

Decision-making Aide for Investments into HIV Prevention Programmes among Adolescent Girls and Young Women

Version for use in 2020 planning processes

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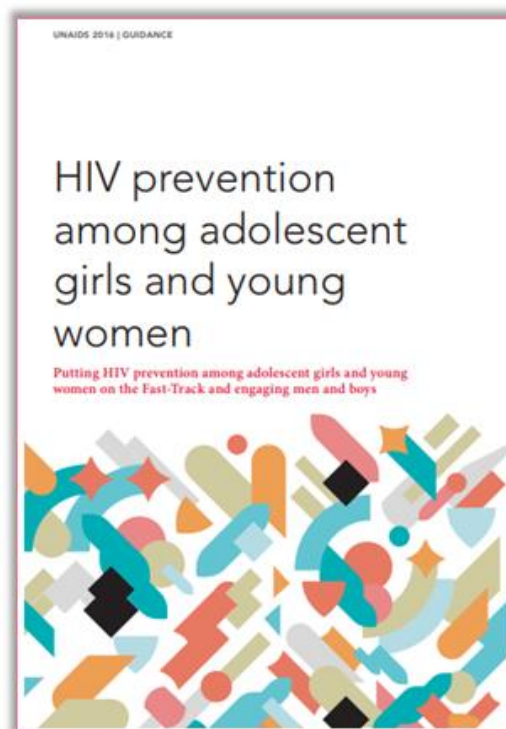
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Introduction

Globally, new HIV infections among adolescent girls and young women (aged 15–24 years) declined by 25% between 2010 and 2018¹. However, 6000 young women still become newly infected with HIV every week. Despite a number of comprehensive and vibrant prevention projects being implemented for adolescent girls and young women through the United States President’s Emergency Fund for AIDS Relief’s (PEPFAR) *DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe)* partnership² and other national programmes (e.g. *She Conquers* in South Africa), the response in settings with high HIV incidence still lacks in scale and hence in impact. According to the 2019 UNAIDS Global HIV Prevention Coalition (GPC) country scorecards, only about a third of the sub-national areas with high HIV incidence have dedicated HIV prevention programmes for this group.

UNAIDS, its cosponsors, The Global Fund³ and PEPFAR⁴ consider it a top priority to accelerate HIV prevention programming among adolescent girls and young women. In 2016, UNAIDS has issued guidance to specifically support countries in developing effective HIV prevention programme packages for reducing HIV incidence among adolescent girls and young women in high incidence settings (focus on location-population)⁵ and in 2018, UNAIDS has facilitated a further dialogue around differentiated prevention packages summarized in a section of the Miles to Go report⁶.



One challenge is that the funding required to scale up comprehensive packages for all young women in locations with high HIV incidence exceeds the internationally and domestically available HIV financing. Furthermore, potentially more new HIV infections could be averted with available resources, if more intensive programmes were provided to adolescent girls and young women in locations with very high risk and more focused HIV prevention packages in other locations. Apart from gaps in HIV prevention financing, there is also insufficient political will to mobilise investments from sources other than HIV funding for critical enablers such as education (including comprehensive sexuality education), social support systems, sexual & reproductive health & rights (SRHR) as well as youth-friendly health systems. Therefore, advocacy for high-level policy change on these enablers and for complementary domestic public and international development funding remains critical.

This decision-making aide – which does not replace more detailed existing guidance (Box 1) – aims to help countries to prioritise investments into differentiated HIV prevention packages (from basic to more comprehensive) taking into account differences in HIV incidence and vulnerability. It provides a step-by-step approach to assist countries in deciding what packages should be provided, by whom, to whom and where, taking into account available HIV funding and complementary funding.

Box 1. Existing guidance

This document is an aide in support of the 2016 UNAIDS Guidance for HIV prevention among adolescent girls and young women but does not replace it. Furthermore, it does not provide detailed technical guidance on biomedical programme areas already covered in other publications, such as condom promotion⁷, HIV testing services (HTS)⁸, PrEP⁹, or services for key populations¹⁰ including young key populations. Guidance related to wider programming for adolescent girls and young women is also available from UNESCO¹¹ (sexuality education), WHO¹² (quality health-care services), UN Women¹³ (social protection), and sexual and reproductive health rights (UNFPA)^{14,15}. Furthermore, PEPFAR is providing extensive support for combination prevention programs in high-burden countries through the DREAMS partnership for which early results have been published¹⁶.

This document focusses on **adolescent girls aged 15 to 19 years and young adult women aged 20 to 29 years** (as HIV incidence among young adult women aged 25-29 years is also very high in many countries). Specific programme areas – in particular in the education sector – may also include actions for adolescent girls aged 10 to 14 years. However, it is acknowledged that preventing new infections among adolescent girls and young women requires a combination of approaches that also reach out to men (Box 2).

Box 2: HIV prevention among adolescent boys, adult men and male partners

In order to prevent new infections among adolescent girls and young women it is important to reach *potential* partners – (young) men as well. This aide is not meant to fully address HIV prevention among adolescent boys and men. It only addresses those components of HIV prevention among men, which will typically be implemented through the same implementation channels as programmes for adolescent girls and young women. This includes activities around normative change around HIV prevention, gender norms and harmful practices, which need to be community-wide by nature and, in fact, many of the standard methodologies for this work like Stepping Stones and SASA! involve both women and men.

Beyond that it is important that VMMC coverage is increased in the relevant priority countries, especially among boys and men aged 15-29 years and that targeted actions are undertaken to ensure men are tested and treated so that they will become virally suppressed.¹⁷ These actions are, however, not covered in detail in this document and will typically be funded separately.

More specifically, *actual* male partners of adolescent girls and young women should be encouraged to get tested and referred for treatment and prevention services. In this context, couples' approaches to HIV prevention are useful, for example through strengthened male partner services in the context of family planning, antenatal and other SRH services as well as related community outreach. Constructive male engagement can support good health outcomes for men, women and children. At the same time, women should always be consulted about whether and how they wish their partners to be involved and male partner engagement should never be a condition to accessing services. While testing and treatment services for men will be funded and programmed separately, elements of demand generation and invitations of male partners, can often also happen as part of HIV prevention programme activities for adolescent girls and young women.

Throughout HIV prevention programming for adolescent girls and young women, the following key principles (Figure 1) are taken into account.

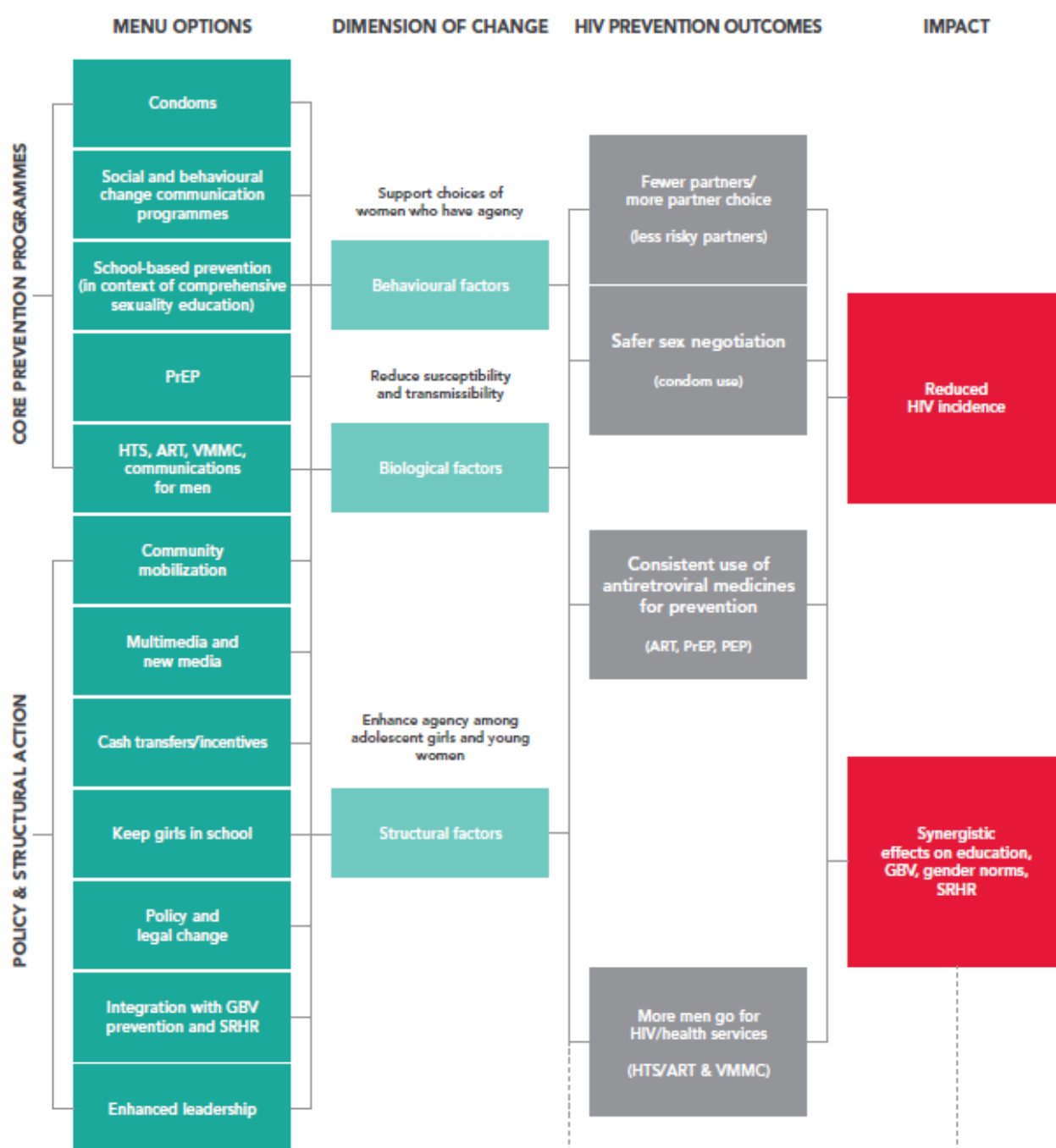
Figure 1: Key principles underlying the prioritisation and investment matrix for HIV prevention programming among adolescent girls and young women

Adolescent girls and young women-centred	Gender-responsive	Removing barriers to implementation such as	Evidence-based design	Sustainable national programmes
<ul style="list-style-type: none"> Ensuring meaningful engagement of adolescent girls and young women in the design and implementation of HIV prevention packages 	<ul style="list-style-type: none"> Including clear measures to address gender-norms, gender-related laws (including against GBV), gender-related inequities and barriers 	<ul style="list-style-type: none"> Stigma and discrimination Legal barriers e.g. lowering the age for consent for HTS and other HIV services Health care provider attitudes 	<ul style="list-style-type: none"> The HIV prevention packages for adolescent girls and young women are based on available research evidence and programming experience 	<ul style="list-style-type: none"> Differentiated, but nationally owned and scalable programmes Building on and strengthening existing health, education and community systems

Summary of existing guidance

2016 UNAIDS guidance on HIV prevention among adolescent girls and young women proposes a simple programmatic framework. This framework is geared towards the implementation of multisectoral programmes that provide the most direct, impactful and cost-effective ways of reducing HIV incidence. Based on available evidence (from systematic and other reviews, high-quality studies, and evidence-informed UN guidance) and programming experience available at the time, the guidance document proposed an options menu (Figure 2) from which countries and sub-national areas could choose.

Figure 2: Detailed strategy mix for HIV prevention among adolescent girls and young women: menu of options



Source: UNAIDS Guidance (2016) HIV prevention among adolescent girls and young women: Putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys.

In line with 2016 guidance, choices for country priorities should be based on local incidence data (as the corresponding risk varies considerably) and contexts (e.g. behaviour patterns, service availability, other vulnerability factors). However, in practice the differentiated approaches and the required detailed epidemic, programme and cost analyses have so far not been implemented systematically. The menu options enabled users to “pick and choose” prevention programme elements, sometimes resulting in core elements not being addressed and sometimes comprehensive packages being provided even in settings with moderate risk, while gaps remained in other locations with higher risk. In addition, the various menu options – and sometimes additional programme components – were implemented through various channels and organisations creating complex and fragmented programmes.

To address this challenge, it was felt that additional guidance for decision-making is needed, which is summarized in the following pages of this document. In this approach, basic HIV prevention packages (integrated into existing activities) would be offered in all locations (including those with low and moderate incidence), while more comprehensive packages would be offered in locations with high HIV incidence (Table 1). Splitting high incidence areas into “high”, “very high” and “extremely high” allows for allocating resources and costing programmes considering the level of risk. HIV prevention financing would provide for the most comprehensive packages in locations where risk is extremely high in few selected countries and locations, but for more basic packages where HIV incidence is not as high. Where additional domestic resources can be mobilized, packages could be expanded.

Table 1: Basic rationale of differentiated packages

HIV incidence levels in a location (new HIV infections among young women aged 15-24 per 100 person/years*)			
Incidence category	Incidence range	Regions including locations in these incidence categories	Service packages for adolescent girls and young women
Low and medium	(<0.1 and 0.1 – <0.3)	Many locations in West and Central Africa, some locations in eastern Africa, virtually all locations outside Africa	
High	(0.3 – <1.0)	Few locations in West Africa, some locations in Central Africa, many locations in eastern and Southern Africa	
Very high	(1.0 – <2.0)	Very few locations in eastern Africa (Kenya, Tanzania, Uganda) and several specific locations in southern Africa	
Extremely high	(2.0 and higher)	Specific locations in four southern African countries (Eswatini, Lesotho, Mozambique, South Africa)	

* Although this decision-making aide covers young women aged 15-29, HIV incidence estimates are commonly provided for the 15-24 age group and therefore reference is made to the age group 15-24 (but the same thresholds could be used for incidence data or estimates for 15-29)

In practice, this guide primarily applies to sub-Saharan Africa, because outside this region, HIV incidence only exceeds 0.3% among key populations and therefore in other regions HIV prevention will primarily focus on key populations. Even within Africa, since in line with available estimates sub-national areas with extremely high incidence are only found in four countries, most countries will only have high incidence (and lower) and some few countries high and very high incidence (and lower). Partners also use simplified versions of these incidence categories for groups of countries. PEPFAR combines *very high* and *extremely high* categories for countries in the DREAMS programme and focuses on these locations with HIV incidence exceeding 1.0%. SADC combines high and very high categories in its guidance.

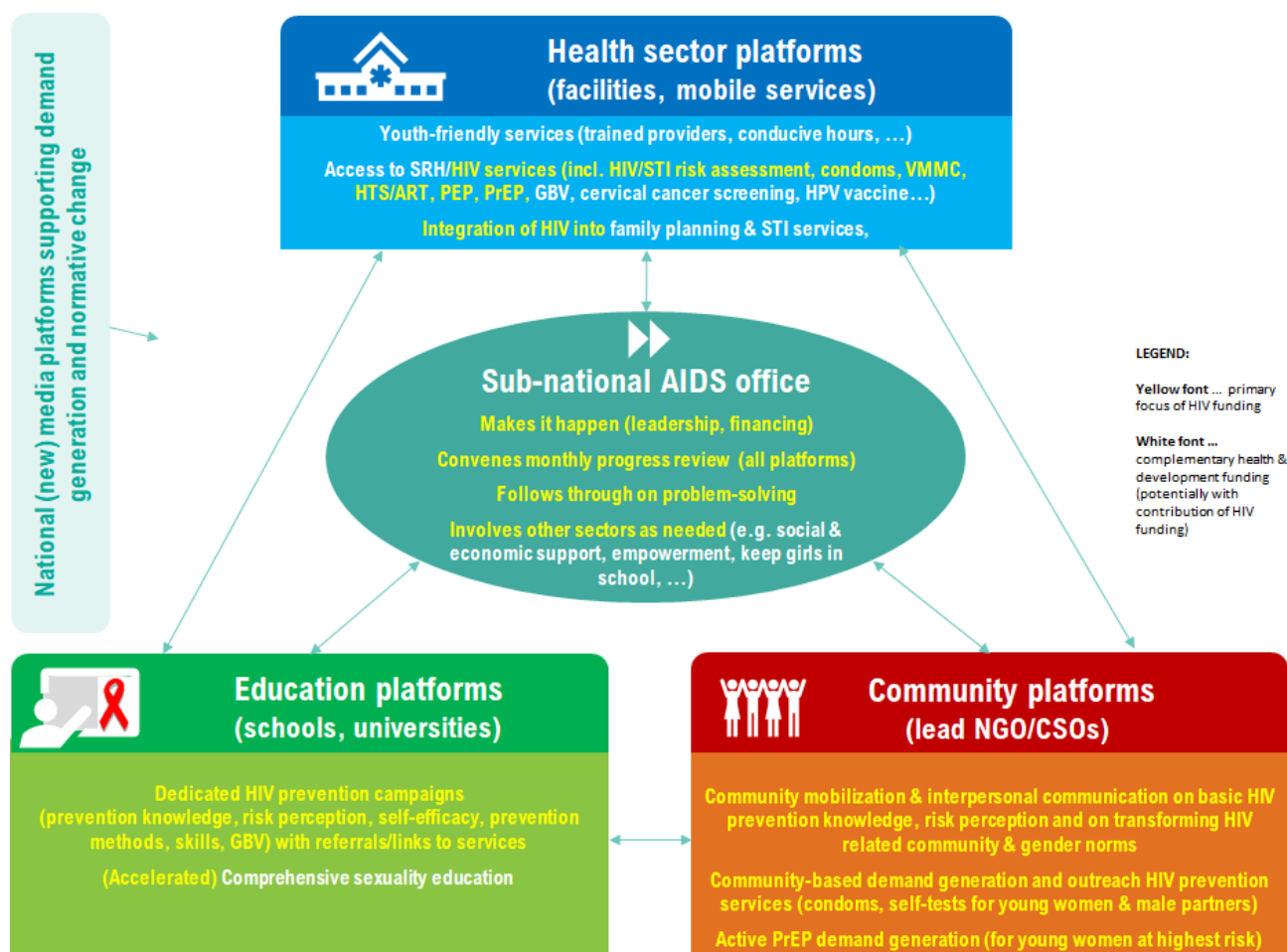
Major platforms for programmes

To make programmes simpler and more scalable, it is proposed to define the most important platforms for delivering HIV prevention programmes among adolescent girls and young women. Figure 2 proposes to prioritise action in settings with high HIV incidence through three platforms working together:

- 1) Provide **effective HIV prevention services as part of health services** (in particular contraceptive and HIV testing services) and make health service delivery youth-friendly to ensure HIV prevention, sexual and reproductive health & rights (SRHR) access for all adolescent girls and young women;
- 2) Strengthen **HIV prevention education in schools** and other education institutions considering risk and vulnerability factors in the local settings (in addition to and within comprehensive sexuality education);
- 3) Provide **systematic community outreach to adolescent girls and young women at higher risk** including interpersonal communication, demand generation and specific outreach services (including condoms, testing and referrals).

Figure 3 illustrates the platforms and their collaboration. Arrows highlight the importance of referral between the different sectors. For example, community-based demand generation should refer adolescent girls and young women to youth-friendly, person-centred and non-judgmental SRH/HIV services. At the same time, young women who are accessing contraceptive services and are at increased risk of HIV/STIs may require community support in mobilizing their partners for HIV prevention, testing and treatment as part of broader efforts to change gender and community norms. Another example are referrals made from school-based HIV programmes to services provided by the health sector and through community platforms (e.g. condom provision, self-testing, prevention counselling).

Figure 3: Delivery platforms for scaling up programs for adolescent girls, young women and male partners in settings with high HIV incidence and limited resources



The role of community organisations is critical to reach young women out-of-school and young adult men. Therefore, scaled community outreach needs to be at the centre of prevention investment in communities with high HIV incidence. A strengthened community outreach platform in settings with high HIV incidence can fulfil multiple functions in communicating about HIV prevention, generating demand for prevention, testing and treatment, making referrals, supporting consistent use/adherence, advocating with gatekeepers and addressing underlying social and gender norms.

In the health sector, other SRH/HIV services – in particular contraceptive services and HIV testing services - provide a critical under-utilized platform for providing strengthened HIV prevention services. In the education sector, many countries have adopted comprehensive sexuality education (CSE), which in settings with very high HIV incidence can be complemented with other, more direct HIV prevention communication in schools and other education institutions – for example short and simple campaigns on the risk of age-disparate sex showed promising effects in two trials.^{18, 19}

Effective collaboration of the three platforms will require active response management to drive the programme and ensure alignment, for example of community demand generation and service accessibility. Where a local AIDS co-ordination office exists, this office would typically be well placed to perform this leadership function in driving HIV prevention among young women. While this could be linked to broader co-ordination – on HIV, health promotion, young people's health or youth development –, broader co-ordination cannot replace the specific leadership needed for HIV prevention among young women in settings with high HIV incidence. The local AIDS co-ordination office could be supported in elements of this co-ordination function by specific implementing partners such as a lead NGO in the field. Additionally, the engagement of adolescent girls and young women as an integral part of sub-national management and implementation should be planned for from the onset including by involving qualified young adult women as professional staff in the management of programmes.

How to prioritise in the context of limited resources

The main purpose of this decision-making aide is to provide more specific guidance on how to focus interventions for adolescent girls and young women where resources for HIV prevention are limited. This does not necessarily mean that other priorities are less important, but it means that there is need to decide:

- Which components should be funded from the following available resources – domestic or international: 1) HIV prevention for adolescent girls and young women; 2) Other HIV prevention; 3) Other HIV; 4) Other health; 5) Other public health or social development funding.
- How HIV prevention packages should vary between locations with different levels of risk given available resources.
- What platforms should be used to deliver the interventions and how can these be implemented at scale with high quality.

The following pages contain the heart of this decision-making aide:

- A prioritisation and investment matrix;
- A step-by-step decision-making aide.

The prioritisation matrix proposes to invest HIV prevention resources for adolescent girls and young women primarily in locations with high HIV incidence. This should be complemented by much broader health, social development and human rights programming in all locations funded from other funding sources.

In addition, it is important to note that in all settings, young women within key populations (including young women who sell sex, who inject drugs and young transgender women) are at particularly high risk. Programmes for key populations, for which other guidance exists, deserve highest priority in all settings and require specific approaches to reach young women within these key populations. In addition, programmes for young women in settings with high HIV incidence as described in this guide should be open to and provide for non-judgmental access and participation of young women from key populations.

Prioritisation matrix

The **first part of the prioritisation matrix** describes services which should be provided to all adolescent girls and young women in all locations (regardless of HIV incidence levels). It is provided here to provide a full picture, however, in order to implement these actions, countries should primarily rely on complementary HIV, health and development funding (beyond the resources allocated for HIV prevention among adolescent girls and young women).

The **second part of the prioritisation matrix** is focussing on the high, very high and extremely high incidence areas, where clear decisions need to be made, which services should be provided where and to whom.

Through **health platforms**, some basic interventions should be routinely offered in all locations with high HIV incidence to all adolescent girls and young women: HIV/STI risk assessment, HIV risk reduction counselling and testing, active provider-initiated condom distribution and promotion. In settings with very high and extremely high incidence, additional services can be provided routinely, while in settings with high incidence, additional services would only be provided to individual young women at high risk. In line with this, more advanced STI diagnosis could be offered everywhere to adolescent girls and young women at high risk, but as a routine offer only in very and extremely high incidence areas. The degree to which HIV/STI services can be integrated into family planning services could also be varied by HIV incidence levels, which is described in more detail in another document²⁰. The same logic applies to the level of HIV testing followed by ART referral for male partners. In areas with extremely high incidence, PrEP should be routinely offered through all SRH/HIV service delivery points to all young women who are sexually active. In settings with very high incidence, PrEP should also be widely available in all facilities and actively offered to individual adolescent girls and young women at higher risk (for example with history of STIs or with a non-cohabiting partner). In high incidence settings young women at highest risk could be offered PrEP – if available at the site – or otherwise referred.

Through **education platforms**, dedicated school-based (or other education institution-based) HIV prevention campaigns should be offered in all schools and tertiary institutions in very and extremely high incidence areas and selected schools in high incidence areas. Ideally these should be linked to service provision (counselling and testing, condom and lubricant distribution and promotion, referrals to other prevention services) within or near the school. Although financing for CSE should in principle be provided through education sector financing, its scale up should be prioritised in areas with high incidence, and in areas with extremely high incidence funding dedicated for HIV prevention among young women could be used to accelerate it.

Through **community platforms**, active community mobilization on HIV prevention should take place in all communities in very and extremely high incidence areas and selected communities in high incidence areas. In very and extremely high incidence areas, basic community-based demand generation and outreach HIV prevention services should be scaled up to reach virtually all adolescent girls and young women (15-29), specifically those out-of-school, as well as men 20-34, while a more focused approach is recommended for other areas. The more resource-intensive structured interpersonal communication interventions (such as Stepping Stones and SASA!) will likely require even more focus and could primarily be scaled up in all locations with extremely high incidence, but more selected locations elsewhere. Active PrEP demand generation for sexually active adolescent girls and young women should be done community-wide in extremely high incidence areas. In very high incidence areas active demand generation for PrEP should still be done for young women at higher risk. In all other settings, PrEP would primarily focus on key populations including young women from key population communities. Additional social support interventions including economic support, social asset building and education assistance should be paid from other development funding in high and very high incidence areas. In extremely high incidence areas dedicated HIV prevention funding could be used to support specific elements of social support for particularly vulnerable young women with the highest HIV risk.

Finally, the table gives a **very rough cost estimate for the different settings**. There is a large difference in proposed per capita investments between high, very high and extremely high incidence settings. This is because the number of young women at high risk varies between these settings. In settings with high HIV incidence, per capita investments will be lower than in extremely high incidence settings, but the limited resources can be focused on the smaller proportion of young women at higher risk. At country-level, decisions should be made in order to match available funding. The cost estimates refer specifically to Part II of this matrix. They are only indicative as countries within sub-Saharan Africa vary greatly by resource availability and programme costs.

PART I. Complementary action for adolescent girls and young women in all locations

- Access to primary and secondary education
- Universal introduction of comprehensive sexuality education (CSE) and school health programmes
- Out of school CSE
- Social support and economic empowerment of vulnerable adolescents
- Access to (integrated) sexual and reproductive health (including family planning, GBV, cervical cancer screening, HPV vaccine and other STI services) and rights including legal and policy support
- Youth-friendly health systems (including trained providers, conducive hours ...)
- HIV testing and treatment services, PEP, prevention of vertical transmission of HIV as part of maternal health
- Action to address HIV related rights, stigma and discrimination
- Male & female condoms and lubricants, VMMC for men (in relevant priority countries), basic national HIV information (prevention and treatment), risk reduction communications including new & social media
- Comprehensive HIV prevention programmes for key populations (including AGYW within key populations)

Typical funding source

→ Other public health & development funding

→ Other health financing

→ Other HIV financing

→ Other HIV prevention financing

PART II. HIV prevention packages for adolescent girls and young women in high, very high and extremely high incidence locations.

Typical funding source

Local HIV incidence (new HIV infections among young women 15-24/100 person years)	High (0.3-<1.0)	Very high (1.00-<2.0)	Extremely high (2.0+)
Health sector platforms (facilities, service delivery points)			
HIV/STI risk assessment/profile	Routine offer	Routine offer	Routine offer
HIV risk reduction counselling & testing	Routine offer	Routine offer	Routine offer
Active provider-initiated condom and lubricant distribution & promotion	Routine offer	Routine offer	Routine offer
STI diagnosis (including as indicator for HIV risk) and treatment	Other funding	All sites, AGYW at high risk	Routine offer
HIV&STI service integration into FP [separate guide under development]	Selected sites, focused offer	All sites, AGYW at high risk	Routine offer
Male partner testing (invitation letter + self-test) + ART referral	Selected sites, focused offer	All sites, AGYW at high risk	Routine offer
PrEP services	Selected sites, focused offer	All sites, focused offer	Routine offer (for sexually active)
Education platforms (schools, universities)			
Dedicated school-based HIV prevention campaigns (knowledge, risk perception, methods, skills, GBV) linked to services	Selected schools & tertiary institutions	All schools & tertiary institutions	All schools & tertiary institutions
Accelerated introduction of comprehensive sexuality education	Other funding	Selected schools & tertiary institutions	All schools & tertiary institutions
Community platforms (NGOs, CSOs)			
Community mobilization around basic HIV prevention knowledge, risk perception and related social norms	Selected communities	All communities	All communities
Community-based demand generation and outreach HIV prevention services (incl. condoms, self-testing, referrals ...)	All AGYW and men 20-39 at high risk	All AGYW and men 20-39	All AGYW and men 20-39
Active PrEP demand generation	AGYW part of key populations	All AGYW at high risk	Community-wide
Structured interpersonal communication outreach (e.g. SASA! etc.)	Selected communities	Selected communities	All communities
Cash transfers, incentives, economic empowerment	Other funding	Other funding	Vulnerable AGYW at high risk
Social asset-building, safe spaces, parenting programmes, mentoring	Other funding	Other funding	Vulnerable AGYW at high risk
Keep girls in-school / education assistance	Other funding	Other funding	Vulnerable AGYW at high risk
Cross-cutting and management			
Local AIDS Office leads regular review & problem-solving	Recommended	Recommended	Recommended
Full-time AGYW lead within local AIDS Office	Optional	Recommended	Recommended
Indicative cost (per year on average per AGYW aged 15-29 living in the location)	5-20 USD	15-50 USD	40-100 USD

HIV prevention financing for adolescent girls and young women

■ Routine offer for all AGYW in the area

■ Focus on specific locations or groups of AGYW

■ Highly focused on AGYW at higher risk

Decision-making aide: Step by step

To assist countries in deciding what packages should be provided, by whom, to whom and where, a step-by-step aide is presented here:

Step 1: Countries should review their HIV incidence patterns, which should be disaggregated by age, sex and location. The most commonly used source for this analysis will be UNAIDS sub-national HIV estimates generated through mathematical models*. On that basis sub-national areas can be differentiated by their level of HIV incidence. For context, it is important to analyse HIV incidence data not only for young women 15-24, but also other age groups of women and men to understand possible interactions.

Step 2: Based on the above and using population figures, the population size of young women in settings with high, very high and extremely high incidence can be estimated. Although not every individual young women may be at risk, this population size provides an estimation of the priority population.

Step 3: In order to know which prevention strategies are more / less important in a sub-national area and to identify the groups “most vulnerable” or “most in need”, it is also critical to have an idea which factors drive HIV acquisition by adolescent girls and young women in the country or sub-national level:

- *Behavioural factors:* age-disparate sex, multiple partnerships, sex work and sexually exploited adolescent girls, transactional sex, early sexual debut, gaps in knowledge and limited personalized risk perception); harmful practices (e.g. drug use).
- *Biological factors:* biological susceptibility of women and adolescent girls, high HIV viral load among male partners, low prevalence of male circumcision, sexually transmitted and other co-infections.
- *Structural factors:* harmful social and gender norms, gender inequality and unequal power dynamics, low secondary school attendance, lack of economic empowerment, labour migration and spousal separation, barriers to accessing sexual and reproductive health and HIV services, orphanhood, child sexual abuse, GBV, marriage patterns.

This information can be obtained using existing survey or (implementation) research results from the country or sub-national area or through rapid assessments at subnational level. The information can be used to further define the population size of young women to be reached with different programme components. In districts with extremely high incidence, this number will be identical to the total number of young women in the district. In districts with high-incidence, this will likely be a smaller sub-population of young women at higher risk – for example young women with a non-regular partner and young women in specific peri-urban locations. These population sizes will be the basis for coverage targets.

Step 4: Review what HIV prevention programme elements are already available (health, education, community) and the coverage of these interventions.

Step 5: Develop a results framework (theory of change):

- Define HIV prevention packages per category using the proposed packages in the prioritisation matrix as a starting point.
- Set programmatic coverage targets for HIV prevention in high, very high and extremely high incidence locations. Targets should be tracked for different age groups (e.g. 15-19 and 20-29) as overall coverage might mask lower coverage in one age group.
- Efforts to scale up prevention among adolescent girls and young women can build synergies with broader efforts in the area of HIV prevention, HIV, SRH, adolescent and women’s health and well-being, GBV prevention and response, social protection and other development activities.

Step 6: In line with the defined HIV prevention packages, clearly define the role of the different delivery platforms (health facilities, schools, community platforms), and develop a simple delivery system. Depending

* There are different ways in which HIV incidence can be measured in young women: Cohort studies (but expensive to get adequate sample size, take time); recency testing in survey (but very large sample size for sub-national or age groups needed); recency testing in antenatal care (but limited to pregnant women); new diagnoses from routine programmes (but patterns of testing change and there are delays in diagnoses); models (prevalence measures or case surveillance, or historical and projections).

on the situation in a country or sub-national area, there could be one lead non-governmental organisation (NGO) or civil society organisation (CSO) for HIV prevention among adolescent girls and young women in a district to lead on community-level components. Such an organization should have the capacity to implement at scale, actively involve young women (including as staff and champions) and collaborate closely with the local AIDS office, health facilities, schools and other partners operating in the area.

Step 7: Define a simple management mechanism for the HIV prevention component to reflect the focus on delivery of core results with the required geographical coverage, intensity and quality. Depending on the context of the country, this could for example be a local AIDS office, which is dedicated to HIV prevention, including adolescent girls and young women, but linking to broader HIV, SRH, GBV, health and development structures.

Step 8: Develop a costed operational plan. Based on the targets and defined packages and operating procedures, countries should develop operational plans, including national and subnational programmes and activities. The resources available in the country (domestic and external funding) should fully cover the proposed programme implementation. To achieve sustainable results, social contracting (defined as the use of government resources to fund non-governmental entities - NGOs and community-led organisations) will be essential to maintain the packages of services when donor funding for prevention of HIV among adolescent girls and young women decreases.

Step 9: Develop an M&E plan. The M&E plan, which should be linked to the results framework and anchored within broader national health information systems, assists with tracking and regularly reviewing progress towards results, thereby ensuring shared responsibility and accountability at various levels of implementation. In addition, the national M&E plan should ideally also include an evaluation component looking at measuring and linking the implementation of the packages to changes in the epidemic. This will facilitate improved understanding of the status of the epidemic and response locally, and effective use of these data support evidence-informed programmatic changes based on what is working for whom.

Conclusion

In order to reach a further reduction in new HIV infections among adolescent girls and young women globally, the response in settings with high incidence should be scaled up and thereby complement HIV programmes for other key and priority populations. This decision-making aide complements existing guidance and focusses on the optimisation of the size of the packages depending on the incidence level and looking at the main programme delivery platforms. The cost of the interventions, as well as the cost-effectiveness are, however, also important factors to decide how to best use available resources. Whilst ensuring strong linkages to broader development programmes including the education, social and health sector, the step by step aide should assist countries in deciding what packages should be provided, to whom and where.

References

- ¹ UNAIDS (2019) Communities at the centre: Defending rights, breaking barriers, reaching people with HIV services. Global AIDS Update 2019. <https://www.unaids.org/en/resources/documents/2019/2019-global-AIDS-update>
- ² Saul J, Bachman G, Allen S, Toiv NF, Cooney C, et al. (2018) The DREAMS core package of interventions: A comprehensive approach to preventing HIV among adolescent girls and young women. PLOS ONE 13(12): e0208167. <https://doi.org/10.1371/journal.pone.0208167>
- ³ The Global Fund. Adolescent Girls and Young Women in High-HIV Burden Settings: Technical Brief. Draft September 2019.
- ⁴ PEPFAR. FY 2020 Country Operational Plan Guidance for all PEPFAR Countries. Draft. https://www.state.gov/wp-content/uploads/2019/11/2019-11-25-COP20-Guidance-Full-Consolidated_Public-2-1.pdf
- ⁵ UNAIDS Guidance (2016) HIV prevention among adolescent girls and young women: Putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys. <https://hivpreventioncoalition.unaids.org/resource/hiv-prevention-among-adolescent-girls-and-young-women/>
- ⁶ UNAIDS (2018) Miles To Go: Closing Gaps, Breaking Barriers, Righting Injustices. Global AIDS Update 2018 https://www.unaids.org/en/20180718_GR2018
- ⁷ UNFPA (2011) Comprehensive condom programming: guide for resource mobilization and country programming. <https://www.unfpa.org/publications/comprehensive-condom-programming>
- ⁸ WHO (2015) Consolidated guidelines on HIV testing services <https://www.who.int/hiv/pub/guidelines/hiv-testing-services/en/>
- ⁹ WHO (2017) WHO implementation tool for pre-exposure prophylaxis of HIV infection <https://www.who.int/hiv/pub/prep/prep-implementation-tool/en/>
- ¹⁰ WHO (2016) Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations - 2016 update. <https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>
- ¹¹ UNESCO (2018) International technical guidance on sexuality education – an evidence-informed approach. <https://unesdoc.unesco.org/ark:/48223/pf0000260770>
- ¹² WHO (2016) Global standards for quality health-care services for adolescents - a guide to implement a standards- driven approach to improve the quality of health-care services for adolescents.
- ¹³ UN Women (2019) Gender and age-responsive social protection: The potential of cash transfers to advance adolescent rights and capabilities <http://www.unwomen.org/en/digital-library/publications/2019/03/gender-and-age-responsive-social-protection#view>
- ¹⁴ UNFPA. Sexual and reproductive Health and rights: An essential element of Universal health coverage. <https://www.unfpa.org/featured-publication/sexual-and-reproductive-health-and-rights-essential-element-universal-health>
- ¹⁵ UNFPA. Rights and choices for all adolescents and youth: a UNFPA global strategy. <https://www.unfpa.org/youthstrategy>
- ¹⁶ Chimbindi N, Birdthistle I, Shahmanesh M, Osindo J, Mushati P, et al. (2018) Translating DREAMS into practice: Early lessons from implementation in six settings. PLOS ONE 13(12): e0208243. <https://doi.org/10.1371/journal.pone.0208243>
- ¹⁷ UNAIDS, PEPFAR (2019) Start Free Stay Free AIDS Free - 2019 report. https://www.unaids.org/sites/default/files/media_asset/20190722_UNAIDS_SFSAF_2019_en.pdf
- ¹⁸ Dupas, P. Do teenagers respond to HIV risk information? Evidence from a field experiment in Kenya. American Economic Journal: Applied Economics. 2011;3(1):1–34
- ¹⁹ Angrist, N., Matshaba, M., Gabaitiri, L. et al. Revealing a safer sex option to reduce HIV risk: a cluster-randomized trial in Botswana. BMC Public Health 19, 610 (2019). <https://doi.org/10.1186/s12889-019-6844-8>
- ²⁰ WHO, UNAIDS. Preventing HIV among women using contraceptives services in contexts with high HIV Incidence. A brief on actions for better choices. Geneva 2020 (under review).