How Policy Affects Practice:
Policy Barriers to Provision of HIV Biomedical Prevention Services in sub-Saharan Africa

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Background

Policies governing HIV prevention product access are critical guardrails that influence the uptake of biomedical HIV prevention options such as oral pre-exposure prophylaxis (PrEP). Policies determine who can access a product, where they access it, and from whom. These policy barriers are especially important to address for key populations and those at highest risk of HIV infection, including adolescent girls and young women (AGYW), men who have sex with men, and transgender individuals. If not addressed, policy barriers can also limit access to next generation products. Improving the enabling environment for biomedical HIV prevention products can increase their reach and impact.

Methods

AVAC conducted a desk review of the HIV prevention policy landscape in eight countries in sub-Saharan Africa. This analysis includes:

- Training requirements for provision of PrEP and contraceptives;
- Clinical guidelines;
- National Strategic Plans for HIV and Sexual and Reproductive Health;
- implementation strategies;
- National policies on age of consent and the criminality of same-sex relationships;
- In-depth interviews were also conducted with 12 stakeholders from the eight countries.

Figure 1. Focus Countries

Results

Of the eight countries examined, three countries specified a minimum age of 15 years old to consent to PrEP use, and both South Africa and Namibia indicate that adolescents must also be rated by the provider a minimum of stage 3 on the Tanner scale for sexual maturity. The

Results (Continued)

remaining countries did not clearly indicate age of consent in the clinical guidelines. Contraceptive policies on the other hand are more flexible, with 7 of 8 countries specifying contraceptives should be made available to any woman of reproductive age, and South Africa with a minimum age of 12 years.

Table 1. Mapping Age of Consent Policies

Country	Age of Consent: PrEP	Age of Consent: Contraceptives	Age of Consent: HTS	Age of Sexual Consent
South Africa	15, Tanner stage 3	12	12	16
Kenya	15	No age limit	15	18
Nigeria	N/A	No age limit	18	18
Zimbabwe	N/A	No age limit	16	16
Zambia	N/A	No age limit	16	16
Uganda	N/A	No age limit	12	18
Namibia	15, Tanner stage 3	No age limit	16	16
Malawi	N/A	No age limit	13	14

With regard to same-sex relationships, 7 out of 8 countries examined criminalize same-sex relationships. This reality not only reduces the likelihood of the LGBTQ+ community to disclose their sexual activity to providers, but it also limits availability of reliable data on population size, as evidenced by the fact that only Lesotho had accurate population sizes reflected in policy documents.

Table 2. Criminalization of same-sex relationships; population estimates for MSM & Transgender Individuals

Country	Decriminalization of same-sex relationships	Accurate population size estimates
South Africa	✓	X
Kenya	X	X
Zimbabwe	X	X
Malawi	X	X
Botswana	✓	X
Uganda	X	X
Nigeria	X	X
Zambia	X	X
Namibia	X	X
Lesotho	✓	✓
Eswatini	X	X

Results (Continued)

Finally, in the case of ART, HTS & VMMC delivery, task shifting has been demonstrated as an effective strategy to improve clinic efficiency (and thus cost-effectiveness) of service delivery. With regard to contraceptives, policies allow for methods such as oral contraceptives and injectables to be provided directly by lay providers like community health workers (CHWs). Dispensing of PrEP has only been officially task shifted to nurses in each of the countries included in the analysis. In 2 countries (South Africa and Zambia), the requirements for a provider to prescribe PrEP include completing both ART training/certification, as well as separate PrEP certifications. Alternatively, 4 countries (Kenya, Zimbabwe, Namibia and Uganda) only require PrEP-specific certifications in order to prescribe. Task shifting for PrEP counselling is more prevalent with 4 countries (South Africa, Namibia, Zambia and Zimbabwe) allowing lay providers to counsel on PrEP after completing PrEP-specific trainings.

Table 3. Task-Shifting for Contraceptives & HIV Prevention Interventions

	Physicians	Clinical Associates	Nurses	Pharmacists	Lay Providers (ex. CHW, HSAs)
PrEP	✓	✓	✓		
ART	✓	✓	✓	✓**	✓**
VMMC	✓	✓	✓		
HTS	✓	✓	✓		✓
OCP	✓	✓	✓	✓	✓
Injectable	✓	✓	✓		✓
Implants	✓	✓	✓		

**Requirements vary by country*
***These cadres can dispense not prescribe*

Conclusion

Policies related to age of consent for PrEP are often not aligned with age of consent policies for HIV testing services (HTS) & contraceptives. Aligning age of consent policies for family planning & PrEP may facilitate increased access and integrated service delivery. Implementing task shifting can increase access to PrEP and facilitate implementation of community-led services for key populations, which reduce stigma, and may improve service quality and adherence. Removing these barriers can improve the impact of oral PrEP and accelerate introduction of future ARV-based prevention products as they become available.