Centring adolescent girls and young women in the HIV and COVID-19 responses

Ameena Goga, Linda Gail Bekker, Philippe van de Perre, Wafaa El-Sadr, Khatija Ahmed, Mookho Malahleha, Trisha Ramraj, Vundli Ramokolo, Vuyolwethu Magasana, Glenda Gray

Centring adolescent girls and young women in the HIV and COVID-19 responses

Published Online November 30, 2020 https://doi.org/10.1016/S0140-6736(20)32552-6

Adolescent girls (10–19 years) and young women (20–24 years) are a key part of the 1·8 billion people who live in fragile contexts.[1] In 2019, adolescent girls and young women comprised an estimated 10% of the population in sub-Saharan Africa but accounted for 59% of new HIV infections.[2,3] Adolescent girls and young women are disproportionally affected by HIV. In eastern and southern Africa in 2017, 79% of new HIV infections among 10–19-year-olds were in females—each day about 460 adolescent girls became infected with HIV and an estimated 50 died from AIDS-related illnesses.[3] Additionally, in 2017 HIV was the leading cause of death for women aged 15–49 years worldwide and among the top five causes of death for girls aged 10–14 years; more than 90% of deaths worldwide from AIDS-related illnesses among adolescents occurred in sub-Saharan Africa.[4] In various contexts, adolescent girls are the unpaid care workers for younger siblings and ill or elderly family members.[4] Gender inequality, gender-based violence (GBV), and poverty increase the vulnerability of adolescent girls and young women to HIV,[4] and those living with HIV face heightened discrimination, stigma, and GBV.[2]

Substantial efforts have been made to reduce the effect of HIV on adolescent girls and young women in high-burden countries through combination prevention approaches and initiatives, such as the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) partnership in sub-Saharan Africa, Sista2sita, SheConquers, and OneLove.[5,6] Notwithstanding these efforts, globally in 2019 girls and women made up almost 50% of the 38 million people living with HIV;[3] ending AIDS by 2030 requires that we address girls' and women's diverse roles by putting them at the centre of the HIV response.[4] If the status quo remains, there will be an HIV resurgence among young women due to the failings of HIV prevention, as the largest population of adolescents move into adulthood.[7,8]

Evidence from population-based surveys in eastern and southern Africa suggest that poorer or less educated adolescent girls and young women are still less able to negotiate male condom use than their more affluent or educated peers.[2] In fact, greater gains have been made in reducing new HIV infections among adolescent girls and young women in countries with higher completion rates of lower secondary school.[2] These gains may be the result of female empowerment as well as behavioural interventions, including sex education, counselling, cash transfers, and stigma and discrimination reduction programmes.[6] Uptake and use of biomedical interventions, including sexual and reproductive health (SRH) services, male and female condoms, pre-exposure prophylaxis, treatment of sexually transmitted infections, and treatment as prevention among adolescent girls and young women are limited, with stagnating funding for condom procurement, suboptimal SRH services, limited access to HIV diagnosis, and low levels of viral suppression.[7,9] Consequently, efforts to improve access to youth-friendly, accessible SRH services, including HIV testing and treatment, long-acting contraceptive options, and women-controlled HIV prevention options are imperative.

Structural challenges to centring adolescent girls and young women in the HIV response include poverty, gender inequality, unavailability of safe centres for health care (including mental health) and safe spaces for recreational time, parental consent requirements that restrict adolescents' access to health care, social constructs of masculinity (patriarchy) and gender norms, laws that punish young women's sexuality, poor access to menstrual products limiting school attendance, and school systems that prevent access to or continuation of education for adolescents who are pregnant or mothers.[2,6,10,11]

COVID-19 has exacerbated these biopsychosocial challenges and eroded progress on improving the health and wellbeing of adolescent girls and young women. While younger children need and value adult involvement in their lives, adolescents, given their crucial stage of biological, cognitive, psychological, behavioural, and social development,[12] value social interaction and face-to-face peer contact. COVID-19 mitigation strategies, including school closures, lockdowns, quarantine, or isolation, have been associated with poorer mental health among young people.[13–16] Although data on the impact of COVID-19 on adolescent girls and young women are still emerging, there are concerns that COVID-19-related school closures will exacerbate gender inequalities, increasing exposure to the risk of early marriage,

pregnancy, child labour, and violence.[17] Additionally, 7·6 million girls from pre-primary to secondary school are at risk of not returning to school as a result of COVID-19.[17] This will further reverse gains made in female education.

Despite calls to continue the provision of a minimum package of SRH care during the COVID-19 pandemic,[1,18,19] what happened during the 2014–16 outbreak of Ebola virus disease in west Africa is instructive.[20] In Sierra Leone adolescents had reduced capability to access or use SRH services during the Ebola outbreak, and cash-strapped health services diverted resources away from essential SRH services to acute responses that facilitated Ebola containment.[21] Consequently, it is likely that during the COVID-19 pandemic the compounding effects of limited access to SRH services, isolation, and loss of family members and income have disproportionately affected adolescent girls and young women, further exacerbating gender inequalities and GBV.[1,18] It will be some months before the impacts of COVID-19 on adolescent girls and young women will be fully appreciated, including the social harms and inadvertent negative outcomes of the COVID-19 response. A risk–benefit assessment is needed to identify and mitigate the indirect effects of COVID-19 mitigation and containment strategies to address these impacts and also to prepare for the next epidemic. Furthermore, COVID-19 has had a disproportionate impact and burden on adolescent girls and women who are more likely to be first responders in health-care delivery; working women often bear the double burden of their formal or informal employment and of caring for families, often with limited safety protection.[4]

In terms of HIV services, data show a reduction in HIV testing at first antenatal visits in at least 17 countries between January and June, 2020, and a reduction in HIV treatment access among pregnant women in at least 15 countries.[22] Treatment access had still not recovered in five countries (Botswana, South Africa, Sierra Leone, Togo, and Guatemala) by October, 2020.[22] Given that pregnant adolescents have poorer access to HIV-related care to prevent vertical HIV transmission than adults,[23] these challenges have no doubt adversely affected the health of adolescent girls and young women. Strategies to ameliorate these impacts, especially in sub-Saharan Africa, are urgently needed.[18]

The COVID-19 pandemic has been a setback for the health and wellbeing of adolescent girls and young women. Consequently, the needs of adolescent girls and young women must be a central consideration in HIV and COVID-19 responses going forwards. On World AIDS Day in 2020, we recommend ten actions to improve the health and wellbeing of adolescent girls and young women and mitigate the effects of HIV in the context of COVID-19 or similar pandemics (panel). These actions will empower adolescent girls and young women to reach their fullest potential and improve their opportunities for gainful employment, with its concomitant socio-economic benefits, thus securing the lives and livelihoods of future generations.[24] Inaction or insufficient action will betray the next generation of women.

***Panel:* Actions to put adolescent girls and young women at the centre of HIV and COVID-19 or similar pandemic responses**

- Keep schools open during the COVID-19 or similar pandemics with appropriate infection prevention and control measures
- Continue unfettered access to quality education, including sexual and reproductive health education through schools and higher institutions of learning and other channels
- Provide community-based safe environments for adolescent girls and young women
- Establish or strengthen community-based mental health services for adolescent girls and young women
- Provide user-friendly, accessible sexual and reproductive health services, including access to contraception, HIV testing, antiretroviral treatment, and pre-exposure prophylaxis
- Provide access to women-controlled interventions to prevent HIV infection
- Engage with adolescent girls and young women so that their voices guide policies and programmes aiming to enhance behaviours, biomedical, and structural interventions for adolescent girls and young women
- Prioritise adolescent girls' and young women's rights to make autonomous decisions about their sexual and reproductive rights
- Ensure that the social, mental, and physical health needs of adolescent girls and young women are a central consideration in future pandemic responses, including those relating to HIV and COVID-19
- Invest in raising male children to be gender-aware, respectful members of society and encourage and support responsive caregiving by parents

We declare no competing interests.

**Ameena Goga, Linda Gail Bekker, Philippe Van de Perre, Wafaa El-Sadr, Khatija Ahmed, Mookho Malahleha, Trisha Ramraj, Vundli Ramokolo, Vuyolwethu Magasana, Glenda Gray*

ameena.goga@mrc.ac.za

South African Medical Research Council, 7505 Cape Town, South Africa (AG, TR, VR, VM, GG); Department of Paediatrics and Child Health, University of Pretoria, Pretoria, South Africa (AG); Desmond Tutu HIV Centre, Institute of Infectious Disease and Molecular Medicine, University of Cape Town, Cape Town, South Africa (LGB); Pathogenesis and Control of Chronic Infections, INSERM, Etablissement Français du Sang, University of Montpellier, CHU Montpellier, Montpellier, France (PVdP); ICAP, Columbia University, New York, NY, USA (WE-S); and Setshaba Research Centre , Soshanguve, Pretoria, South Africa (KA, MM)

1 Tran N, Tappis H, Spilotros N, Krause S, Knaster S, for the Inter-Agency Working Group on Reproductive Health in Crises. Not a luxury: a call to maintain sexual and reproductive health in humanitarian and fragile settings during the COVID-19 pandemic. *Lancet Glob Health* 2020; **6:** e760–61.

2 UNAIDS. UNAIDS data 2020. https://www.aidsdatahub.org/sites/default/files/resource/unaids-2020-aids-data-book.pdf (accessed Nov 20, 2020).
3 UNAIDS. Global HIV & AIDS statistics—2020 fact sheet. 2020. https://www.unaids.org/en/resources/fact-sheet (accessed Nov 25, 2020).
4 UNAIDS. Women and HIV: a spotlight on adolescent girls and young women. 2019. https://www.unaids.org/sites/default/files/media_asset/2019_women-and-hiv_en.pdf (accessed Nov 20, 2020).
5 Hosek S, Pettifor A. HIV prevention interventions for adolescents. *Curr HIV/AIDS Rep* 2019; **16:** 120–28.
6 Avert. HIV prevention programmes overview. 2019. https://www.avert.org/professionals/hiv-programming/prevention/overview (accessed Nov 25, 2020).
7 Schaefer R, Gregson S, Fearon E, Hensen B, Hallett TB, Hargreaves JR. HIV prevention cascades: a unifying framework to replicate the successes of treatment cascades. *Lancet HIV* 2019; **6:** e60–66.
8 UNAIDS. 2015 Progress report on the Global Plan towards the elimination of new HIV infections among children and keeping their mothers alive. 2015. http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf (accessed Nov 25, 2020).
9 UNAIDS. Condom use is declining. Nov 23, 2020. https://www.unaids.org/en/resources/presscentre/featurestories/2020/november/20201123_condom-use-declining (accessed Nov 25, 2020).
10 UNAIDS, African Union. Empower young women and adolescent girls: fast tracking the end of the AIDS epidemic in Africa. 2015. http://www.unaids.org/sites/default/files/media_asset/JC2746_en.pdf (accessed Nov 25, 2020).
11 Goga AE, Dinh T-H, Essajee S, et al. What will it take for the Global Plan priority countries in Sub-Saharan Africa to eliminate mother-to-child transmission of HIV? *BMC Infect Dis* 2019; **19:** 783.
12 WHO. Adolescent health. 2020. https://www.who.int/health-topics/adolescent-health/#tab=tab_1 (accessed Nov 25, 2020).
13 Human Rights Watch. Impact of Covid-19 on children's education in Africa. 2020. https://www.hrw.org/news/2020/08/26/impact-covid-19-childrens-education-africa (accessed Nov 25, 2020).
14 Xie X, Xue Q, Zhou Y, et al. Mental health status amongst children in home confinement during the coronavirus 2019 disease outbreak in Hubei province, China. *JAMA Pediatr* 2020; **174:** 898–900.
15 Caffo E, Scandroglio F, Asta L. Debate: COVID-19 and psychological well-being of children and adolescents in Italy. *Child Adolesc Ment Health* 2020; **25:** 167–68.
16 YoungMinds. Coronavirus: impact on young people with mental health needs. 2020. https://youngminds.org.uk/about-us/reports/coronavirus-impact-on-young-people-with-mental-health-needs/ (accessed Nov 25, 2020).
17 Save our Future. Averting an education catastrophe for the world's children. 2020. https://saveourfuture.world/white-paper/ (accessed Nov 25, 2020).
18 Addae E. COVID-19 pandemic and adolescent health and well-being in sub-Saharan Africa: who cares? *Int J Health Plann Manage* 2020; published online Aug 27. https://doi.org/10.1002/hpm.3059.
19 Inter-agency Working Group on Reproductive Health in Crisis. Programmatic guidance for sexual and reproductive health in humanitarian and fragile settings during COVID-19 pandemic. 2020. https://iawg.net/resources/programmatic-guidance-for-sexual-and-reproductive-health-in-humanitarian-and-fragile-settings-during-covid-19-pandemic (accessed Nov 25, 2020).
20 Bandiera O, Buehren N, Goldstein M, Rasul I, Smurra A. Lessons from Sierra Leone's Ebola pandemic on the impact of school closures on girls. *The Conversation,* May 20, 2020. https://theconversation.com/lessons-from-sierra-leones-ebola-pandemic-on-the-impact-of-school-closures-on-girls-137837 (accessed Nov 25, 2020).
21 UNFPA. Rapid assessment of Ebola impact on reproductive health services and service seeking behaviour in Sierra Leone. March, 2015. https://reliefweb.int/sites/reliefweb.int/files/resources/UNFPA%20study%20_synthesis_March%2025_final.pdf (accessed Nov 25, 2020).
22 UNAIDS. COVID-19's impact on HIV vertical transmission services reversed. Oct 27, 2020. https://www.unaids.org/en/resources/presscentre/featurestories/2020/october/20201027_covid19-impact-hiv-vertical-transmission (accessed Nov 25, 2020).
23 Ramraj T, Jackson D, Dinh T, et al. Adolescent access to care and risk of early mother-to-child HIV transmission. *J Adolesc Health* 2018; **62:** 434–43.
24 World Health Assembly. Global Strategy for Women's, Children's and Adolescents' Health, 2016–2030: survive, thrive and transform. 2015. http://everywomaneverychildorg/images/2-pager_on_GS2_draft6pdf (accessed Nov 25, 2020).

Urgent actions and policies needed to address COVID-19 among UK ethnic minorities

Published **Online** November 19, 2020 https://doi.org/10.1016/S0140-6736(20)32465-X

As the UK enters a winter wave of the COVID-19 pandemic, our understanding of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) continues to evolve. However, what is strikingly clear from early data is the disproportionate effect of COVID-19 on elderly, socioeconomically deprived, and ethnic minority groups, both in the UK and globally.[1,2] Rapid analyses of large-scale population-based data show increased risk of exposure to SARS-CoV-2 and poor outcomes in these groups.[3,4]

The intersecting effects of occupation, community interactions, household environments, and structural racism are key drivers of excess exposure to SARS-CoV-2 among ethnic minorities.[5] Ethnic minority groups in the UK typically have higher occupational exposure to SARS-CoV-2[6] and reduced opportunity to work from home. Transmission of infectious diseases is known to be more intense in densely populated and deprived areas, and within closely interconnected social networks. Highly socially and physically connected households with extended kinship and social support ties are generally more common in ethnic minority communities.[7] Furthermore, many of these households are multigenerational, with older age adults, working age adults, and children living together.[8] Multigenerational living can intensify transmission of SARS-CoV-2 and efforts to isolate vulnerable or older individuals can be difficult, especially when combined with overcrowded living conditions.[9,10]

In the UK, SARS-CoV-2 transmission is higher in larger households.[11,12] Additionally, risk of death from COVID-19 has been shown to be higher in south Asian women aged 65 years or older in multigenerational households than in south Asian men, suggesting an intersection with gender (Nafilyan V, Office for National Statistics,