They may be forced into 'protective silence' which means that they do not seek support from the community or services – including in terms of accessing ART and other medication – for fear of rejection by their family members and loss of shelter, status, stability and access to their children.[213]

4.9 HIV, DISABILITY, REFUGEE STATUS, DRUG ABUSE, AND OTHER CRISIS SITUATIONS, INCLUDING COVID-19

Over the last two decades, complex emergencies resulting from conflict and natural disasters have occurred with increasing frequency throughout Africa. Since 2010, violent conflicts have spiked dramatically, and despite efforts by various stakeholders to ensure peace and stability in Africa, armed conflicts continue in several parts of the continent.[239],[240] Currently, there are seven peacekeeping operations and many other humanitarian operations.

Furthermore, climate change, rising inequality, demographic change and other trends continue to create fragility risks.[239] 2019 will be remembered as the year the climate crisis devastated parts of East and Southern Africa, with floods, landslides, drought and cyclones leaving at least 33 million people at emergency levels of food insecurity or worse.[141] Across the continent, 600 million people live in countries affected by fragility.

The very conditions that define fragility - conflict, social and economic instability, poverty and powerlessness - are also the conditions that facilitate the spread of HIV/AIDS. Humanitarian emergencies and conflict disrupt normal social and economic structures and activities and often involve mass displacement.[242] The breakdown of social cohesion, lack of income, shortage of food, sexual violence, increased drug use and the disruption of health, education and infrastructure that characterise complex emergencies all contribute to putting populations affected by these crises at greater risk of HIV and present challenges for those living with HIV.[243] Essential HIV services may be disrupted during situations of humanitarian crises. People may no longer have access to information about HIV prevention or to services for PMTCT.[242]

People living with HIV often suffer from disruption of ART and treatment for opportunistic infections. Displacement may bring populations, each with different HIV/ AIDS prevalence levels, into contact. This is especially true in the case of populations migrating to urban areas to escape conflict or disaster in the rural areas.

Disease outbreaks affect women and men differently, and epidemics make existing inequalities for women and girls and discrimination of other marginalised groups such as persons with disabilities and those in extreme poverty, worse. This deserves specific attention, given the different impacts surrounding detection and access to treatment for women and men, as well as for their overall well-being.

Conflict and emergency situations augment the intersections of GBV and HIV. In crisis situations, women and children are at increased risk of violence. Studies report that seven out of 10 women in conflict settings and in refugee populations are exposed to sexual and gender-based violence. In certain contexts, women who have experienced violence are 50% more likely to be living with HIV.[244]

The COVID-19 (coronavirus) pandemic is exacerbating already existing risks of violence. Sexual and gender-based violence (SGBV), and particularly intimate partner violence (IPV), has spiked dramatically during the COVID-19 pandemic and has been labelled by global leaders as a "pandemic within a pandemic"[245] Reports released by UNDP and UNFPA shows that GBV has significantly increased during COVID-19 outbreak with UNFPA estimating that estimates that "6 months of lockdowns could result in an additional 31 million cases of gender-based violence".[246]

Pre-existing toxic social norms and gender inequalities, economic and social stress caused by the COVID-19 pandemic, coupled with restricted movement and social isolation measures, have led to an exponential increase in GBV. Many women are in 'lockdown' at home with their abusers while being cut off from normal support services.[247]

In recognising that African girls and women bear a disproportionate global disease burden from the HIV/AIDS pandemic due to the factors outlined above, the global and continental development and health stakeholders have put weight behind a shared commitment to advance universal access to integrated SRH&RR and HIV/AIDS services. These commitments are highlighted below with some of the good practices that have been witnessed on the continent as a contribution to south-to-south learning across AU Member States.

5 GLOBAL POLICY AND LEGAL COMMITMENTS ON GEWE AND HIV

There are several international commitments which recognise that tackling gender inequality is vital to ending the global HIV epidemic and achieving wider development outcomes.

> *"Empowering women and girls…with the agency to claim their rights, receive a quality education, enjoy healthy lives and take measures to protect themselves from HIV is a requisite component of combination HIV prevention—structural change that reflects the interconnected nature of the Sustainable Development Goals."*[248]
>
> Phumzile Mlambo-Ngcuka, Executive Director, UN Women[249]

Several internationally agreed norms and standards relating to women and HIV and AIDS were adopted globally. The most prominent are[250]:

- **1994 International Conference on Population and Development,** Programme of Action: It recognises women's particular vulnerability to HIV infection. Chapter 7 of Article C addresses sexually transmitted diseases and HIV prevention in the context of reproductive health services. Recommendations for dealing with the gender dimensions of the epidemic call for "special attention to girls and women."
- The **Beijing Declaration and Platform for Action** calls for the involvement of women in HIV/AIDS policies and programmes; the review and amendment of laws that contribute to women's vulnerability to HIV and AIDS and implementation of legislation, policies and practices to protect women and girls from HIV/AIDS-related discrimination; and the strengthening of national capacity to create and improve gender-sensitive policies and programmes on HIV/AIDS.
- The **Convention on the Elimination of All Forms of Discrimination against Women** (CEDAW) and its **General Recommendations** contain important substantive provisions for advancing gender equality. They equip states parties with tools to promote the full realisation of women's human rights, including in developing gender-sensitive national responses to HIV/AIDS.
- **Millennium Development Goal 6** aimed to halt and reverse the spread of HIV by 2015. The world **met and exceeded** these targets by achieving a 35-per-cent reduction in new infection rates, a 41-per-cent decrease in AIDS-related deaths, and 15 million people on antiretroviral treatment.
- Building on the Millennium Development Goals, the 17 **Sustainable Development Goals** (SDGs) seek to end poverty by 2030 and promote social development, economic prosperity, and environmental protection for all. Goal 3 aims to ensure healthy lives and well-being, with a target to end AIDS by 2030. Goal 5 aims to achieve gender equality and empower all women and girls. These goals, along with all others, are critical roadmaps to address the cross-cutting gender inequalities in the HIV epidemic.
- The **2001 UN General Assembly declaration of commitment on HIV/AIDS** stressed that gender equality and women's empowerment were fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS. The **2006 Political declaration on HIV/AIDS** recognised that the promotion of gender equality and women's empowerment and the protection of the rights of the girl child must be key components of any comprehensive strategy to combat the epidemic. In the **2011 Political declaration on HIV/AIDS: Intensifying our efforts to eliminate HIV/AIDS**, UN Member States pledged to increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, and to take all necessary measures to create an enabling environment for empowering women. In the **2016 Political declaration on HIV and AIDS: On the fast-track to accelerate the fight against HIV and to end the AIDS epidemic by 2030**, UN Member States made firm commitments to achieve gender equality and empower all women and girls as part of the efforts to end AIDS by 2030. The Declaration calls upon the Member States to implement gender-responsive[250] national HIV strategic plans, promote women's leadership and engagement in the HIV response, address intersections of HIV, violence against women and harmful practices, and protect women's sexual and reproductive health and reproductive rights. The Declaration includes a specific focus and target to reduce new HIV infections in adolescent girls and young women.
- Human Rights Council resolutions on the protection of human rights in the context of HIV and AIDS include **resolution 16/28**. Adopted in 2011, it stresses ensuring the availability, accessibility and affordability of medicines and health care services for HIV-positive pregnant women. It also calls for establishing or expanding gender-sensitive national HIV/AIDS policies and programmes.
- **UN Security Council resolution 1983** from 2011 notes the disproportionate burden of HIV and AIDS on women. It urges Member States, UN entities, international financial institutions and other relevant stakeholders to support national health systems and civil society networks in assisting women living with or affected by HIV in conflict and post-conflict situations. **Security Council resolution 1308**, adopted in 2000, addresses the HIV and AIDS–related responsibilities of international peacekeeping operations.
- The **UN Commission on the Status of Women** has passed resolutions on women, the girl child, and HIV and AIDS, including **resolution 60/2** in 2016. It has issued agreed conclusions on the **equal sharing of responsibilities between women and men, including caregiving in the context of HIV and AIDS** in 2009, and on **women, the girl child and HIV/AIDS** in 2001.

6 CONTINENTAL POLICY AND LEGAL COMMITMENTS ON GEWE AND HIV

Continentally, the AU has shown exceptional leadership in uniting Africa's leaders to leverage on the power of policies and accountability mechanisms as efficacious tools to fight AIDS on the continent.

6.1 AGENDA 2063

Agenda 2063 is Africa's blueprint and master plan for transforming Africa into the global powerhouse of the future. It is the continent's strategic framework that aims to deliver on its goal for inclusive and sustainable development and is a concrete manifestation of the pan-African drive for unity, self-determination, freedom, progress and collective prosperity pursued under Pan-Africanism and African Renaissance. The genesis of Agenda 2063 was the realisation by African leaders that there was a need to refocus and reprioritise Africa's agenda from the struggle against apartheid and the attainment of political independence for the continent which had been the focus of The Organisation of African Unity (OAU), the precursor of the African Union; and instead to prioritise inclusive social and economic development, continental and regional integration, democratic governance and peace and security amongst other issues aimed at repositioning Africa to becoming a dominant player in the global arena.

As an affirmation of their commitment to support Africa's new path for attaining inclusive and sustainable economic growth and development, African heads of state and government signed the 50th Anniversary Solemn Declaration during the Golden Jubilee celebrations of the formation of the OAU /AU in May 2013. The declaration marked the re-dedication of Africa towards the attainment of the Pan African Vision of An integrated, prosperous and peaceful Africa, driven by its own citizens, representing a dynamic force in the international arena and Agenda 2063 is the concrete manifestation of how the continent intends to achieve this vision within a 50 year period.

6.2 AFRICA HEALTH STRATEGY (AHS) 2016-2030

The goal of AHS 2016-2030 is to ensure healthy lives and promote the well-being for all in Africa in the context of "Agenda 2063: The Africa We Want" and the Sustainable Development Goals. The overall objective is to strengthen health systems' performance, increase investments in health, improve equity and address social determinants of health to reduce priority diseases burden by 2030.

Strategic Objective 2 of the AHS highlights 'Ending AIDS, TB and Malaria… as part of Reducing morbidity and ending preventable mortality.

This policy framework seeks to provide strategic direction to Africa's efforts in creating better performing health sectors, recognises existing continental commitments and addresses key challenges to reducing the continent's burden of disease, while also drawing on lessons learned and existing opportunities. Its strategic directions require multi-sectoral collaboration, adequate resources and leadership to champion its implementation coupled with effective accountability frameworks. In this light, the AHS 2016-2030 seeks to complete the unfinished agenda, adjust the course based on lessons learned from implementing AHS 2007-2015 and build on Member States and RECs achievements.

6.3 THE CATALYTIC FRAMEWORK TO END AIDS, TB AND ELIMINATE MALARIA IN AFRICA BY 2030

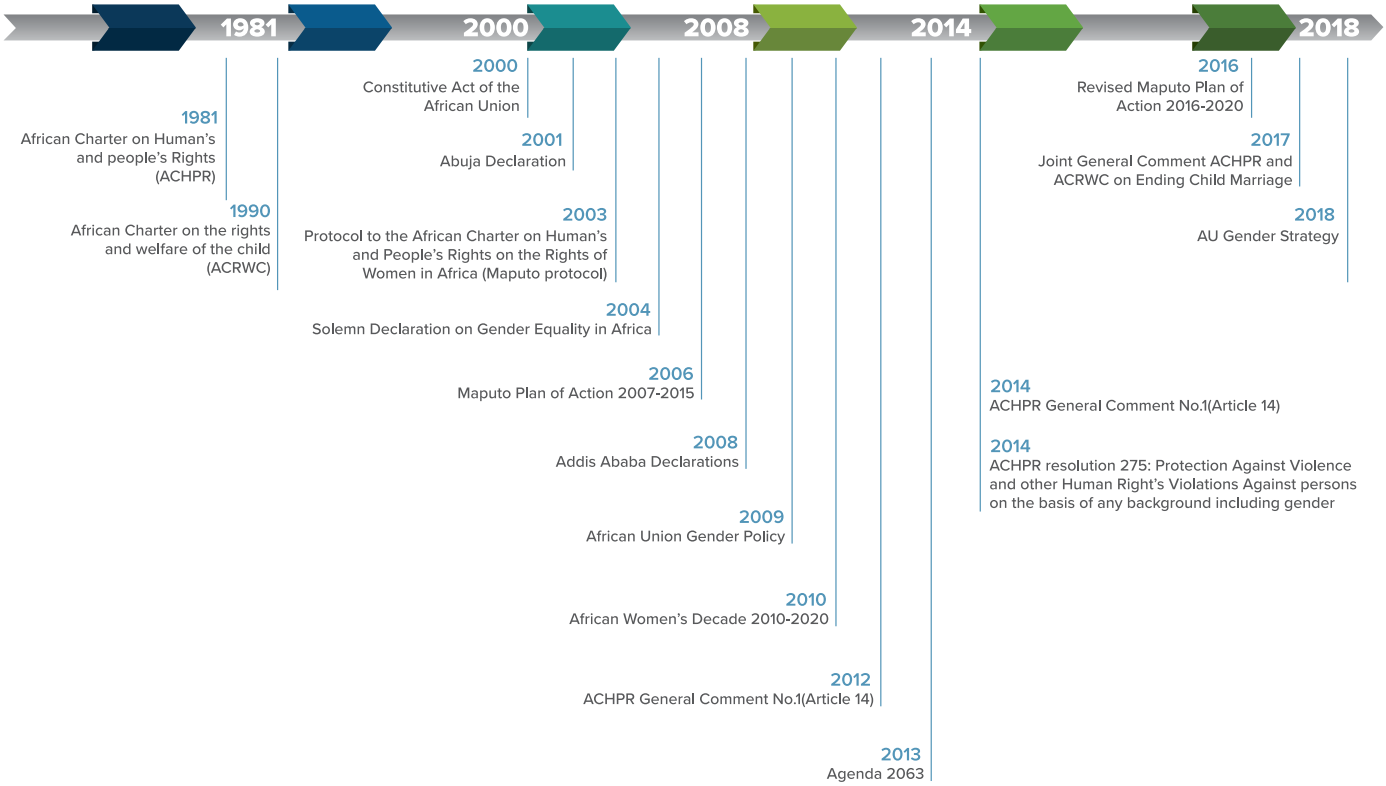
Endorsed in 2016, it has been dubbed Africa's blueprint to end HIV by 2030 and the most comprehensive policy framework after the Abuja Declaration on HIV/AIDS, TB and other related infections diseases. It presents a historic opportunity to end AIDS as a public health threat. This is because it was formulated based on the progress and experiences from the implementation of Abuja commitments since 2000 and the AU roadmap on shared responsibility and global solidarity for AIDS, TB and Malaria by the AU Member States. It seeks intensification of the commendable progress attained on the continent since 2001.

The strategy is premised on the idea that for Africa to achieve and sustain social and economic development, there is a need to address the major cause of the burden of disease. These causes include the impact of AIDS, TB and Malaria, arguably the top reasons for morbidity and premature mortality on the continent. Given these serious threats to African development, its leaders have demonstrated leadership and political will to combat these health vices. This framework identified gaps, challenges and opportunities that have existed on the African continent with the view to ending AIDS, TB and malaria in the context of the Abuja +12 targets.

The Catalytic Framework 2016-2030 was adopted with the vision to create an "Africa free of AIDS, tuberculosis and malaria".

It is expected that the African continent through the catalytical framework which is consistent with Agenda 2063 and Agenda 2030 will end these three diseases in Africa by 2030. Its approach is the coherent implementation of the targets in the AU Agenda 2063 and other global aspirations. Figure 15 below shows the key instruments and timelines.

FIGURE 15 - KEY INSTRUMENTS AND TIMELINES FOR THE PROMOTION AND REALISATION OF GEWE, SRH&RR AND HIV (ORIGINAL DIAGRAM TO BE UPLOADED WITH GRAPHIC SUPPORT)



6.4 THE AU GENDER EQUALITY AND WOMEN'S EMPOWERMENT STRATEGY

In 2018, the AU adopted its first Gender Equality and Women's Empowerment Strategy (2018–2028), to reaffirm its commitment to advancing gender equality. The Gender Strategy is instrumental in strengthening/catalysing gender mainstreaming in the AU in line with Agenda 2063,[251] the Maputo Protocol, and the Sustainable Development Goals (SDGs). Specifically, the Gender Strategy contributes to the realisation of Aspiration 6 of Agenda 2063 through the achievement of 'full gender equality in all spheres of life' and requires, among others, the ratification, domestication, and full implementation of the Maputo Protocol.[252] The AUC- Women, Gender and Youth Directorate (WGYD) carried out extensive consultative process involving AUC departments, divisions and organs, gender structures of the RECs, national gender machineries, UN system, local, national, regional and international CSOs and faith-based organisations.

Child marriage, FGM, GVAW and other harmful practices featured as prominent priorities, as did the eradication of preventable maternal mortality and HIV and AIDS.

The strategy urges Member States to ensure affordable and accessible SRH services, with specific emphasis placed on SRH&RR for youth (especially in terms of adolescent pregnancies, commercial sexual exploitation, lack of youth-friendly SRH services, and sexual violence/harassment in schools). The Gender Strategy is grounded on key GEWE and women's rights provisions in global and continental normative frameworks, including Agenda 2063 and the Sustainable Development Goals. Among the notable key commitments are.

- Aspiration 1 – A prosperous Africa based on inclusive growth and sustainable development
- Aspiration 3 – An Africa of good governance, democracy, respect for human rights, justice, and the rule of law.
- Aspiration 6 – An Africa, whose development is people-driven, relying on the potential of African people, especially its women and youth, and caring for children.[253]

Key transformational outcomes by 2023 include:

- Reducing all forms of violence against women by a third
- Ending all harmful social norms and customary practices
- Reducing the proportion of 2013 youth unemployment by a quarter

6.5 THE AFRICAN CHARTER ON HUMAN AND PEOPLES' HHRIGHTS (ACHPR) THE BANJUL CHARTER

The ACHPR has developed General Comments as well as Guidelines on specific topics, to provide interpretative guidance to member states on the Maputo Protocol provisions and the required state response on women and girls' rights.

It recognises that people living with HIV and those at risk are currently one of the most vulnerable groups exposed to serious violations of human rights in Africa.

It has five key articles,

- Article 2 – Non-Discrimination
- Article 16 – Right to Health
- Article 17 – Right to Education
- Article 18(4) – Elimination of Discrimination Against Women
- Article 22 – Right to Development

Currently, two countries have ratified the protocol with seven countries that ratified with reservations, mainly the provisions related to women and girls' rights, marriage, and access to safe abortion. 13 countries have not (yet) ratified the Maputo Protocol

6.6 THE MAPUTO PROTOCOL

This ground-breaking protocol on women and girls' rights was adopted in 2003 and came into force in 2005.

The Maputo Protocol[254] is a progressive instrument with strong provisions regarding VAW, harmful practices, FGM, child marriage, SRH and RRs , access to safe abortion, and HIV and AIDS.

It includes 32 articles and an explicit definition of discrimination against women and pays specific attention to vulnerable and marginalised women and girls. Some of these articles are:

- Article 2 – Elimination of Discrimination Against Women
- Article 3 – Right to Dignity
- Article 4 – Rights to Life, Integrity and Security of the Person
- Article 6 – Marriage[255]
- Article 8 – Access to Justice and Equal Protection Before the Law[256]
- Article 12 – Right to Education and Training

Progress on the ratification of the Protocol has been slow. Only 42 of the 55 AU Member States have ratified the treaty 16 years after its adoption.

6.7 THE SOLEMN DECLARATION ON GENDER EQUALITY IN AFRICA

In July 2004, the AU Member States adopted the Solemn Declaration on Gender Equality in Africa to reaffirm their commitment to gender equality, gender parity, and women and girls' human rights as enshrined in Art. 4(L) of the Constitutive Act of the AU as well as other international, regional, and national commitments.

The Solemn Declaration commits AU MS to;

- accelerate the implementation of gender-specific economic, social, and legal measures aimed at combating the HIV/AIDS pandemic and effectively implement both Abuja and Maputo Declarations on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Disease.
- commit to ensuring that treatment and social services are available to women at the local level making it more responsive to the needs of families that are providing care;
- enact legislation to end discrimination against women living with HIV/AIDS and for the protection and care for people living with HIV/AIDS, particularly women;

- increase budgetary allocations in these sectors so as to alleviate women's burden of care
- In addition, it commits OAU Member States to ensure women's full participation in peace processes; and to launch a campaign to end GBV; as well as to expand and promote gender parity; to ensure the education of girls and literacy of women; and to promote and protect all human rights for women. Some of the relevant provisions include.
    - Para 1 – Accelerate implementation of gender specific economic, social, and legal measures aimed at combating HIV/AIDS pandemic […];
    - Para 4 – Initiate, launch and engage within two years sustained public campaigns against gender-based violence…Reinforce legal mechanisms that will protect women at the national level and end impunity of crimes committed against women […]
    - Para 8 – Take specific measures to ensure the education of girls and literacy of women, especially in the rural areas, to achieve the goal of "Education for All

6.8 THE MAPUTO PLAN OF ACTION

Following the review of the Maputo Plan of Action 2007-2015, MPoA 2016-2030 was adopted built on ten strategic action areas, including: political commitment, health legislation, gender equality, empowerment of girls and women and respect for human rights, investing in SRH needs of adolescents and youth,[257] and partnerships and collaborations. The MPoA 2016–2030 urges African governments, civil society, the private sector and multi-sectoral development partners to join forces and redouble their efforts.

In the area of service delivery, it emphasized integration of sexual and reproductive health and reproductive rights (SRH&RR) with STI/HIV/AIDS programme.

The ultimate goal of the MPoA 2016–2030 is to end preventable maternal, newborn, child and adolescent deaths by expanding contraceptive use, reducing levels of unsafe abortion, ending child marriage, eradicating harmful traditional practices including FGM, eliminating all forms of violence and discrimination against women and girls and ensuring access of adolescents and youth to SRH by 2030 in all AU Member States.

6.9 THE AFRICAN CHARTER ON THE RIGHTS & WELFARE OF THE CHILD

An important normative framework regarding children, also called the African Children's Charter, was adopted in 1990 and came into force in 1999. It is the most significant regional charter on children's rights.[258] Its implementation is monitored by the African Committee of Experts on the Rights and Welfare of the Child which developed a Plan of Action on Orphans and Vulnerable Children.[259]

The Plan of Action emphasises resource allocation for implementing children's programmes; enhancing the life chances of children; overcoming HIV and AIDS to ensure child survival, developing the potential of children by realising their right to education, protecting children to ensure their development and survival and ensuring the participation of children.

Key commitment articles are

- Article 3 – Non-Discrimination
- Article 11 – Right to Education[260]
- Article 14 – Right to Health and Health Services
- Article 16 – Protection Against Child Abuse and Torture
- Article 21 – Protection Against Harmful Social and Cultural Practices

In 2016, ACERWC established a 25-year Agenda namely, "Agenda 2040: Fostering an Africa fit for children". The main objective of the Agenda is to restore the dignity of the African child through assessing the achievements and challenges faced towards the effective implementation of the African Children's Charter. The Agenda, by further elaborating Paragraph 53 of Agenda 2063, intends to establish long-term strategies that will contribute towards sustaining and protecting children's rights in Africa. The overall target is to expand significant goals and priority areas to which the respective Member states and the African Union commit to for the upcoming 25 years.[261]

6.10 THE AFRICAN YOUTH CHARTER

The African Youth Charter which was adopted in 2006 to respond to the need to prioritise youth development and empowerment.[262] It has several strong articles on youth.

- Article 13 that advocates Education and Skills Development,[263]
- Article 13.4 – Progressively Free Secondary Education,
- Article 13.4 (h) – Pregnant Girls' Right to Education
- Article 13.4 (n) – Right to Culturally Appropriate Life Skills education
- Article 16 – Right to Health.[264],[265]

It underscores the need for enhancing youth participation in debates and decision-making on development in the continent and seeks to ensure their effective involvement in the development agenda.

It reiterates the need to protect and realise the fundamental rights of young people and girls to access knowledge to protect themselves, including on HIV/AIDS, reproductive health, harmful cultural practices (art.13, art.16).

It calls for the elimination of all forms of discrimination and violence against girls and young women and protect their rights, to ensure their equal access to healthcare, education, and economic opportunities (art.23).

6.11 AFRICAN WOMEN'S DECADE (AWD)

Launched in 2010 by the AU, the aim of AWD is the advancement of gender equality by accelerating the implementation of global and regional commitments and decisions regarding gender equality and women and girls' empowerment, through both a top-down and a bottom-up approach, including grassroots participation. Its main objective is to 'enhance the implementation of the African Union Members States commitments related to gender equality and women's empowerment and to support activities resulting in tangible positive change for African women at all levels.

Among its objectives is Women's Health, Maternal Mortality and HIV&AIDS, whose sub-objectives are to;

1. Improve Women's Health
2. Reduce Maternal Mortality
3. Address HIV/AIDS and;
4. Address HIV/AIDS inappropriate burden on women and girls on infections, spread, and increased workload, as well as unequal access to ARV's, good nutrition, and formal medical services

At the 33rd Ordinary Session of the Assembly held in Addis Ababa, Ethiopia in February 2020, the AU adopted the new phase of the AWD 2020-2030 under the theme "Financial and Economic Inclusion for African Women." The Decade continues to advance the key priorities outlined in the first decade including " Women's Health, Maternal Mortality, and HIV&AIDS and will seek to mobilise political commitment backed by concrete financial commitment for gender-transformative HIV response in all levels in AU Member States.

6.12 KEY PRIORITY ACTIONS FOR REALISING THE BEIJING PLATFORM FOR ACTION

African ministers responsible for gender and women's affairs, who attended the 9th African Regional Conference on Women for the twenty-year review of the implementation of the Beijing Declaration and Platform for Action (BPfA) in Addis Ababa, Ethiopia on 19 November 2014 adopted the Addis Ababa Declaration on Accelerating the Implementation of the Beijing Platform for Action calling for their respective governments to achieve gender equality by 2030, as spelled out in the African Union's (AU) Declaration on Agenda 2063.

Among others, in advancing the key pillar on women's reproductive health and HIV/AIDS, the ministers called for actions to improve access for all women and girls to prevention, treatment, and drugs to reduce the negative impact of HIV/AIDS among women. They further called actions to scale up combined preventive HIV/AIDS measures for young women and girls and expand programmes to eliminate mother-to-child transmission,

Among the key priority actions on the implementation of the Beijing Declaration and Platform for Action are'

- Investing in education, training, science and technology for women and girls to promote their equal access to employment and eliminate occupational segregation:
- Eliminating all forms of discrimination and violence against women and girls as a prerequisite for gender equality and women's empowerment:

Similarly, at the 25th anniversary and Africa regional review of the Beijing Declaration and Platform for Action carried out in October 2019, Ministers of Gender and Women's Affairs recognised that HIV/AIDS remains one of the drivers of the high maternal mortality rates in Africa. They further acknowledged that punitive and discriminatory laws and practices continue to undermine and block access to health and HIV-services for vulnerable groups, including stigma and discrimination to reach vulnerable groups assuring their right to non-discriminatory health care and HIV/SRH and RR-services.

Member States reported that they have undertaken gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues and noted that progress has been achieved around investments including in defaulter tracing of TB and HIV/AIDS patients and enhancing access to services that address the burden of the disease on women and girls. They however underlined the need for ensuring universal access to health care, including for HIV and SRHR-services, as priorities in achieving health targets within global and regional political commitments, such as the SDGs, the aspirations of Agenda 2063, the African Union Catalytic Framework to end HIV/AIDS, TB and Malaria by 2030, the Maputo Plan of Action on SRHR 2016-2030, and most recently the SADC SRHR Strategy 2019-2030. They further called on the disruption of negative stereotypes, social norms and harmful and traditional practices that perpetuate inequalities among societies as a game- changer for GEWE.

6.13 AU CAMPAIGNS AND ACCOUNTABILITY MECHANISMS ON GEWE AND HIV

6.13.1 CAMPAIGN ON ACCELERATED REDUCTION OF MATERNAL MORTALITY IN AFRICA (CARMMA)

This campaign is in line with AU's vision to eliminate new HIV infections in children and keep their mothers alive. In 2009, the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA)[266],[267] was initiated by the AUC as a response to the crisis of high maternal deaths by placing maternal death firmly on the AU agenda. CARMMA's main objective is to expand the availability and use of universally accessible quality health services, including those related to SRH. The campaign aims to achieve this objective by generating and providing data on maternal and new-born deaths and increasing political commitment. By building on existing efforts and mobilising domestic resources tosupport maternal and newborn health, the campaigns seek to accelerate actions to reduce maternal and infant mortality in Africa.[268]

6.13.2 FREE TO SHINE[269]

Free to shine is a new Pan-African advocacy campaign launched in January 2018 by the AU and the Organisation of African First Ladies (OAFLA). The main objective is to end childhood AIDS by raising awareness on the HIV epidemic in children and on the critical importance of prioritising women and children by highlight the importance of removing barriers that prevent women and mothers engaging with HIV- and AIDS-related health services for themselves and their children. The approach is to mobilise resources and prioritise the delivery of effective and sustainable HIV and AIDS health services that are accessible by all who need them.

In addition to global and continental commitments to integrate Gender in HIV, there are several initiatives by Member States that have shown success.

6.13.3 AFRICAN UNION CAMPAIGN TO END CHILD MARRIAGE[270]

The Campaign recognises that child marriage is a key driver of HIV//AIDS which enhances the vulnerabilities of girls to multiple discriminations and violations of human rights.[270] The main purpose of this Campaign is to accelerate the end of child marriage in Africa by enhancing continental awareness of the effects of child marriage. The Campaign is aimed at promoting, protecting, and advocating for the rights of women and girls in Africa.[270] The specific objectives are to;

- Promote the effective implementation of AU legal and policy instruments with a bearing on young people/ adolescents especially the Girl-child promoting the fulfilment of their human rights;
- Promote and support the AU member states to frame, launch and execute National Strategies and Programmes including building a social movement at grassroots level involving lawyers, magistrates, judges, teachers, health and social workers, traditional and religious leaders, men, boys, among others to Prevent and End Child Marriage as an issue of human rights and harmful traditional practice;
- Promote universal access to birth registration, quality education, and sexual and reproductive health and reproductive rights (SRH&RR) services, including meeting the unmet needs of married and unmarried adolescents for family planning .
- Strengthen the evidence base needed to design and implement effective policies and programmes for reducing child marriage at scale.
- Contribute to the Implementation of Item five (5) from the Eight (8) African Union Commission priority areas (2014-2017) on "Mainstreaming Women and Youth in all AUC and Continent-wide activities within an Inter-departmental collaboration and coordination mechanism

The Campaign works towards building on existing activities of governments and partners in ending child marriage and is based on advocacy, monitoring and evaluation (M&E) as well as the facilitation of technical assistance and capacity building.[270]

6.13.4 AIDS WATCH AFRICA

Created at the Abuja 2001 Special Summit, AIDS Watch Africa (AWA) is a statutory entity of the African Union and an accountability mechanism for the AU member states. Its specific mandate is to lead advocacy, accountability, and resource mobilisation efforts to advance a robust African response to end AIDS, Tuberculosis, and Malaria by 2030. It has Strategic framework (2016-2030) with five key pillars, which are (1) leadership and governance, (2) political support and ownership, (3) mobilisation of an Effective Response and Sufficient Resources, (4) Accountability and Oversight for Results and (5) Information for Action.

However, to combat HIV/AIDS, there is a need for the full realisation of human rights for all as an essential element in a global response. This is so critical in the areas of prevention, care, support, and treatment. A human rights perspective reduces individual's vulnerability to HIV/AIDS, prevents stigma and discrimination against people living with HIV/AIDS, or at risk of it[271] (para. 16).

> *"Belief is that a woman is a person that is led by (or is under the command of) a man so even if she is beaten, she knows that is part of her life; that is the reason many do not report."*
>
> Police Gender Desk

7 SELECT PROMISING PRACTICES ON GENDER RESPONSIVE HIV/AIDS INITIATIVES AND OUTSTANDING ISSUES

7.1 PROMISING PRACTICES

There are several initiatives/programmes that have been implemented across Africa that have recorded tremendous results.

TRAINING OF NATIONAL AIDS COORDINATING BODIES IN GENDER EQUALITY

- Seventeen national AIDS coordinating bodies or other governmental institutions responsible for coordinating of the national HIV response increased their knowledge, skills, and capacities to address gender inequality in HIV policies and programmes, with UN Women's support.
- This led to gender analysis of HIV epidemic in planning, integration of gender-responsive priorities and actions into the national HIV strategies, use of gender-responsive indicators to track progress, meaningful engagement of women living with HIV, and implementation of evidence-based, community-led initiatives to prevent the twin pandemics of HIV and violence against women.
- For instance, the Uganda AIDS Commission established a central dashboard with gender-responsive indicators to track the progress of key gender equality priorities in implementation of the National HIV and AIDS Strategic Plan.

ENGAGING OF WOMEN LIVING WITH HIV IN DECISION-MAKING PROCESSES AROUND THE HIV RESPONSE

- Women living with HIV across 30 countries engaged in decision-making processes around the HIV response due to targeted advocacy carried out by UN Women and other relevant partners. In 2018-2019, 10,000 women living with HIV directly benefitted from UN Women's support, resulting in increased advocacy and leadership skills, expanded participation in decision-making spaces in the HIV response, and increased access to HIV services.
- UN Women convened spaces for women living with HIV to collaborate with health institutions to identify and address the stigma and discrimination women face when accessing HIV services. For instance, in South Africa, UN Women revitalised the work and strengthened the capacity of the National AIDS Council's Women's Sector to participate in and influence the mid-term review of the national HIV strategy for 2017-2022, responding to specific priorities women and girls face in the context of HIV.

HEFORSHE COMMUNITY-BASED INITIATIVE

- Across 15 countries, UN Women scaled up evidence-based interventions to transform unequal gender norms to prevent violence against women and HIV, to reduce gender-based stigma and discrimination, and to enhance access to HIV testing and adherence to HIV treatment.
- In three districts of South Africa, UN Women's HeForShe community-based initiative on engaging men and transforming harmful norms to prevent violence and HIV engaged 39 577 people in 206 taverns, soup kitchens, and churches, resulting in improved attitudes and behaviours and increased uptake of HIV testing.
- In just eight months of 2018, 22 579 beneficiaries (46% women and 54% men), or 57%, got tested and were linked to treatment and care. The initiative included regular community-level dialogues regarding violence and HIV prevention, led by trained 'changemakers' – tavern owners and faith leaders.
- In 2019, UN Women expanded its work to eight additional poorest communities, where community-level dialogues and peer support groups discussing unequal gender norms and harmful masculinities, as well as counselling on HIV, resulted in 17 781 men who had previously been lost to follow-up re-starting and adhering to their HIV treatment regimens.
- UN Women adapted its HeForShe methodology and rolled it out in Malawi and Zimbabwe.

OPERATIONALISATION OF RESOLUTION 60/2

CSW 60/2 Resolution on Women, the Girl child, and HIV/AIDS offers a framework for addressing the gendered aspects of the epidemic, including harmful gender norms and practices as well as SRH&RR aspects within the HIV/AIDS response.

The AU, Member States have showed commitment to the implementation of the resolution through policy, legal, institutional and other measures at national levels in Africa.[272] For instance;

- Member States are urged to adopt and implement measures that promote access to, retention in and completion of education by girls, including catch-up and literacy education for those who did not receive formal education, special initiatives for keeping girls in school through post-primary education, including those who are already married or pregnant, or caring for people living with or affected by HIV/AIDS, and adopt social protection measures as protective strategies to reduce new HIV infections among young women and girls.
- Governments are urged to promote the active and meaningful participation, contribution, and leadership of women and girls living with HIV, civil society actors, the private sector, youth, and young men and women's organisations, in addressing the problem of HIV and AIDS in all its aspects, including promoting a gender-responsive approach to the national response;
- Governments are called upon to enact and intensify the implementation of laws, policies and strategies to eliminate all forms of gender-based violence and discrimination against women and girls in the public and private spheres and harmful practices, such as child, early and forced marriage, female genital mutilation and trafficking in persons, and ensure the full engagement of men and boys in order to reduce the vulnerability of women and girls to HIV

The SADC region in particular has championed the implementation of the resolution by adopting a Programme of Action (POA) to implement the Commission on the Status of Women Resolution 60/2 in 2017. The POA seeks to employ a five-point strategy guide with progress indicators from such as the SADC Monitoring and Evaluation Framework on Gender as well as other global and regional frameworks. It highlights global and regional targets to ensure alignment with SDGs and the Political Declaration on AIDS and proposes mechanisms for strengthened regional support and accountability. Its central lever is a gender equality approach for the prevention of HIV and response to AIDS by addressing the structural drivers of inequality.

As part of the advocacy strategy, SADC region coordinates dialogue platforms at every CSW annual session to garner commitment to accountability and regular reporting of progress in line with global, continental and regional commitments.

In addition, SADC Ministers of Health adopted the SADC Scorecard for HIV Prevention in 2018 to complement efforts to strengthen monitoring, among others, progress towards the realisation of gender equality indicators adopted in the POA and other key HIV commitments.

LEGISLATION TO ADDRESS GENDER-BASED DISCRIMINATION

- Algeria, Kenya, Senegal, and Zimbabwe are among thirteen countries that have reformed their laws over the past ten years in a bid to address gender discrimination, particularly those that concern passing on nationality to their spouses and children.
- In Eswatini, a national Sexual Offences and Domestic Violence Act, 2018 was enacted to enable the protection of adolescent girls and young women against abuse.

ERADICATION OF FGM AND CHILD MARRIAGE

- Twenty out of twenty-nine countries that traditionally practiced FGM have specific laws against the procedure across the continent.
- The Economic Community of West African States (ECOWAS) adopted a Strategic Framework to strengthen national child protection systems and protect children against violence. The framework counts child marriage as one of five priority areas for action. This is the first-time child marriage is prominently featured in a critical ECOWAS policy document! Kenya, Benin and Guinea also launched the AU campaign to End Child Marriage in Africa, bringing the total number of countries which have launched it to 21.
- Malawi officially banned child marriage, amending its Constitution to reflect legislation adopted in 2015 that raised the age of marriage to 18 years.
- SADC region: Since 2016, the SADC region has developed its Model Law to create a robust and uniform legal framework relating to the prohibition and prevention of child marriage and is a key path to addressing Sexual Reproductive Health Rights. The objective of the Model Law is, therefore, to serve as a yardstick and an advocacy tool for legislators in the SADC Region. It also provides best practice language without loopholes which can be easily adopted or adapted by Member States in their laws dealing with the eradication of child marriage.[273]

ACCESS TO SRH AND RR SERVICES AND PRODUCTS

Overall, North Africa has made important progress in advancing sexual and reproductive health and reproductive rights.

- Tunisian law protects the right of a woman to decide whether to practice birth control or have an abortion.[274] Nearly all Tunisian women live within 5 kilometres of a source of family planning. They typically wait until about age 27 to get married, compared to about age 16 in Sub-Saharan Africa and the Middle East.[275]
- In Egypt, 96% of women live near a family planning centre and about 60% use the centres' services.
- The Algerian government has created an innovative family planning policy that reimburses people for purchasing contraceptives. More than 90% of births in Algeria and Tunisia take place in public health facilities, drastically reducing maternal and child mortality in those countries.
- Namibia and Zimbabwe, active condom distribution and promotion over two decades led to some of the highest levels of condom use at last sex with non-regular partners.
- Kenya, Morocco, and South Africa have made progress in introducing Pre-Exposure Prophylaxis (PrEP), and hence these programmes can guide the introduction of PrEP for the most vulnerable populations in other countries.

- Lesotho and Eswatini report high coverage of programmes among adolescent girls and young women, a high level of condom use in non-regular partnerships in this group and increasing HIV treatment coverage. In both countries, HIV incidence reduction has accelerated.
- Ghana and Uganda have made progress in adopting life skills education in schools as part of the curriculum.
- Côte d'Ivoire and Zimbabwe have large-scale programmes for sex workers.
- Uganda and the United Republic of Tanzania conducted the largest numbers of VMMCs in 2018 (1.5 million boys and men received VMMC), demonstrating that scale-up of services is possible.
- The development of the PMP for Africa Business plan to increase pharmaceutic capacity, Kenya, South Africa, Uganda, and Zimbabwe now produce WHO prequalified ARVs.

DOMESTIC FUNDING

- South Africa contributed USD 2 billion between 2006-2011 per year of domestic funding towards AIDS response, the second largest in the world.

THE MALAWI PROGRAMME FOR GIRLS

- After its first year of operation, Malawi's Conditional Transfer Programme led to a large increase in self-reported school enrolment, as well as declines in early marriage, teenage pregnancy, sexual activity, and risky sexual behaviour.
- The implication strongly suggests that as girls and young women returned to or stayed in school, they significantly delayed the onset of their sexual activity. In addition, girls and young women who were already sexually active reduced the frequency of their sexual activity.
- The programme also delayed marriage, which is the main alternative for schooling young women in Malawi and reduced their likelihood of becoming pregnant.[276]

TANZANIA'S 'HER' PROGRAMME

Tanzania has made the most progress in addressing HIV infections among AGYW. This has been through integrated and comprehensive programmes for AGYW, particularly, through the government's joint efforts supported by the PEPFAR's DREAMS initiative, and similar programmes supported by the TGF, UNICEF and the Tanzania Social Action Fund (TASAF), which aim to address a combination of structural and biomedical drivers of HIV among AGYW.

The Global Fund's "HER Voice" Fund recognises the vital role adolescent girls and young women play in driving and to shape the HIV response. It provides small grants to AGYW-led community-based groups so that the logistical, administrative, and language barriers to participation in decision-making forums and processes can be overcome so that AGYW influence decision-making spaces.

AGYW participated through the signature HER programme, of which one component – the HER Voice Fund – was piloted in Tanzania between 2018-2019 to enable AGYW through the provision of small grants to participate in GF and national level processes.

For AGYWs, in particular, the evidence for comprehensive combination prevention, including cash transfers, skills development and income-generating activities (IGA) for out of school AGYW, is quite strong and validates further investments within the response, given the positive impacts on knowledge and health outcomes, and the possible role in reducing socio-economic vulnerabilities leading to transactional sex. Given the interlinkages between HIV and GBV, and related power structures.

Although it makes sense to offer integrated GBV prevention and screening interventions with PrEP delivery to AGYW, as evidenced by the EMPOWERMENT study done in Mwanza by the STRIVE consortium,[277] lack of funding as only 3% of domestic HIV financing is directed towards AGYW remains a big challenge.

PEPFAR-DREAMS

The programme focuses on reducing HIV risk and incidence among AGYW and their male partners.

- The programme aimed to reduce HIV infections among adolescent girls and young women by 40% in Kenya, Lesotho, Malawi, Mozambique, South Africa, Eswatini, Tanzania, Uganda, Zambia, and Zimbabwe between 2015-2017/18.
- It focused on social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, gender-based violence, and education.[278]
- Data on DREAM's impact from one the programme's main donors, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), suggests that communities or districts involved in DREAMS which had the highest HIV burdens when the programme began had seen new HIV diagnoses among young women decline by between 25% to 40% as of 2017[279]

SOUTH AFRICA'S 'SHE CONQUERS' CAMPAIGN

The 'She Conquers' campaign was a national campaign in South Africa from 2016 to 2019, aimed at empowering adolescent girls and young women.[280] The Campaign was based on data from 2015, which suggests a disproportionate burden of HIV among 15-24-year-old adolescent girls and young women in South Africa. The high HIV burden observed was compounded by high levels of unplanned teenage pregnancy, high school dropout rates and low education attainment, and high prevalence of gender-based violence – all occurring in a context where there were limited economic opportunities for young people. This resulted in a large section of the population who were under-equipped to contribute to the national economy, and thus many experience.[280]

South Africa needed an evidence-based, strategic response to "lift the burden of ill-health and disadvantage from the shoulders of young women and release its communities from the web of health and social problems". The campaign, which was partly funded by PEPFAR and The Global Fund adopted a targeted approach to scale-up and fast-track efforts to empower young people, especially adolescent girls and young women. The campaign provides a comprehensive package of interventions to address current barriers experienced by young women and girls; this includes biomedical, socio-behavioural, and structural interventions to increase access to information, services, and support.[280]

A full review of the impact of the campaign is yet to be published, however a preliminary study shows a reduction in teenage pregnancy with increased adoption of protective behaviours among young people in certain districts.[281]

THE SASA PROJECT!

SASA! means 'now!' in Kiswahili. This comprehensive approach combines tools and a systematic process for community mobilisation to prevent violence against women and HIV. SASA! was developed by Raising Voices and is being implemented in Kampala, Uganda by the Centre for Domestic Violence Prevention (CEDOVIP). SASA! is an acronym for a four-phase process:[282]

- Start thinking about violence against women and HIV/AIDS as interconnected issues and the need to personally address these issues
- Raise awareness about communities' acceptance of men's use of power over women, which fuels HIV/AIDS and violence against women
- Support women and men directly affected by or involved in these issues to change
- Take action to prevent HIV/AIDS and violence against women

SASA! takes an innovative approach to community mobilisation. Rather than providing factual information on violence and HIV risk, SASA! addresses the imbalance of power between women and men that underlies both epidemics.

- Secondary findings from an evaluation of SASA on IPV showed community mobilisation interventions were an effective means of preventing diverse types of abuse, including physical IPV, sexual IPV, emotional aggression and controlling behaviours. SASA! was associated with a lower onset of abuse and continuation of prior abuse.[283]
- Community activists lead a wide range of activities in their own neighbourhoods designed to decrease the social acceptability of violence by influencing knowledge, attitudes, skills and behaviours on gender, power and violence.[284]
- When implemented in four communities, the programme was associated with significantly lower incidence and acceptance of intimate partner violence among men and women as well as more supportive community responses to women who experienced it. SASA! has been implemented by over 25 organisations in Sub-Saharan Africa in diverse settings such as religious, rural, refugee, urban, and pastoralist communities.[285]

AU'S CAMPAIGN TO END CHILD MARRIAGE

In 2014, the AU Campaign to End Child Marriage[286] was launched to promote, protect and advocate for the rights of women and girls in Africa. The purpose for the campaign was to accelerate an end of child marriage in Africa by enhancing continental awareness of the implications of the practice, by supporting legal and policy actions in the protection and promotion of human rights; mobilising continental awareness of the negative socio-economic impact of child marriage; building social movement and social mobilisation at the grassroots and national levels and increasing the capacity of non-state actors to undertake evidence-based policy advocacy.[286] The campaign worked towards building on existing activities of governments and partners in ending child marriage and is based on advocacy, monitoring, and evaluation (M&E) as well as the facilitation of technical assistance and capacity building.[286]

The campaign aims to accelerate change across Africa by encouraging governments to develop strategies, raise awareness and address the harmful impact of child marriage.[286],[287]

RELIGION, GENDER & AIDS

- In Uganda, for example, imams from 850 mosques include information about HIV in religious lectures and Friday sermons.
- Koranic verses that deal with sexual ethics and integrity are being widely used in educational campaigns and counselling sessions. Nearly 7,000 community volunteers have visited more than 100,000 households since 1992 to spread the message about prevention.
- In Swaziland, Christian and traditional leaders are raising awareness about moral obligations to children, especially in the context of AIDS.

UNIVERSAL HEALTH COVERAGE

- Ghana has been innovative in financing, on how to package services and build a stronger public sector contribution to national health insurance schemes.
- In Ghana, we see reasonable levels of health coverage. They have a lot to share with the rest of the continent.
- Kenya's president has made a firmcommitment to ensure the provision of UHC.
- Some states in Nigeria have developed interesting partnerships where private sector entities have invested in affordable primary health care.

ETHIOPIA'S SUCCESS IN HIV PREVENTION

- The success of the country's HIV response has largely been driven by external funding -90% of total funding for HIV between 2011 and 2019 as well as sectoral integration and development of a multi-sectoral HIV/AIDS response.
- With the understanding of the link between gender and HIV, the government reformed legal frameworks to facilitate coordination mechanisms of HIV prevention through sectoral integration and developing a multi-sectoral HIV/AIDS response strategic plan.
- Gender was integrated into policies and programmes to address gender inequalities and make the services more responsive to the social, economic and cultural realities of users and beneficiaries also created an enabling environment to support individual behaviour change and risk reduction.
- There is meaningful participation of communities and WLHIV and women members of other key populations.
- For adolescent girls and young women, there are targeted and intensified efforts to fight FGM and establishment of girls' clubs in schools. The implementation of HIV prevention interventions targeting particularly adolescent girls and young women as priority population groups are also scaled up.
- Through its National Youth Policy[288] in 2004 followed by the National Adolescent and Youth Health Strategy (2016-2020). The most pertinent issues included in the youth policy[289] related to HIV and SRH&RR include:
    - Ensure their participation in fighting harmful traditional practices that are detrimental to their health
    - Creating a favourable environment for the youth to mobilise themselves on HIV prevention, control and bringing behavioural change;
    - Ensuring that the youth benefits from HIV related Information, education, communication and counselling services
    - Increase their participation in the fight to HIV and reduce their vulnerability to problems that Increase their vulnerability to the pandemic
    - Provide care and support to young PLHIV including AIDS orphans;
    - Encourage and create a favourable environment for the young PLHIVs in the fight against stigma and discrimination

Led by the above national and continental policies, commitments and frameworks over the past decade, the AU, Member States have made a significant progress in lowering HIV incidence across the continent. However, targeting to reduce new HIV infections to less than 150,000 per year by 2030 will require halving the number of new HIV infections of women and girls which currently stands at 5,500 a week.

7.2 OUTSTANDING ISSUES

Africa has made tremendous progress in reducing the number of new infections and HIV-related deaths in the last decade. However, progress has not been consistently achieved across all the regions and countries on the continent. The salient issues include:

- Stigma and discrimination which remain a major barrier to ending HIV/AIDS. The epidemic of fear, stigmatisation, and discrimination has undermined the ability of individuals, families, and societies to protect themselves and provide support and reassurance to those affected. This hinders, in no small way, efforts at stemming the epidemic. It complicates decisions about testing, disclosure of status, and ability to negotiate prevention behaviours, including the use of family planning services.[290]
- Widespread poverty and illiteracy, as well as political instability, pose obstacles to sustain the gains made.
- The laws, policies and frameworks fail to enable rights, services, or equitable access in practice because of poor and fragmented implementation.
- Limited women and girls' empowerment coupled with harmful practices hinder the achievement of global, continental, and national commitments.

- There is a dearth of information from AU member states in the North which hampers the efforts of the continent to address gender inequalities and HIV in this region.
- There is a lack of intersectional and multi-sectoral strategic approaches to fighting HIV/AIDS. This results in a lack of access to basic services for HIV and GBV. Where basic support services exist, they are typically underfunded, of insufficient quality, and/or lack appropriately trained staff to provide support and care.
- There is limited political commitment to and engagement in the implementation of national programmes. This starves the programmes of resources leading to unsustainability.
- The tendency to focus on women's empowerment, rather than taking on a rights-based approach in relation to economic development, discourages an inherently holistic approach and vision of outcomes.[291] It leads to a failure of member states to combat all forms of discrimination against women through appropriate legislative measures. However, the advantage of a human rights-based approach to development and governance, including the realisation of gender equality, encourages a people-centred and sustainable development approach to planning and decision making.
- Inadequate domestic financing for health and high donor dependency. For instance, the Gender Assessments in Tanzania and Ethiopia point to a heavy reliance on donor funding and the danger of unsustainability should the donor funding decline.

> *"They challenge constructed social and gender norms that make violence against women acceptable and aim to ensure that survivors of violence have a positive experience of external support, which in turn will build trust within communities to hold perpetrators of violence to account."*
>
> UNFPA, 2019

8 CONCLUSIONS AND RECOMMENDATIONS

Across the continent, the HIV response is partly being held back by gender inequalities. In this regard, the study has shown that stigma and discrimination remain key barriers to the full realisation of women, men, girls and boys enjoy equal rights and access to HIV preventive and treatment services. The findings of this document show a high prevalence of GBV across Africa, the inextricable link between GBV and HIV among women and re-emphasises the urgent need to address violence against women and girls (VAWG) and harmful practices such as FGM.

It is also noteworthy that HIV funding across Africa is losing momentum. Between 2017 and 2019, domestic funding for the HIV/AIDS response has decreased in eastern and southern Africa (14% decrease)[292] and western and central Africa (12% decrease) both high HIV burden regions. Additionally, women's meaningful participation – particularly that of women living with HIV/AIDS – in HIV policy and decision-making as well as implementation remains limited, and their potential contributions of leadership and perspectives on the epidemic are lost.

On the other hand, COVID-19 has revealed the gendered nature of the health crisis and the critical need for gender-transformative responses.[293] Within households, COVID-19-related mobility restrictions are contributing to increases in violence against women and children in some contexts.[294] School closures are posing an unprecedented challenge to young people's right to education, with more than 90% of the world's student population affected by closures. For both HIV and COVID-19, women play critical roles as frontline health workers and community leaders and caregivers, and measures are needed to enable support for women in those roles and to enable them to play active roles in key decision-making bodies.[294]

Similarly, every year, millions of people in Africa are affected by humanitarian crises, both natural (earthquakes, floods, droughts, etc.) and human-made (e.g. external and internal conflicts).[295] The growing number of humanitarian crises, which are often linked to displacement, disruption in health and social services, food insecurity and poverty – increases vulnerability to HIV and negatively affect people living with HIV.[295] During humanitarian crises, gender inequalities may be further exacerbated, making girls and women disproportionately more vulnerable to HIV.[295]

Tackling gender inequality is key to achieving substantiable development goals such Universal Health Coverage and Ending the HIV/AIDS epidemic by 2030. Therefore, to better understand how these inequalities are shaping national response, Member States should assess their HIV epidemics, context, and response from a gender perspective. In addition, efforts towards the realisation of the targets should ensure the meaningful involvement of women particularly, women living with HIV/AIDS in HIV policy and decision-making. Women living with HIV/AIDS need to be recognised as agents of change in their own health, not simply passive recipients of services.

Evidence shows that gender equality and women's rights are critical drivers of health, wellbeing, and socioeconomic development, and that gender-transformative health services are health promotive, preventive, low cost, and cost-effective.[296] In order to make the sustainable development goal of Universal Health Coverage (UHC) a reality in Africa, gender equality and gender-transformative programming must be fully addressed in health systems' design, financing, and delivery and in the health workforce.

The importance of education to the HIV response cannot be underestimated. Effective HIV education programmes equip young people with essential knowledge about HIV/AIDS, such as HIV transmission, prevention, and testing; but it also tackles broader issues that drive the spread of infection. Education empowers young women with knowledge and skills to make informed decisions and adopt behaviours that reduce their risk of HIV infection.[297] Therefore, school-based HIV/AIDS education must not be an optional add-on for school curriculums in Africa. It needs to be part of comprehensive skills-based health education programmes and included in the mainstream curriculum. Accurate information about reproductive health and HIV/AIDS, along with life skills and links to services, are integral components of quality education.

At the continental level, AU Member States committed to accelerating the implementation of gender-specific economic, social, and legal measures aimed at combating the HIV/AIDS pandemic by adopting various policy and legal frameworks including the Abuja and Maputo Declarations on HIV/AIDS, Tuberculosis, Malaria, and, Other Related Infectious Diseases, the Solemn Declaration on Gender Equality in Africa (SDGEA), the Maputo Protocol, the AU Gender Strategy for Gender Equality and Women's Empowerment, among others. As a key continental priority, Member States need to accelerate efforts to annually report on progress made in the implementation of the commitments.

The AU plays a pivotal role in ensuring that Member States are mobilised and supported to deliver on their commitments by ensuring that gender equality, women's empowerment and human rights are mainstreamed in HIV programming, planning, budgeting, and service delivery at national and local levels. The AUC, NEPAD and a number of RECs have pioneered notable initiatives which add value to national efforts and serve as models that could be replicated to enhance intra and inter-regional integration and cooperation.[298]

Towards accelerated action, the study underlines the need for sustained continental advocacy for the adoption and implementation of national policies and legislation on HIV and GEWE. There is additionally a need to intensify HIV/AIDS investments and governance systems for gender transformative interventions and effective implementation of HIV and GEWE commitments.

The centrality of disaggregated data collection is also stressed to galvanise political commitment at the highest levels. Gender-sensitive HIV data offer a deeper picture of progress toward gender, including as critical inputs to continental policy accountability mechanisms and structures such as AIDS Watch Africa and the Africa CDC.

9 RECOMMENDATIONS

STAKEHOLDER	KEY RECOMMENDATIONS
AU and its Organs	**AU and its organs to:** 1. Strengthen monitoring of and accountability for the implementation and reporting progress under global and continental HIV/AIDS and GEWE commitments by Member States. 2. Strengthen the capacity of national statistical offices and promote harmonised data collection tools as well as methodologies to enhance routine collection, analysis and dissemination of sex disaggregated national and continental data on GEWE and HIV/AIDS to inform policies, strategies, guidelines and interventional at all levels in the Africa. 3. Develop and review national, regional and continental Universal Health Coverage (UHC) policies to ensure the needs of girls and women are fully addressed in their design and implementation. 4. Strengthen internal coordination and partnerships to step up the advocacy including through the AU "Africa Educates Her' Campaign for improved access to and retention in quality education for adolescent girls and young women across Africa and promote the integration of HIV/AIDS education into school curriculums. 5. Carry out strategic advocacy and resource mobilisation for the implementation of catalytic GEWE and HIV initiatives at continental, regional and national levels 6. Facilitate South-South learning and dissemination of good practices among AU Member States for harmonisation of policies and strategies.
Member States	**Member States to:** 1. Intensify efforts to achieve gender equality and the empowerment of women and girls in all spheres of life, recognising that structural gender inequalities, discrimination, violence against women and girls and harmful masculinities undermine effective HIV responses and the full and equal enjoyment of human rights and fundamental freedoms by women and girls. 2. Address gender-based HIV-related stigma and discrimination against and among women and girls, so as to ensure the dignity, rights and privacy of women and girls living with and affected by HIV and AIDS, including in education, training and informal education and the workplace; 3. Promote universal health coverage, as part of a comprehensive social protection package and through the promotion of primary health care, by ensuring that the use of those services does not expose women and girls to financial hardship.

STAKEHOLDER	KEY RECOMMENDATIONS
Member States	4. Review, and where appropriate, amend or abolish all laws, regulations, policies, practices and customs that discriminate against people living with HIV or have a discriminatory impact on women, and ensure that the provisions of multiple legal systems, where they exist, comply with international and continental GEWE and women rights commitments and principles, including the principle of non-discrimination. 5. Allocate adequate and sustainable financial resources for the implementation of international, continental and national commitments, especially through the strengthening of their national capacities for gender responsive planning, budgeting, research and resource allocations HIV and GEWE in gender expertise and in sexual and reproductive health and reproductive rights (SRH&RR) 6. Recognise women's contribution to the economy and their active participation in caring for people living with HIV and AIDS and recognise, redistribute and value women's unpaid care and domestic work through the provision of public services, infrastructure, the promotion of equal sharing of responsibilities with men and boys, and social protection targeted at women and girls who are vulnerable; 7. Conduct national gender assessments including on the GEWE and HIV intersecting factors, collect sex- and age-disaggregated data and develop gender-sensitive indicators, as appropriate, to inform policymaking, implementation, monitoring and reporting. 8. Design and implement initiatives, including awareness-raising programmes to promote the active involvement of men and boys in eliminating gender stereotypes, gender inequality, gender-based violence and harmful practices. 9. Collaborate with stakeholders to intensify combination prevention initiatives for women and girls for the prevention of new infections and to reverse the spread of HIV and reduce maternal mortality. 10. Promote the active and meaningful participation, contribution and leadership of women and girls living with HIV, civil society actors, the private sector, youth and young men and women's organisations, in addressing HIV and AIDS in all its aspects for a gender-responsive approach to the national response. 11. Take measures to protect and address the needs of women and girls in humanitarian and armed conflict situations including refugees, internally displaced persons who are at increased risk of HIV infection and carry a disproportionate burden of caregiving responsibilities.

STAKEHOLDER	KEY RECOMMENDATIONS
Development partners	**Development partners to:** 1. Strengthen international cooperation in order to assist in the development of human resources for health, through technical assistance and training, as well as to increase universal access to health services, including in remote and rural areas. 2. Support collaborations with research and academic institutions in Africa for the documentation and dissemination of national promising practices as well as exchange of expertise as critical aspect of the investment in evidence-based research for to promote replication and South-South learning on the continent. 3. Support the AU in adapting and contextualising the global Education Plus Initiative[299] for implementation across AU Member States including through technical and capacity assistance to the AU CIEFFA for accelerated realisation of the AU education agenda for women and girls. 4. Support national governments and AU organs in ensuring that all COVID-19 responses are gender-sensitive and transformative, ensuring the needs of girls and women are effectively addressed.
CSOs, GEWE and HIV advocates	**CSOs, GEWE and HIV advocates to:** 1. Collaborate with national governments and local partners to ensure the implementation, monitoring, and reporting of progress towards the realisation of HIV policies, legislation and guidelines. 2. Ensure that the provision of HIV services (prevention, treatment, care and support services) are effectively integrated and implemented at all stages of the humanitarian response (rapid assessment, programmes etc) especially for victims of gender-based violence and conflict-related-sexual-violence. 3. Support the establishment and operationalisation of independent reporting, collection, analysis and utilisation of data to monitor the implementation of HIV commitments and initiatives including in conflict-related settings. 4. Build the capacity of GEWE and HIV advocates to enhance women's meaningful participation and leadership in HIV policy and decision-making 5. Monitor the meaningful involvement of women with HIV/AIDS and hold governments and development partners accountable to their commitments on HIV and GEWE.

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253. Flagship programmes of Agenda 2063 include: "Increasing access to tertiary and continuing education in Africa by reaching large numbers of students and professionals in multiple sites simultaneously and developing relevant and high quality Open, Distance and eLearning (ODeL) resources to offer the prospective student a guaranteed access to the University from anywhere in the world and anytime (24 hours a day, 7 days a week."
254. See Article XII of the Maputo Protocol requiring states to take all appropriate measures to (a) "eliminate all forms of discrimination against women and guarantee equal opportunity and access in the sphere of education and training"…(c) protect women, especially the girl-child from all forms of abuse, including sexual harassment in schools and other educations institutions and provide sanctions against perpetrators of such practices;…(e) integrate gender sensitisation and human rights education at all levels of education curricula including teacher training"
255. See Article VI of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa: "Minimum age of marriage for women shall be 18 years"
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257. In particular, including age-appropriate and culturally sensitive comprehensive education on sexual and reproductive health and rights and referrals to SRH services, and (as a priority intervention) ensuring that all girls and boys complete free, equitable and good-quality primary and secondary education.
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260. See Article 11.1(h) of ACRWC stipulating that education shall promote "the child's understanding of primary health care"; and Article 11.2(e) specifies that parties "shall take special measures in respect of female…children, to ensure equal access to education…". Article 11.6 further requires that "all appropriate measures" be taken "to ensure that children who become pregnant before completing their education… have an opportunity to continue with their education on the basis of their individual ability".
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262. The African Youth Charter defines youth or young people as 'every person between the ages of 15 and 35 years.

263. See Article 13 of the AYC: "every young person shall have the right to education of good quality" to develop "life skills to function effectively in society and include issues such as HIV/AIDS, reproductive health, substance abuse prevention and cultural practices that are harmful to the health of young girls and women as part of the education curricula".
264. See Article 16.2 of the AYC calls for the (b) "involvement of youth in identifying their reproductive and health needs and designing programmes that respond to these needs with special attention to vulnerable and disadvantaged youth"; (e) availability of "protective measures and reproductive health services";
265. See Article 23.1, which obliges states to (a) "introduce legislative measures that eliminate all forms of discrimination against girls and young women and ensure their human rights and fundamental freedoms"…(d) "guarantee universal and equal access to and completion of a minimum of nine years of formal education"; (e) "guarantee equal access to and completion of vocational, secondary and higher education in order to effectively address the existing imbalance between young men and women in certain professions"; (j) "offer equal access to young women to employment and promote their participation in all sectors of employment".
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CONTACT DETAILS

+251 (0) 11 551 77 00
+251 (0) 11 551 78 44

www.au.int

African Union Headquarters,
PO Box 3243,
Roosevelt Street (Old Airport Area),
W21K19,
Addis Ababa,
Ethiopia