The role of education and stigma in relation to high rates of HIV in young women in Eastern Southern Africa

The world now has the medical knowledge to prevent HIV from being deadly: AntiRetroVirals are advanced to the point where being HIV positive does not necessarily mean a short life span. However despite these advances in medicine and a focus from the international community to reach the sixth Millennium Development Goal of halting and beginning to reverse the spread of HIV by 2015, '…during the period 2005– 2012, AIDS-related deaths among adolescents increased by about 50%... in contrast with a 32% decrease among all other age groups during the same period.' (Idele et al, 2014, pg S151). This is evident in Eastern and Southern Africa (ESA) where HIV prevalence among young people aged 15-24 is 2.7% (UNICEF, 2013).

In light of these statistics the work The Mango Tree (TMT) is doing with young people and communities in Tanzania and Kenya is essential in bridging the current gap between the needs of young people and the available support. Globally, the barriers to accessing treatment are: the financial cost of medicine, the lack of knowledge in regard to the spread of HIV and the social stigma towards those who are HIV positive. These factors are essential in understanding why 'eighty-two per cent of the estimated 2.1 million adolescents aged 10–19 years living with HIV in 2012 were in sub-Saharan Africa, and the majority of these (58%) were females' (Idele et al, 2014, pg S144). While a lack of finances for medication is a factor in people remaining untreated, even when AntiRetroViral drugs are free at the point of access, this does not guarantee their use. This assertion has been researched by Roura et al, whose outcomes suggest that despite the provision of free AntiRetroVirals, if nationwide health infrastructure and distribution mechanisms for AntiRetroViral drugs are not established, along side tackling social stigma, then medication alone will have a limited impact on HIV rates (Roura et al, 2009).

Youth increases an individual's chances of contracting HIV and not treating it effectively, but gender is also very significant. In Tanzania young women aged 15-24 are nearly twice as likely as young men to be HIV positive (UNICEF, 2013). This is seen to be a direct result of fewer girls completing secondary education, which in turn lowers the age of marriage and increases the risk of unprotected sex. These factors place the high number of young women who are HIV positive within circumstances of gender violence and more broadly, issues around women's rights and status within society. This is because the higher statistical probability of young women having HIV in comparison to young men is a result of inequalities within society; 'in addition to HIV risk, early sexual activity is associated with early marriage and early childbearing across the world, which curtails education and other opportunities for adolescent girls to reach their full potential' (Idele et al, 2014, pg S148). In addition women are more susceptible to contracting HIV due to biological factors, such as having herpes virus, which is

statistically higher in women compared to men, and is one factor which increases the likelihood of being HIV positive (Glynn, 2001).

Completing secondary education significantly reduces the chances of a young woman being HIV positive, as a result of better knowledge and understanding of practising safe sex, a later sexual debut, strengthened financial status with the ability to be self-sufficient and more opportunities to seek advice and treatment. And according to Idele et al '… basic disaggregation by sex can help to understand factors such as social and economic inequalities and age-disparate sex, which are key factors in the epidemic affecting young women and girls.' (2014, pg S152).

This article will explore how education, or a lack thereof, and social stigma impact on young women in ESA in relation to contracting and getting treatment for HIV. These factors will be situated within the broader context of gender dynamics in ESA, and how this affects the status of young women and increases their likelihood of being HIV positive. Finally the programmes and initiatives which TMT has developed to combat this problem, specifically within communities in Tanzania and Kenya will be discussed.

Education is the key to preventing the spread of HIV: with knowledge and understanding of how it is spread, and how to use the protection available, it can be stopped. However 'just 30 per cent of girls and boys in the region have adequate knowledge of HIV in ESA' (UNESCO, 2013, pg 46). Consequently a focus on access to education is essential to understanding why some groups remain vulnerable; girls are less likely than boys to have access to education, and within the broader region of '…sub-Saharan Africa, approximately 80% of young women have not completed their secondary education, and one in three young women cannot read' (UNAIDS, 2014, pg 140).

Educational achievement is linked to lower HIV rates, because it results in later commencement of sexual activity, independent sources of income and better health outcomes overall. A lack of education and dropping out before completing secondary education statistically increases the risk of HIV contraction, as well as early marriage and pregnancy (UNAIDS, 2014). In Tanzania only 30% of girls are expected to complete the first grade of secondary school, and when asked why, they highlighted the following barriers: '…economic hardship…and forced marriage as the factors behind their decisions to leave school' (Restless Development, 2013). In Kenya HIV prevalence for women '…aged between 15 and 24 is about five per cent, compared with just one per cent of their male counterparts…[while] better educated girls were less likely to marry early, more likely to practice family planning, and their children had a higher survival rate' (TMT, *Support Girls for the Future*). Evidently there is a gendered dynamic to the contraction of HIV; young women without education are much more likely than those with education, or their male counterparts to become HIV positive.

Furthermore girls who fail to complete secondary education have an increased chance of developing age-disparate relationships and having sexual partners who are significantly older, perhaps to supplement low or unstable incomes. Arguably this is an act of agency allowing poor girls to access social mobility and improve their job prospects despite a lack of education; however it remains dangerous in terms of contracting HIV as young women are often not in a position to demand the use of condoms from older male partners who have paid for sex (Leclerc-Madlala, 2008). As a result it can be asserted that 'transactional relationships (for money, gifts such as school provisions or shelter and protection)…further disempower the receiving partner, usually girls or young women…[as] the greater the economic gift or transfer, the less likely it is for safe sex to be practised' (UNESCO, 2013, pg 16). Given these studies international aid agencies and health campaigners have increasingly put an emphasis on young women completing secondary education, as this is such an influential factor in decreasing their chances of contracting HIV: 'completion of secondary education contributes to protection against HIV. Efforts must be doubled to keep adolescents girls and young women in school, free of HIV, able to plan their pregnancies and safe from all forms of stigma, discrimination and violence.' (UNAIDS, 2014, pg 143).

The effect of social stigma cannot be overstated when discussing the rise in HIV rates for young people; social acceptance is especially important during teenage years, and the negative perception of HIV-positive status, as both a perceived 'death sentence' and something to be ashamed, of certainly has an effect. AntiRetroVirals are now available in ESA, and can considerably prolong the life of HIV positive patients; however young people are statistically less likely to access either AntiRetroVirals or the accompanying HIV Testing and Counselling (HTC) also available. According to UNESCO there are a number of reasons for this: '…varying from availability of services, worries about confidentiality, inaccurate risk perceptions, fear of being stigmatized and perceptions of the consequences of living with HIV'(UNESCO, 2013, pg 36).

According to Roura et al, the availability of AntiRetroVirals in communities in Tanzania, and the ability to live with HIV/AIDS, has had some unforeseen consequences. Because HIV is now treatable, two contradictory scenarios have emerged. On the one hand, HIV has become a chronic, invisible and manageable condition and is no longer life-threatening. This allows families to live with HIV and reduces the fears, myths and stigma associated with it. Conversely, *because* it can now be treated, and those who get treatment can hide their HIV positive status, there has been an increase in negative stigma attached to those on AntiRetroVirals, because of the fear that they could potentially "trick" others into unsafe sex, and are considered to be immoral as a result (Roura, M et al, 2009 ,pg 311). This research shows the many factors that contribute to a culture of stigma, and how broad society-wide perspectives on HIV impact on individuals' choices. While the logical path for an individual with HIV may be to get onto

AntiRetroVirals, the logistics and direct outcomes of this choice are not simple, and can have unforeseen consequences.

Social stigma and gender-based violence are closely intertwined for young women in ESA; in societies where women suffer infringement of their rights and gross inequalities of power and status, such inequality is reflected in attitudes to women living with HIV, as compared with men. In addition a young age of sexual début, early marriage and generational gaps between young girls and older husbands, all increase young women's chances of contracting HIV, in comparison with young men. This causes inequality between the genders in essential areas such as education, health and wellbeing, and can be described as a form of gender violence because of the ultimate impact on life expectancy - contracting HIV can still be deadly if AntriRetroVirals are not accessed and used for considerable lengths of time.

From the wealth of research and evidence it is clear that young women face a broad and complex range of interlinked barriers that make them less likely to complete education, more likely to face social stigma if they contract HIV and have a higher chance of being involved in age-disparate sexual relationships which further increases their chances of contracting HIV. In the face of these gender-based inequalities, NGOs, governments and international bodies such as UNICEF and UNESCO have all made recommendations for dealing with the problem. The resounding consensus is that the *education* of young women is the key to stopping the increase in HIV in 15-24 year old girls, as with education comes the knowledge and access of how to prevent and treat HIV.

The emphasis TMT has placed on the education of orphans, and young women more generally, is in line with the global focus on education; initiating a number of projects in Kenya and Tanzania, including HIV awareness campaigns in Rachuonyo North District, Kenya and Kyela District, Tanzania which have collectively reached nearly 40,000 people (TMT Annual Report 2014, pg 26). TMT's community-run rural development programmes prioritise HIV awareness and prevention in young people. In addition, by funding girls' access to education , constructing adequate toilet facilities, and providing free HIV counselling and testing services TMT does essential work on combating the spread of HIV. To retain girls in school gender sensitive infrastructure is necessary – which is why TMT builds private toilets for girls. Other causes of school drop-out include a lack of sanitary towels , parental support for education, and onerous domestic responsibilities for girls.

TMT's health clinics and awareness and information campaigns have been successful in providing young girls with the knowledge they need to avoid HIV: 'in the villages where we work we are seeing greater awareness around safer health practises and positive attitudes to health and sanitation by disadvantaged people, especially secondary school aged girls.' (The Mango Tree Report 2014, pg 21). According to Juliet Obuom, a Health Manager for TMT in Kenya, the results of such programmes are '⋯translating

awareness and knowledge into positive behaviour change to help improve sexual health amongst young people' (TMT 2014, pg 21). These successes can be measured through statistics showing an '86% reduction in… girl dropout rates from 46 girls in 2012 to 6 girls in 2014' (TMT Annual Report 2014, pg 8). Equipped with an education, young girls are less likely to contract HIV, and also better able to deal with the impact of being HIV positive, because they are more financially independent, more aware of how to access treatment and more likely to be part of a community network which can emotionally support them.

Research has shown that in addition to young women being vulnerable, orphans are disproportionately more likely to contract HIV due to a lack of parental support and financial stability: 'global analysis of HIV related vulnerability show that double orphans usually have worse educational attendance than non-orphans and that poverty intensifies the impact of HIV and AIDS on children's lives' (UNESCO, 2013, pg 15). In response to this TMT has been using its Alternative Family-based Care Home Programme to support young female orphans to complete secondary education. This programme includes providing female orphans with an older female mentor from the community who can provide homework support and sexual health information, and is a highly effective way of providing female orphans with essential guidance. More broadly the programme aims to reduce '…early marriage and teenage pregnancy among vulnerable and orphaned girls. They attend school regularly, and grades and performance have increased considerably over the past three years.' (TMT Annual Report 2014, pg 11).

TMT also provides long term support for those who are HIV positive, or are supporting family members with HIV. TMT does this by ensuring food security and sustainable livelihoods via its Community Development Programmes, for example providing land and training for individuals and families to grow mangos, cassava and spirulina (TMT Annual Report 2014, pg 23). There are also community support groups where individuals who are HIV positive can meet and talk together, providing a network to help rebuild lives. These initiatives provide food for the family, surplus to sell and work for the unemployed, alongside emotional and social support, which sends out a clear message to young people who do contract HIV that they will be assisted and aided in their goals to live normal lives. In Mozambique support groups have evolved into Community Adherence Support Groups, or GAAC's; made up of local people on AntiRetrovirals, these groups assign one individual (rotating each month) to collect the medication for the entire group, thus cutting down the waiting times at clinics, giving individuals more freedom and ensuring all members of the group take their medication each month (Vanderbilt University, 2014). These types of schemes could be adapted to communities in Tanzania and Kenya, to support those on AntiRetroviral treatment.

In order to combat the increasing numbers of young women who are contracting HIV, it is important to understand, and therefore target, the broader circumstances of young women in ESA. While women are stigmatised and denied the same opportunities as men in many aspects of life, their probability of contracting HIV will remain high, and their ability to survive will be low. An acknowledgement of gender violence in society and how this can be combated is required; one way of doing this is to provide girls with equal education to boys, and support to attain goals and careers. By empowering women to be equally as successful as men within education, university and work, gender violence is reduced as women come to be considered valuable assets to society and attain positions above and beyond those within the family. Consequently the education of young women will not simply improve their individual lives, but through the opportunities education offers, whole families and communities will benefit as well.

An emphasis on providing education and career opportunities for young women, including physical infrastructure (such as adequate female toilets), support and guidance is essential. When girls are enrolled and supported within education, and where learning is prioritised over domestic responsibilities, they can benefit from a nurturing school environment, within which advice and knowledge regarding safe sexual practises, access to health services and knowledge of HIV can be disseminated. In such an environment girls would be less likely to contract HIV (due to later sexual débuts, later age of marriage and fewer intergenerational relationships), and if they were to contract it would have help and support at hand to assist them in getting tested, engaging with counselling and onto a course of AntiRetroVirals. Young women have many disadvantages to overcome, but this does not make them victims. TMT has helped female orphans to reach their full potential and overcome inequality and discrimination, and these powerful young women act as role models to others in their communities. In the long term the emphasis on female education will impact on society more broadly, and help to reduce the gender based violence and inequalities which girls currently experience, and in the short term educating young women brings each one life-changing opportunities and a chance to fulfil their potential.

References

Glynn, JR et al. 2001. Why do young women have a much higher prevalence of HIV than young men? A study in Kisumu, Kenya and Ndola, Zambia. *AIDS.* [online]. **15**(4), pp.S51-60. [Accessed 9th April 2015]. Available from:

http://www.ncbi.nlm.nih.gov/pubmed/11686466

Idele, P et al. 2014. Epidemiology of HIV and AIDS Among Adolescents: Current Status, Inequities, and Data Gaps. *UNICEF Supplement Article*. [online]. **66**(2), pp.S144-S153. [Accessed 28th February 2015]. Available from: http://data.unicef.org/corecode/uploads/document6/uploaded_pdfs/corecode/Epidemiology_of_HIV_and_AIDS_Among_Adolescents_169.pdf

Leclerc-Madlala, S. 2008. Age-disparate and intergenerational sex in southern Africa: the dynamics of hypervulnerability. *AIDS* [online]. 22(4), pp.S17-S25. [Accessed 7th March 2015]. Available from: http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/AgeDisIntergenAIDS2008.pdf

Remien, Robert H. et al. 2009. Gender and Care: Access to HIV Testing, Care and Treatment. *Journal of acquired immune deficiency syndromes*. [online]. **51**(3), pp. S106–S110. [Accessed 11th March 2015]. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2793673/

Restless Development. 2013. *Annual Report 2013*. [online]. [Accessed 10th March 2015]. Available from: http://restlessdevelopment.org/file/annual-report-2013-pdf

Roura, M. et al. 2009. Scaling up stigma? The effects of antiretroviral rollout on stigma and HIV testing. Early evidence from rural Tanzania. *Sex Transm Infect.* [online]. **85**, pp.308-312. [Accessed 25th February 2015]. Available from: http://sti.bmj.com/content/early/2008/11/26/sti.2008.033183

The Mango Tree. 2014. *The Mango Tree Annual Report 2014*.

The Mango Tree. *Website*. [online]. [Accessed 25th January 2015]. Available from: http://www.themangotree.org/

The Mango Tree. *What we do: Support Girls for the Future.* [online]. [Accessed 1st February 2015]. Available from: http://www.themangotree.org/What-does-the-Mango-Tree-do-/Support-girls-for-the-future.aspx

UNAIDS. 2014. *The Gap Report: Beginning of the end of the AIDS epidemic*. [online]. [Accessed 7th March]. Available from:

http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf

UNESCO. 2013. *YOUNG PEOPLE TODAY. Time to Act now. Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in Eastern and Southern Africa*. [online]. [Accessed 3rd March 2015]. Available from: http://youngpeopletoday.net/wp-content/uploads/2014/08/SummaryReport-English.pdf

United Nations.2015. *Millennium Development Goals*. [online]. [Accessed 10th March 2015]. Available from: http://www.un.org/millenniumgoals/aids.shtml

UNICEF. 2013. *State of the World's Children*. [online]. [Accessed 9th March 2015]. Available from: https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CCQQFjAA&url=http%3A%2F%2Fwww.data.unicef.org%2Fcorecode%2Fuploads%2Fdocument6%2Fuploaded_pdfs%2Fcorecode%2FSOWC_2015_all-countries-update_214.xlsx&ei=XHMAVYnsI4ndar_rgIAL&usg=AFQjCNE_NteQSmRscEWd3sKkj87QARvQHA&sig2=qOOYycpH3GIFZjCA-_BmqA&bvm=bv.87611401,d.d2s

Vanderbilt University. 2014. Community support groups improve HIV ART adherence in rural Mozambique. *News Posts.* [online]. Published February 28, 2014. [Accessed 12th April 2015]. Available from:

http://globalhealth.vanderbilt.edu/2014/02/community-support-groups-improve-hiv-art-adherence-in-rural-mozambique/