
# Preventing HIV in Adolescent Girls and Young Women

## Guidance for PEPFAR Country Teams on the DREAMS Partnership

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## Rationale: Why focus on adolescent girls and young women?

Despite considerable progress in the overall global HIV/AIDS response, the epidemic among females aged 15-24 in a subset of critical countries is out of control. AIDS is the leading cause of death for adolescent girls in Eastern and Southern Africa (1). As many as 7,000 new infections a week are occurring in our most vulnerable girls and young women in Eastern and Southern Africa (2) – people who are critical to the future of their countries (Figure 1). An urgent response in programming is needed now.

Globally, 15% of women living with HIV/AIDS are aged 15-24, with 80% of these women living in sub-Saharan Africa (2). Studies in Kwazulu-Natal province in South Africa reveal shockingly high HIV incidence rates—6.5 per 100/women-years (WY) for females aged 14 – 30 (3), and 7.5 per 100/WY among unmarried women under age 25 (4). This corresponds to prevalence in females aged 15-24 well over 10% in Swaziland, Lesotho, and South Africa. Across eastern and southern Africa, HIV incidence and prevalence among adolescent girls and young women (AGYW) is several times higher than that of their male peers (Figure 2). Add to this the "youth bulge" in sub-Saharan Africa: since 2003, the total population between the ages of 10-24 in this region has increased by 26%, and it is predicted to increase by an additional 28% by 2030 (5). These realities lead up to staggering numbers of new infections; according to data from UNAIDS, 380,000 females between the ages of 10 and 24 are infected annually (2) and, if we do not rapidly reduce incidence, this number will continue to grow.

### For their own health, well-being and development

Keeping AGYW HIV- and AIDS-free is critical for their well-being and health, the health of their families and communities, and their countries' future. Evidence suggests that women infected with HIV are eight times as likely to die as uninfected women (5). Furthermore, evidence shows more rapid disease progression among females infected with HIV in South Africa, where the largest numbers of new infections are occurring (6).

Many of the same factors associated with HIV acquisition among girls and women– lack of education (7), transactional sex (8) and experience of gender-based violence (9) – increase the risk of other negative outcomes, such as poverty, early pregnancy, and depression. By addressing the structural issues that predispose some young women to becoming infected, we will also protect them from other harmful outcomes.

### For the health and well-being of the next generation of children

Focusing our HIV prevention efforts on adolescent girls and young women will have tremendous impact on the lives of children (10). Recent modeling commissioned by PEPFAR has shown that one of the most effective interventions to impact the overall health, development, and well-being of children affected by HIV and AIDS is to prevent HIV infection in this population (11). When girls and young women living with HIV go on to become mothers, their children are at substantially greater risk for a host of negative sequelae, including death; depression; school dropout; and physical, sexual and emotional abuse (12). Mothers who contract HIV early in life are much more likely to become ill or die before their children turn 18—whereas mothers who contract HIV later in life are much more likely to be asymptomatic

and alive before their children turn 18. Therefore, focusing our HIV prevention efforts on adolescent girls has tremendous impact on the lives of children (10).

For example, in some communities in South Africa, where close to half of the approximately 5,000 new infections in girls and young women occur every week, by the time children reach the age of 5, close to 40% of their mothers already have HIV (Figure 1). Modelling suggests a one third reduction in new infections among 15-24 year old women and girls in South Africa would have a larger impact on children's school completion than universal coverage of treatment and near perfect adherence (Figure 3).

### But do we know what to do for girls and young women?

While PEPFAR and other partners have been working to prevent HIV in AGYW for over a decade, our efforts have not resulted in the depth of impact required. It is time for a substantial, focused effort to protect these young people from new infections, for their own health and wellbeing and as an essential element of reaching epidemic control.

While no single intervention has emerged that can avert most new infections in this age group, there are a range of high-quality studies on conditional cash-transfers, empowerment programs, interventions that reduce levels of gender-based violence and pre-exposure prophylaxis that suggest a new, more effective strategy for reducing incidence. It is time to move boldly forward with comprehensive packages of social, economic and biomedical interventions to both reduce girl's vulnerability to HIV and increase their agency. At the same time, we must step up our efforts to build HIV testing and treatment programs that attract and retain the male sexual partners of these young females.

This guidance synthesizes the literature on preventing new infections for females 15-24 and presents those interventions and approaches approved for PEPFAR-funded programs. All recipients of funds through the PEPFAR DREAMS Initiative will follow this guidance in programming HIV prevention for this population. Other PEPFAR programs in countries where the numbers of new infections in females 15-24 exceed that of males and contribute substantially to the epidemic are encouraged to use this guidance, as well, as together we must decrease the number of new infections in young women.

## Steps for an effective HIV prevention response

To quickly and significantly decrease HIV risk in AGYW, a core package of evidence-based interventions must be brought to scale in specific subpopulations living in the geographic focus areas of highest prevalence. Teams are encouraged to go through a process that identifies: WHERE? WHO? WHAT? and HOW?

### WHERE?

HIV prevalence varies substantially across and within regions. The core package of interventions should be geographically focused in areas of high burden (i.e. specific provinces, and within them, specific districts and communities). The geographic area should be selected based on HIV incidence, where data is available, or HIV prevalence where it is not, and should align with

current efforts underway within PEPFAR to target key HIV regions within a country. While country teams are free to choose the most appropriate sub-national unit (SNU) for DREAMS implementation, all SNUs must be a subset of those chosen for geographic prioritization within the larger PEPFAR program and align with SNUs identified in the Integrated PEPFAR Site List . This package should not be implemented at a national level.

## WHO?

Within the chosen geographic locations, each intervention should be specifically targeted to prevent infections in the most vulnerable sub-groups of females 15-24. Programming should begin with 10-14 year old girls with OVC programming. These sub-groups will vary across and within countries; some commonly include those whose parent or parents have HIV or have died of AIDS, those having sex with older men, those engaged in transactional sex with high-risk partners, those engaged in sex work, those who are food insecure, those who are married early, those whose partners are violent, those who have experienced violence in the past, and those who are mobile or whose partners are mobile. Because vulnerability may be the result of earlier occurring factors (e.g., dropping out of school), interventions for younger age cohorts of girls should also be included where evidence exists for these risk factors.

To determine which sub-groups are most at-risk in a given geographic area, PEPFAR teams and implementing partners will need to gather both quantitative and qualitative data. In many cases, data are already available, but need to be compiled and analyzed. In some other situations, rapid assessments using program data (in particular HIV testing data), focus groups, key informant interviews and other techniques will be needed in order to understand both which AGYW are at greatest risk and why. *It is critical that these populations be identified not solely on the basis of behavior, but also on the basis of HIV prevalence* (Figure 4).

Many PEPFAR programs and implementing partners may be under-utilizing existing sources of information when identifying populations at highest risk. For example, careful analysis of DHS data can yield substantial insights into populations of AGYW with especially high prevalence. Figure 5 shows an analysis of the relationship between age and marital status and HIV prevalence conducted by Rick Olsen of UNICEF on the most recently available DHS or AIS data. In Cameroon, Mozambique and Lesotho, we can see divorced/separated/widowed females in this age group have substantially higher HIV prevalence than other females 15-24. These kind of closer analyses can help teams and partners more tightly focus HIV prevention programs as part of a comprehensive approach. Similar analyses can be conducted looking at wealth quintile, and have revealed patterns of prevalence suggesting that AGYW with access to more funds may be at increased risk. However, teams should keep in mind that a population with very high prevalence might also be small in size and therefore contributing relatively few new infections (e.g. divorced or widowed AGYW). When prioritizing sub-populations for interventions, both HIV prevalence and the relative contribution to new infections should be taken into account.

In addition, other relevant data sources should be used to inform programming. For example, Violence against Children Surveys (VACS) can provide data on the levels of both physical, emotional and sexual violence experienced by children, as well as an understanding of who is perpetrating violence and where (Figure 6) (Figure 7).

## WHAT?

This guidance presents a core package of evidence-based and scalable interventions designed to work together to reduce new infections in females 15-24 (Figure 8). The chosen categories of interventions demonstrate effects on HIV-related biological outcomes, HIV risk behaviors, experience of violence, or they are considered prudent practices for linking, delivering, and supporting high-impact interventions. (Refer to Appendix A for more details regarding the Core Package evidence and how specific categories and interventions were chosen.)

The core package of interventions requires a multi-faceted, integrated response from the health, education, psychosocial, economic and civil society/community sectors in each country. Some interventions have the potential to directly reduce HIV risk in AGYW; others have the potential to reduce HIV risk more distally, by influencing contextual factors that contribute to vulnerability.

### The Core Package of Interventions

The core package of interventions addresses HIV prevention for AGYW through work with four, overlapping populations (Figure 8) and aligns with the Nike Foundation's approach to keeping girls HIV Free (Figure 9):

1. AGYW – interventions for this population aim to empower girls and to reduce their risk for HIV and violence;
2. Their families – interventions for this population aim to strengthen the family economically, as well as in their ability to parent positively[1];
3. Their sexual partners – this activity aims to characterize "typical" sexual partners of AGYW in order to target highly effective HIV interventions – specifically voluntary medical male circumcision (VMMC) and antiretroviral treatment (ART) to men in the community who likely to pose a transmission risk to AGYW;
4. Their larger communities – these interventions aim to educate AGYW and young men, as well as mobilize communities for change regarding keeping girls HIV free and safe from violence.

These interventions, supported by ongoing data collection and use for decision-making, work together to reduce risk and vulnerability of girls and young women. Table 1 identifies interventions within each category, the groups who would be targeted for each intervention, the outcome expected from implementing that intervention, and the technical activities that should accompany that intervention.

This package was developed through intensive review of existing evidence (see Table 3 and Table 4). Stakeholders from across the UNAIDS Secretariat as well as research experts from a range of disciplines provided input on this core package.

[1] Interventions for families of AGYW should be funded primarily by focused OVC programs.

The package is meant to act synergistically, reducing new infections in AGYW by reducing their vulnerability as well as by increasing their agency. Data collected by Dr. Lucie Cluver on the impact of a range of preventative interventions in South Africa shows that comprehensive packages addressing multiple needs of young people have greater impact on risk behaviors than any single intervention (Figure 10).

While all elements of the core package are important for reducing HIV incidence in AGYW, some will require financial support from PEPFAR's partners. Specifically, funding of ARVs for PrEP and commodities for expanding the contraceptive method mix should be sought from other donors or governments. Some cash transfer programs may also be better funded through non-PEPFAR sources. Country teams should work with PEPFAR headquarters to identify requirements for funding to implement these activities, and collectively we will work with foundations and the private sector to increase resources for these specific areas.

## Pre-exposure prophylaxis (PrEP)

DREAMS is the first instance of PEPFAR funding pre-exposure prophylaxis (PrEP) through its HIV prevention programs. As of the publication of this guidance, the DREAMS Task Force is still consulting with a range of experts on how best to implement PrEP for AGYW; further guidance will be provided in the first half of 2015. However, some guidelines for the implementation of PrEP under DREAMS are already in place:

- Under DREAMS, PrEP is to be funded in demonstration projects, designed to further our understanding of how best to implement this intervention to maximize its positive benefits and minimize adverse outcomes.
- Until further notice, only oral PrEP is to be provided under DREAMS.
- PrEP should always be provided in the context of the full core package of services, with beneficiaries receiving at least monthly supportive services to identify and address sources of risk. The goal is "PrEP as a bridge," where the most vulnerable AGYW are assisted to reduce their risk and move to more sustainable forms of HIV prevention.
- PrEP demonstration projects should be carefully targeted to young women at the highest risk in the highest prevalence areas. *These women should know they are at high risk of contracting HIV and be motivated to protect themselves.* Country teams are expected to restrict implementation of PrEP demonstration projects to females 18-24 years of age; exceptions may be made on a case by case basis.
- PrEP demonstration projects should only be conducted with the full support and buy-in of partner governments. In countries where this support and buy-in are not yet in place, DREAMS advisory councils should make the development of PrEP-friendly policies and regulations a focus of their efforts.
- PEPFAR country teams should seek funding for PrEP ARVs from external donors. The DREAMS Task Force will pursue opportunities for external funding and country teams should work with the Task Force as they look for similar opportunities at the national level. The Gates Foundation is already funding PrEP demonstration projects in several countries and will be a key supporter of this work.

## The Core Package of Interventions in Your Country

While the core package of interventions specifically highlights opportunities for action to reduce HIV risk among AGYW, it should not be considered separate from the integrated health, education and social systems operating within country contexts. To leverage existing country capacity and infrastructure, both clinical and community platforms must be considered, alongside work to address the relevant policies and laws that hinder or help implementation. Enhanced coordination must be demonstrated between OVC programming and other platforms. This will involve working closely with country stakeholders and local partners to maximize current service platforms. Table 1 provides examples of special considerations for each intervention.

Although the objective of DREAMS is to reduce incidence in 15-24 year old girls and women, many interventions to keep AGYW HIV-free will need to reach them in their younger, pre-risk years (ages 10-14), or target their male sexual partners. For example, in communities where many girls experience coerced or forced sex, interventions to protect these girls and change community norms around violence will be appropriate and may be funded by DREAMS.

With the exception of PrEP, PEPFAR OUs participating in the DREAMS Initiative should plan to implement the majority of interventions from each category of the core package. OUs may "opt-out" of an intervention when evidence can be provided that the intervention is inappropriate or duplicative of existing services. PEPFAR OUs may choose to include additional interventions within each category if they can show evidence to support that intervention and with approval from the DREAMS Task Force.

Once OUs have determined which general interventions they will implement, and which, if any, they will opt-out of, teams must specify the specific intervention models that will be used (e.g., which of the many evidence-based school-based prevention interventions will be implemented). Table 6 lists specific interventions models that have been shown to impact HIV and/or violence outcomes. When possible, these specific models should be used. However, because the evidence base for the interventions in the core package varies greatly, some flexibility on substituting other intervention models is allowed with justification. Acceptable reasons for substituting a model not specified in Table 6 include: 1) the team has experience with another model that has been shown to impact important risk factors for HIV or violence; and 2) the model has been adapted from an evidence-based model that has been shown to have an impact on HIV or violence outcomes. In addition to listing specific evidence-based intervention models, Table 6 specifies where there is and is not flexibility within the core package.

Each intervention requires a specific set of actions or "Technical Activities" in the relevant sectors as outlined in Table 1. Country work plans should be established for each intervention and be used in routine assessments of how PEPFAR country teams are meeting goals.

Interventions categories not listed in the core package are not to be provided using DREAMS funding without explicit approval from OGAC.

The principles of the core package of interventions are relevant to many countries, not just those OUs receiving DREAMS initiative funding. Wherever PEPFAR countries are implementing

HIV prevention programs for AGYW, they are strongly discouraged from adopting a "piecemeal" approach to prevention programming for this population.

### How?

The core package of interventions should be geographically focused on high prevalence areas only, and within those high prevalence areas, on sub-populations at highest risk. Once these populations have been identified and their respective size estimations completed, the team should set coverage goals, with the aim of reaching 70-80% of the sub-populations selected with the core package of interventions. Speed to coverage is essential. Census, Integrated Bio-Behavioral Survey (IBBS) and program data can be used to estimate population size. Different technical areas and platforms within PEPFAR should work together to set targets, implement the interventions, monitor performance, and track progress in real time. Note that where interventions involve sectors beyond health, these programs and partners will also need to be engaged in setting targets and monitoring interventions.

Existing platforms and programs should be used to identify the most vulnerable and at-risk AGYW within the broader population of females 10-24. For example, PEPFAR-supported OVC programs in high-priority geographic areas should identify the most at-risk girls in their programs and ensure they have access to the package of interventions. AGYW identified through HIV testing and counseling (HTC) on any clinical platform – ANC, outpatient, inpatient – should be linked to appropriate services. Those who are positive should be linked to youth-friendly treatment programs, while those who test HIV negative and are members of prioritized sub-populations should be linked to the core package of interventions.

Where a large proportion of girls start childbearing before the age of 19, antenatal clinics, PMTCT programs, and MCH services in the high priority geographic regions are important places to identify at-risk sexually active adolescent girls (Figure 11).

## Governance

Each DREAMS country should establish a multi-sectoral advisory committee at the national level, as well as in each region where DREAMS is being implemented. These committees should have membership from the PEPFAR team, national and local government (as appropriate), other donors, the UNAIDS secretariat, UN Family, civil society and, most importantly, *adolescent girls and young women from the specific sub-groups targeted*. These girls and young women should be supported to gain the skills and confidence necessary to plan an active role on these committees.

These committees should have several roles:

- Identify and address relevant policy issues, such as age of consent for HIV testing;
- Identify and coordinate with other relevant initiatives targeting this population;
- Provide advice to PEPFAR and DREAMS its implementing partners on the core package as well as on sub-groups to target with interventions;
- Provide ongoing feedback and insight on program effectiveness.

Where existing groups play a similar role (for example, in countries where a violence against children (VACS) study has been conducted and a committee formed to take action on its findings), the DREAMS advisory committee may be subsumed within it, should all parties agree. See the DREAMS Roles and Responsibilities document for more information.

### Implementation Science

During development of your country work plan we expect that critical Implementation Science (IS) research questions may arise. Please note that the Country Strategy template includes a space to compile IS research questions from your group. These questions might address gaps in geospatial and temporal epidemiology; or they might address how best to tailor or deliver the intervention package to reach young women and adolescent girls at risk. These questions will be shared with the Gates Foundation, who will fund a subset of IS questions through its partner, the Population Council. PEPFAR HQ staff will also cross-reference ongoing PEPFAR-supported IS projects with your submission. This exercise will help us to create linkages between Principal Investigators and PEPFAR teams, to share implementation lessons and early scientific learnings where appropriate. Furthermore, your submissions will help to inform potential future IS research priorities and projects that are centrally-funded. Lastly, we encourage PEPFAR teams that have ongoing agreements with evaluation partners through 2017 to consider proposing Impact Evaluation concepts related to HIV prevention in females 15-24 in COP15.

## Monitoring and Evaluation

DREAMS follows a logic model that should guide how programs are monitored and evaluated (Figure 12). The model lays out the epidemiological context that puts AGYW at additional risk of infection, the interventions proposed to address these contextual factors, the expected outputs and outcomes of these programs, and the overall impact of those outcomes in combination. The DREAMS partnership will use several approaches to measure outcomes and impact: HIV impact assessment surveys, other available survey data (DHS, VACS, ANC surveillance, etc.) as they become available, site level data from PMTCT programs. Impact will also be modeled based on the coverage of the core package in each sub-national unit (SNU) selected for implementation. PEPFAR country teams are expected to provide a subset of this information to assess impact:

- PMTCT: baseline followed by quarterly assessment of the percentage and number of pregnant females testing positive for HIV at the ANC clinics in the implementing SNUs, disaggregated by age, 15-19 and 20-24.
- MER indicator data collected quarterly or semi-annually for: PP_PREV, HTC_TST, GEND_GBV, OVC_SERV (see the indicator table for some special disaggregations associated with some of these indicators)
- SIMS data to allow us to broadly confirm quality of inputs.

PEPFAR country teams will not be expected to fund or implement other impact assessments related to DREAMS.

The outputs and outcomes colored in red in the logic model will be monitored through program data gathered by PEPFAR implementing partners and reported to the PEPFAR country team. Some of these outputs and outcomes will be captured through regular program indicators, some through standard OVC surveys, and others through triangulation of program data from different sources (e.g. number of males fitting the profile of AGYW sexual partners initiating ART or receiving VMMC). This data will be used for several purposes:

- To track the progress of DREAMS programs towards coverage goals;
- To ensure that programs are reaching their intended target groups;
- To identify problems with implementation that require course-correction;
- To feed into models of program impact at the end of the first two years of DREAMS implementation.

PEPFAR teams implementing DREAMS activities should develop plans for how they will collect, analyze and act upon this data in concert with implementing partners. The key DREAMS indicators (see the DREAMS section of the MER Indicator Reference Guide) will be reported to headquarters quarterly.

Many AGYW who are at high risk of contracting HIV are also likely to become pregnant. Thus, rates of HIV positivity in patients testing in ANC settings are a good proxy for incident infections in the population of at-risk females 15-24. HIV rates in ANC settings are therefore an essential element of monitoring program impact. PEPFAR teams will be tracking the percentage of pregnant females 15-19 and 20-24 presenting at ANC sites in DREAMS implementing areas with HIV+ status. Teams should plan a baseline assessment of HIV serostatus in these sites in 15-19 and 20-24 year olds prior to or very early in DREAMS implementation. Programs should be tightly focused on reducing percentages of women who are pregnant and HIV +, with quarterly reviews of data to assess progress.

Partners should use the MER PP_Prev indicator to track provision of the core package to target populations (except where young sex workers are the target population, in which case KP_Prev should be used). Teams should work with partners to establish population size estimates at the sub-regional level, and set coverage targets with a goal of reaching 70-80% coverage.

Teams should plan on submitting quarterly reports to S/GAC on implementation progress and challenges. This quarterly reporting should be used by the team to ensure programs are successfully targeting the populations selected for the package, and that the populations selected are indeed at substantially higher levels of HIV prevalence than the national average. Yield data from HTC programs, in particular, should be actively tracked by partners and the PEPFAR team to ensure correct targeting. Teams and partners are expected to actively monitor programs and make real-time adjustments in order to achieve programmatic goals.

Additionally, teams should plan ongoing evaluation of program delivery, to ensure fidelity to program design, identify areas for immediate improvement, and track appropriate program growth. Where countries are planning HIV Impact Assessments or other forms of AIDS Indicator Surveys, sampling plans should ensure that incidence in females 15-24 is captured.

## Working with Governments to Build DREAMS

PEPFAR has learned several important lessons for ensuring that DREAMS programs are poised to sustain the gains they make in reducing new infections.

First, government engagement and leadership in planning and management of HIV activities is essential, both at the beginning and throughout – this was evident at the January 2015 DREAMS Planning Meeting. Without government leadership, political will, and shared responsibility through direct commitments, successful multi-sectoral engagement is not likely, which is of particular importance given the multi-sectoral nature of the DREAMS Initiative. Collaborative planning and decision making between the government, key stakeholders including civil society, and donors (PEPFAR and GF) is a mechanism to enable governments to lead and commit vital resources to the initiative.

Second, feasibility of DREAMS activities is likely to be dependent on the use of, or integration into, existing, government-supported systems and structures. New interventions should not be established within parallel structures unless necessary nor integrated into broken or dysfunction existing systems or structures unless efforts are made to improve the systems. Thus, it will be important to identify and assess the functionality and durability of local health, education, and judicial structures necessary for DREAMS interventions.

Finally, PEPFAR resources for DREAMS activities will not be sufficient to reduce the vulnerabilities of adolescent girls and young women to achieve an AIDS-free generation. In some instances, important policy, structural, and system reforms within the current health, education, and judicial system are necessary to ensure the sustainable impact of these interventions. Many of these reforms, such as government policies and regulations ensuring universal access to secondary education for girls, can be leveraged as part of a partnership with the government in reaching DREAMS goals. In the justice sector, enforcement of existing laws prohibiting child marriages, statutory rape/defilement and female genital mutilation (FGM), and ensuring that young girls at risk for child marriage and/or FGM have legal protection may contribute to the long term impact of programs designed to reduce HIV risk for adolescent girls. Prosecution of perpetrators of sexual violence who abuse young girls is another area where the national response can enhance specific programs for post-violence care.

These reforms, therefore, should be seriously considered as a form of commitment made by partner governments to demonstrate shared responsibility in partnership with the US government to reduce HIV risk for adolescent girls as well as part of the partnership for the Initiative.

For more information, please reference Table 2: Recommended Activities to Support Sustainability of DREAMS.

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# Appendix A: The Core Package of Interventions

## Evidence

In order to limit the package to those interventions most likely to impact HIV incidence in AGYW, several criteria were applied in the selection of interventions.

Each intervention (or category of interventions) was rated with regard to the level of evidence supporting it (See Table 3 for the evidence classification scheme used in our reviews). Other criteria applied included scalability, sustainability, maximizing the effect of existing PEPFAR platforms and programs, linkages to other priorities (e.g., ACT initiative), and whether the intervention was likely to have a direct rather than an indirect effect on AGYW. Finally, the package also includes prudent practices – those interventions, policies, or practices that may not have been evaluated but are a sensible foundation or complement to the rest of the interventions in the package. Each intervention's level of evidence and the outcomes impacted are provided in Table 4.

## Rationales for interventions

**Adolescent-Friendly Sexual and Reproductive Health for Girls:**

Condoms, increase consistent use and availability (female & male)

- Rationale → Highly effective when used correctly and consistently (13) (14) (15); unethical to not provide when intervening with high risk population
- Rationale → Research indicates that pregnancy prevention is a primary motivating factor behind many young women's use of condoms. Condom promotion efforts can capitalize on young women's desires to avoid unwanted pregnancy.

PrEP

- Rationale → PrEP is a highly effective intervention if adherence is maintained. (16) (17) (18) (19) (20)
- Four of six PrEP trials conducted in African HIV serodiscordant couples, young men and women in Botswana, men who have sex with men in a multi-country trial, and injection drug users in Thailand showed efficacy of daily oral tenofovir (TDF) or emtricitabine/tenofovir (FTC/TDF) ranging from 44% to 75% [provide references]; efficacy was strongly related to adherence, which ranged from 52% to 82% based on plasma tenofovir testing in a subset of participants In the active arms of such trials, the presence of drug in plasma was estimated to provide 85-92% protection against HIV. Efficacy of daily oral PrEP among young African women was high in two trials – the Botswana TDF-2 study and in the Partners PrEP Study, both in all women and women < 30 years old and all other subgroups of women (21).
- In two trials (VOICE and FEM-PrEP) which enrolled young African women, overall adherence was too low to observe efficacy, with tenofovir detected in ~30% of

plasma samples; however, a subset of women consistently adhered to PrEP based on longitudinal tenofovir detection in plasma. However, adherence in these studies was undermined by doubts among participants about the treatment's efficacy.

- Oral PrEP has the potential for significant reduction in HIV incidence among young southern African women, if delivered with education about PrEP efficacy and the importance of adherence and counseling and risk assessment to assess women's perceived risks and benefits of PrEP, and cognitive reminders about PrEP adherence. The impact will be greatest if the subset of young women who are at highest risk of HIV are motivated to use PrEP and able to establish daily pill-taking habits and sustain high adherence while they remain at risk**.**
- Topical PrEP – Topical PrEP was observed to be efficacious in a population of young women in South Africa (Karim Abdool, S et al. 2010). Confirmatory studies are ongoing, therefore it is not considered for this package of interventions.

Violence prevention and post-violence care, including PEP

- Rationale → Research shows a strong association between violence, especially intimate partner violence and violence against children, and HIV status in women. Preventing, screening for and treating the outcomes of violence in AGYW is an effective way to reduce risk as well as identify those at greater risk for HIV infection. Programs that increase women's social capital and agency as well as economic self-sufficiency have been show to decrease reports of IPV in participants (22)
- Rationale → Post violence care is part of PEPFAR portfolio, but most effective interventions are often not used (23) (24)
- Rationale → Provision of PEP after sexual assault is considered the standard of care and is part of PEPFAR portfolio, but rarely available; should be bolstered if coverage is low. (25) (26) (27) (28) (29)

HTC

- Rationale → This is an essential intervention to increase knowledge of serostatus among ALHIV, and earlier diagnosis facilitates earlier linkage to care and initiation on ART (30). HTC is also a crucial point of entry for the entire package of services, and can link these efforts to the ACT initiative. Finally, there is some emergent data that HTC may have prevention benefits among youth (31).

Increasing contraceptive method mix

- Rationale → AGYW in low income countries experience high rates of pregnancy due to unmet need for voluntary family planning, which increases their risks for pregnancy-related morbidity and mortality and affects lifelong education and economic opportunities (32). Increasing access to voluntary family planning methods and a range of contraceptive methods will increase the likelihood that

AGYW are able to achieve fertility goals; including prevention of pregnancy until desired, and an ability to switch methods if/when they elect to (33). The promotion of dual protection, in which condom use is combined with another modern contraceptive method, is a critical component of FP/HIV services for AGYW. Dual protection will help reduce the risk for STI/HIV infection as well as unintended pregnancy.

- Furthermore, data suggest potential associations between the use of certain injectable hormonal contraception and an increased risk of HIV acquisition. (IHC) (32) (33) (34) (35) (36). Some of the countries that have the highest risk for HIV among AGYW also have a limited contraceptive method mix, with a dependence on injectable contraceptives. Expanding AGYW access to a full range of contraceptive methods and providing them with good quality counseling (including information on hormonal contraception and HIV acquisition) is critical to ensuring that they are able to make informed choices about FP use (36) (37). In particular, expanding access to long-acting reversible contraceptive methods (LARCS) such as implants and intra-uterine devices may offer better protection for AGYW against unintended pregnancy to this population (40) (41). Therefore, expanding the contraceptive method mix to include LARCS, as well as encouraging dual protection with condoms, is an important way to protect the health of AGYW.

Social-asset building

- Rationale → The most at-risk AGYW often lack strong social networks – relationships with peers and adults who can offer emotional support as well as information and material assistance. Interventions that build social capital have been shown to increase agency and empowerment among AGYW (42) (43). Such interventions may improve girls' ability to protect themselves by reducing their social isolation and providing them with social safety nets through mentors, peer groups, civic engagement, and access to health information and services. Social asset building methodologies such as "Safe Spaces" employ a '"whole girl" approach to addressing the multiple vulnerabilities to HIV infection—social isolation, economic insecurity, lack of access to services, and sexual and gender-based violence—experienced by the most marginalized adolescent girls in the poorest communities. The "Girl Effect" builds on findings of Safe Spaces and emphasizes girl-centered program design that "puts girls at the center of each and every program decision - from identifying which girls to target, when and why, to measuring results at the level of the girl" [girleffect.org].

**Strengthening the Community:**

School-based HIV prevention

- Rationale → HIV/AIDS and sex education that meets established standards can lower sexual risk behaviors (38) (39) (40). See Table 6 for more information on effective programming.

Community Mobilization/Norms Change

- Rationale → Community mobilization provides an essential support framework for HIV prevention programs (41) and serves as a way to engage boys, men and the broader community in addressing social norms that increase HIV risk for AGYW. Community mobilization efforts in related areas like gender-based violence prevention have demonstrated a significant impact on norms change, as well as decreases in violent victimization and perpetration (42) (43).

**Strengthening the Family:**

Parenting/Caregiver Programs

- Rationale → Having a positive relationship with a parent, caregiver, or other caring adult is a consistent protective factor for young women and girls against a variety of negative health and social outcomes. Skills building programs involving parents and caregivers have shown promise to change HIV related sexual behaviors among youth (e.g., use of male and female condom, delayed sexual debut, as well as decreased exposure to negative outcomes such as violence and abuse (44).

Cash transfers, either unconditional or with schooling conditions

- Rationale → Cash transfers have demonstrated consistent effects on biological and behavioral outcomes (45) (46) (47) (48) (49) (50) (51). Most governments in East and Southern Africa are supporting unconditional or schooling-conditioned cash transfers to benefit vulnerable children that could be a scalable platform to achieve PEPFAR outcomes.

Educational subsidy

- Rationale → Girl students are especially vulnerable to school dropout. Educational subsidy is an effective intervention for keeping girls in school [38, 39] and is correlated with reduced sexual risk behaviors and higher HIV testing acceptance. Education also has a myriad of other positive effects in the lives of girls and young women (44) (52) (53) (54).

Combination socio-economic approaches

- Rationale → Stand-alone economic empowerment interventions demonstrate variable effectiveness (55) (56) (57). Approaches that combine economic and social empowerment interventions have more consistent effects on both behavioral and violence outcomes (58) (59) (60) (61) (62) (63) (64) (65). Economic strengthening interventions, especially low-cost savings-led approaches, are already common in PEPFAR OVC programs and can provide a solid platform for this initiative. The “social empowerment” interventions supported by the literature include discussion groups on GBV/IPV and couples communication (61) (62), mentoring (59) (64), and comprehensive, evidence-based HIV prevention curricula (56) (58) (60) (63).

**Decreasing Risk in Sex Partners:**

Characterization of male sexual partners of AGYW to better target HIV services.

- Rationale → Antiretroviral treatment for men living with HIV is a highly effective intervention to prevent transmission to their sexual partners (30) (66), however many men are reluctant to be tested (73) and those testing positive may be reluctant to be treated (74). Better characterizing the male sexual partners of at-risk AGYW will allow HTC and ART programs to better target these men and develop services they are more likely to use. [2]
- Rationale → Likewise, VMMC is a highly effective intervention for reducing the likelihood of HIV acquisition among men and boys (67) (68) (69) (70), as well as protecting their female sex partners (69) (71) (72) (73). Better characterizing the male sexual partners of at-risk AGYW will allow HTC and VMMC programs to better target these men and develop services they are more likely to use.

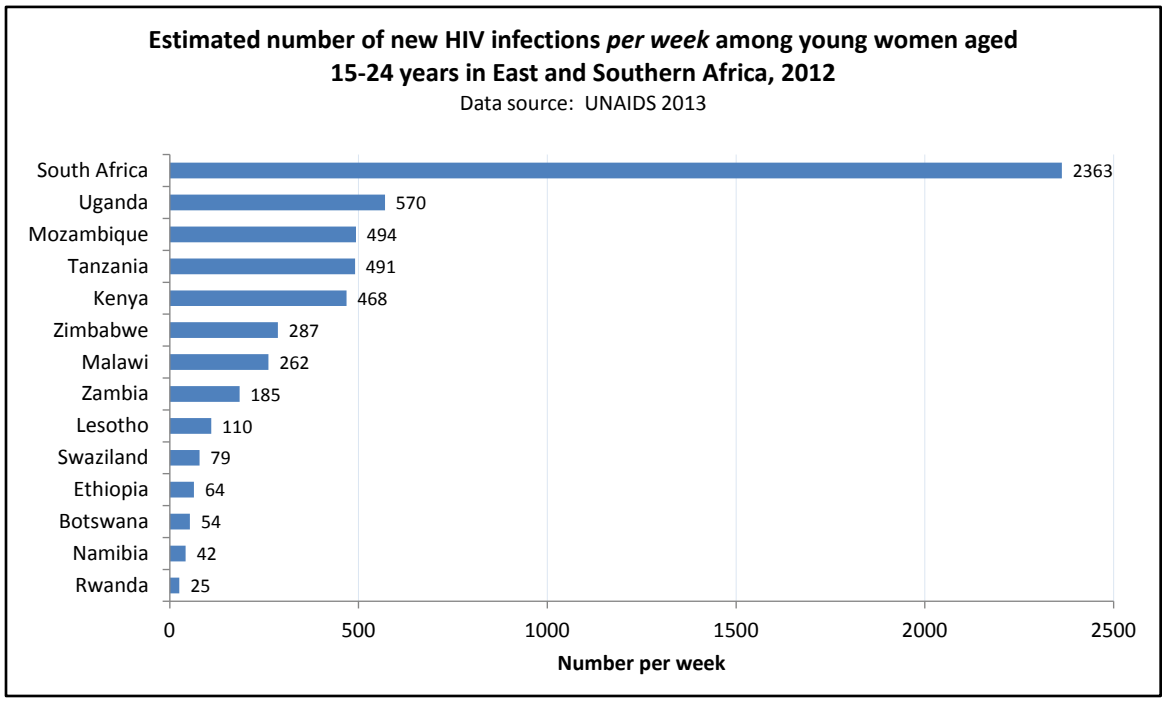
## What NOT to do

In addition to data on which interventions will have the maximum impact on reducing HIV incidence among females 15-24 years of age, there is also data on interventions that will NOT likely have a significant impact or are not appropriate for this comprehensive package. Note that some of these interventions may be worth evaluating further, or could serve to reach an alternate goal. However, they should not be included in a package focused on reducing HIV incidence in AGYW. For more information, see Table 5.

[2] Funding for these activities should come from the HTXS budget code.

# Appendix B: Figures for DREAMS Guidance

## Figure 1: Estimated New infections among females 15-24, UNAIDS




## Figure 2: Estimated HIV prevalence among females and males, ages 15-24, UNAIDS

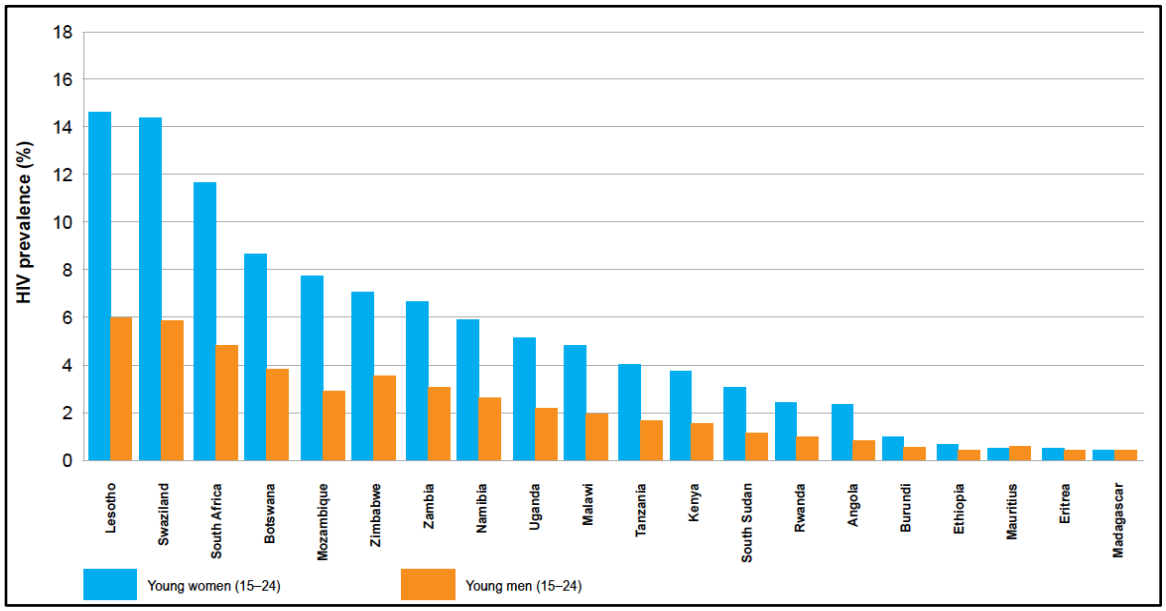


**Figure 3: Impact of preventing new infections in adolescent girls and young women on rates of school completion in their children based on modeling**

by Chris Desmond for the PEPFAR Orphans and Vulnerable Children Technical Working Group. The blue bars indicate the relative rates of school dropout among children of women living with HIV with the indicated treatment. Preventing just 30% of new infections in females 15-24 would have a greater impact on school retention than universal treatment and adherence among women living with HIV.

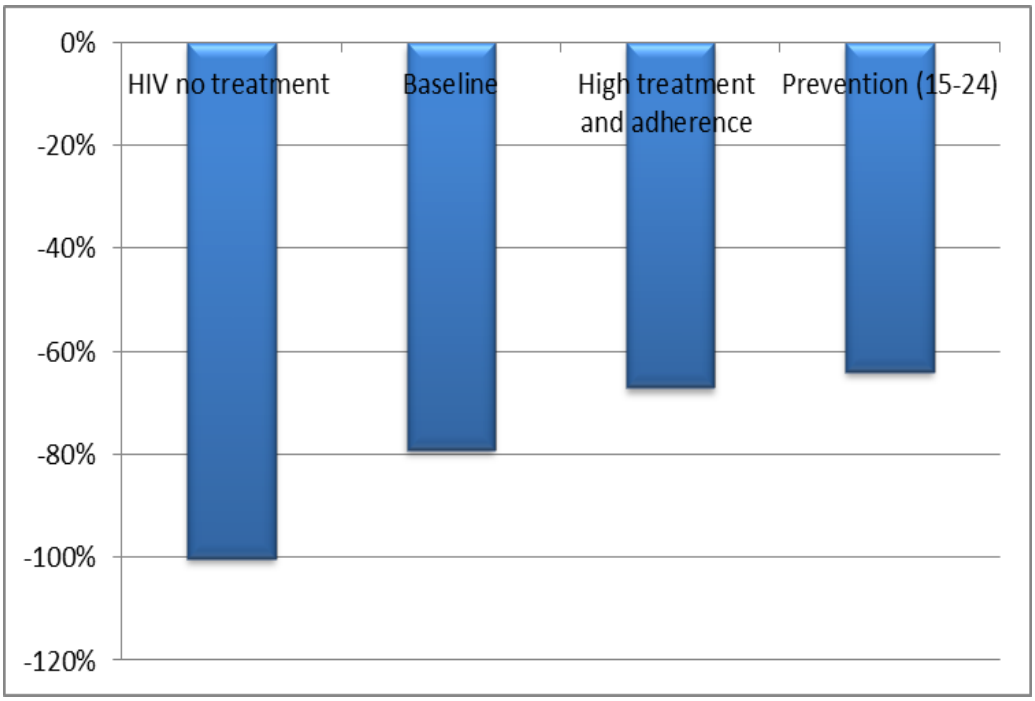


**Figure 4: Targeting on the basis on the behavior alone will not be sufficient.**

Data from the most recent DHS and AIS in several African countries analyzed by Rick Olson of UNICEF comparing the numbers of new infections in females 15-19 compared to the numbers of sexually active females 15-19.

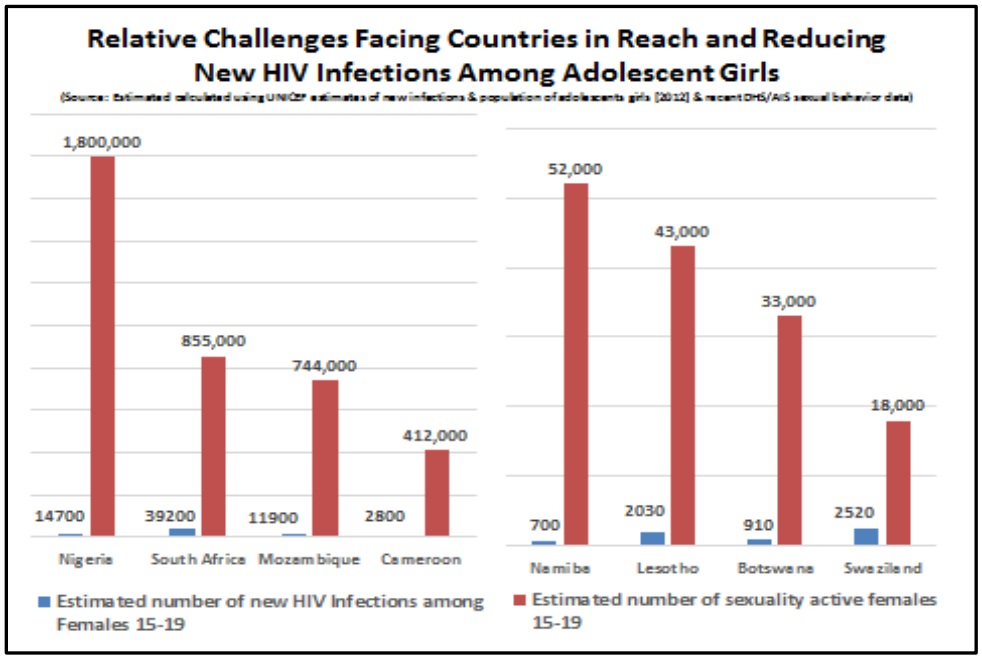



**Figure 5: Further analysis of existing data can provide useful insights on females most at risk.**

Data from the most recent DHS in several African countries analyzed by Rick Olson of UNICEF showing the relative prevalence of HIV among sub-groups of women living with HIV.

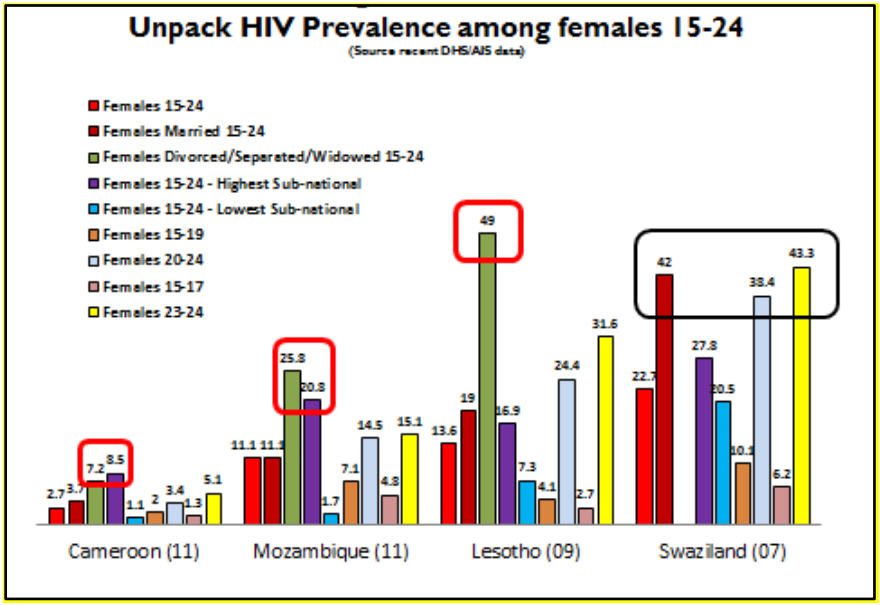


**Figure 6: Experience of gender-based violence among children is high.**

Data from five Violence Against Children Studies on experience of unwanted sexual intercourse among children.

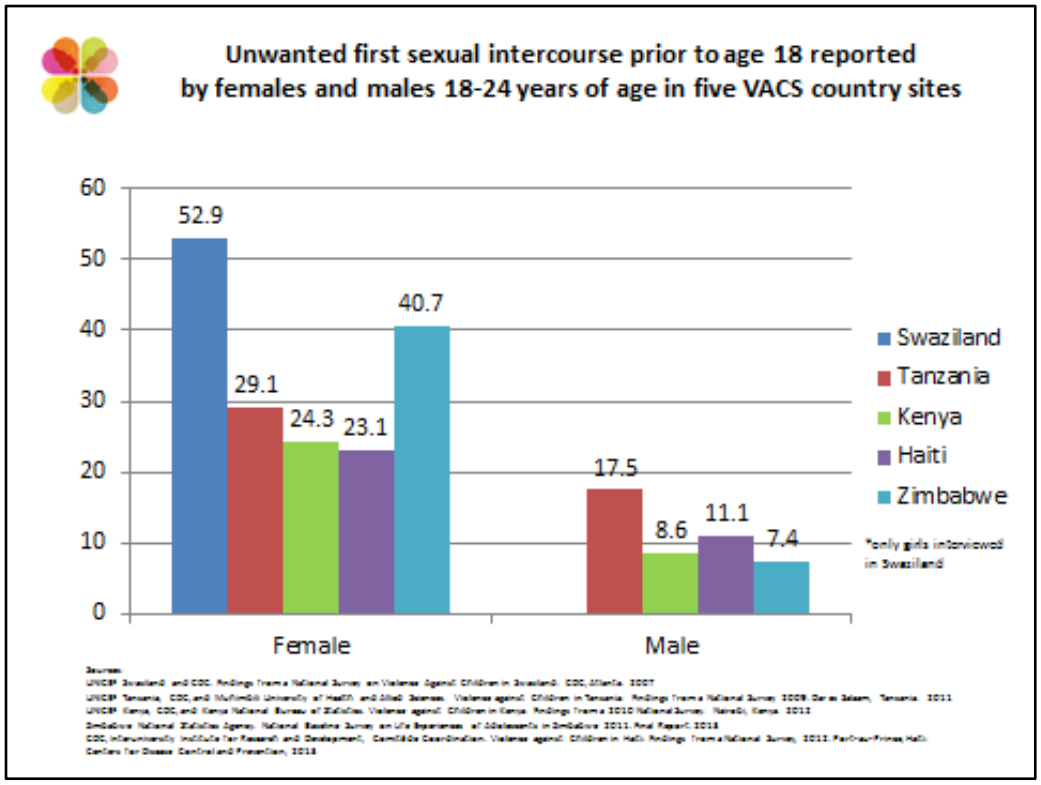


**Figure 7: Intimate partner violence is common among girls and young women.**

Data from Violence Against Children Studies on perpetration of sexual violence among children.

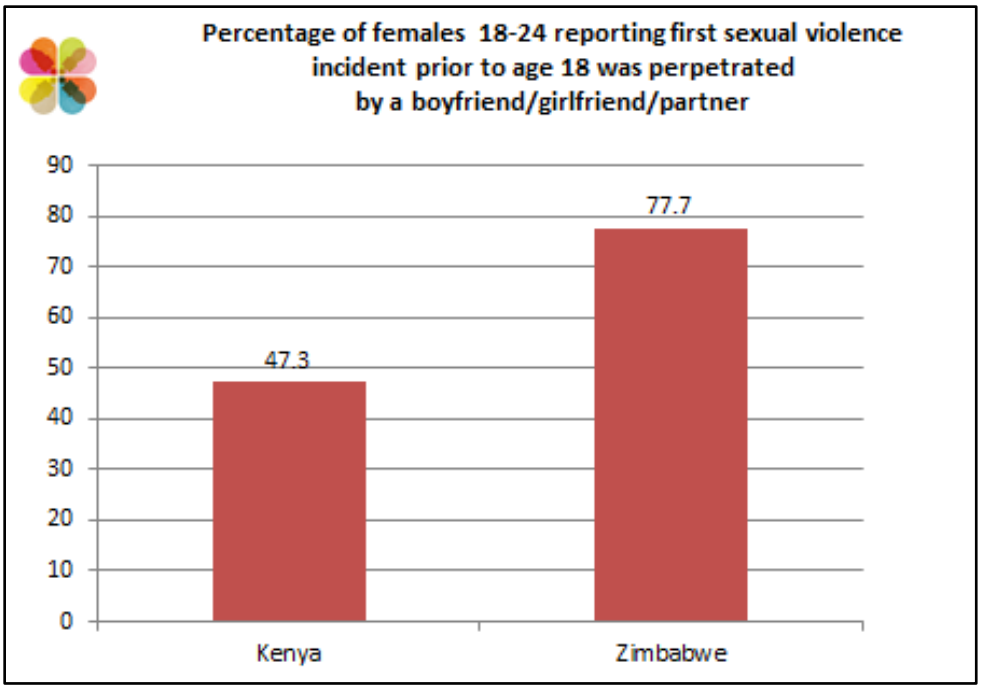


**Figure 8: A schematic overview of the DREAMS core package of interventions.**

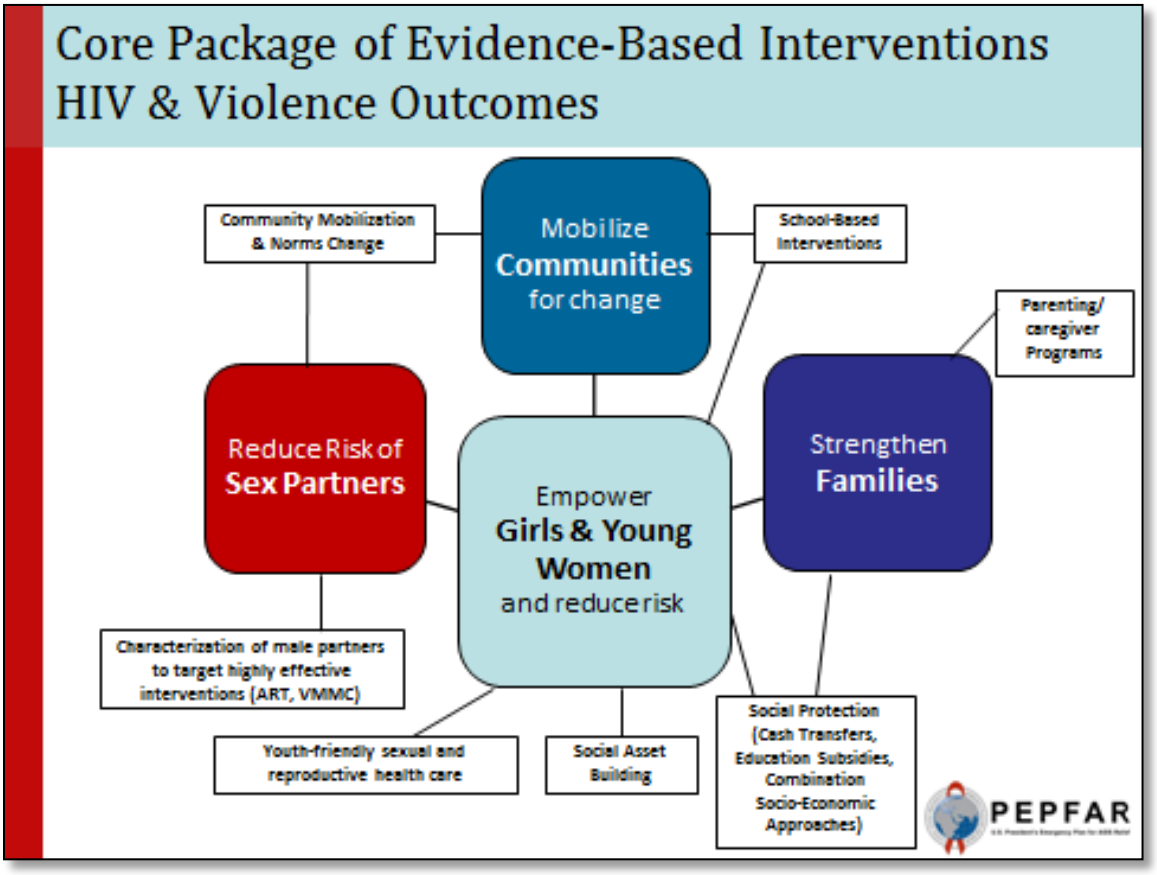


**Figure 9: Nike Foundation's 5+1 Approach to Keeping Girls HIV Free**


**Figure 10: Comprehensive packages of interventions have more impact than any single intervention.**

Analysis of South Africa's school protection interventions in combination with other interventions conducted by Dr. Lucie Cluver and shared through personal communication.

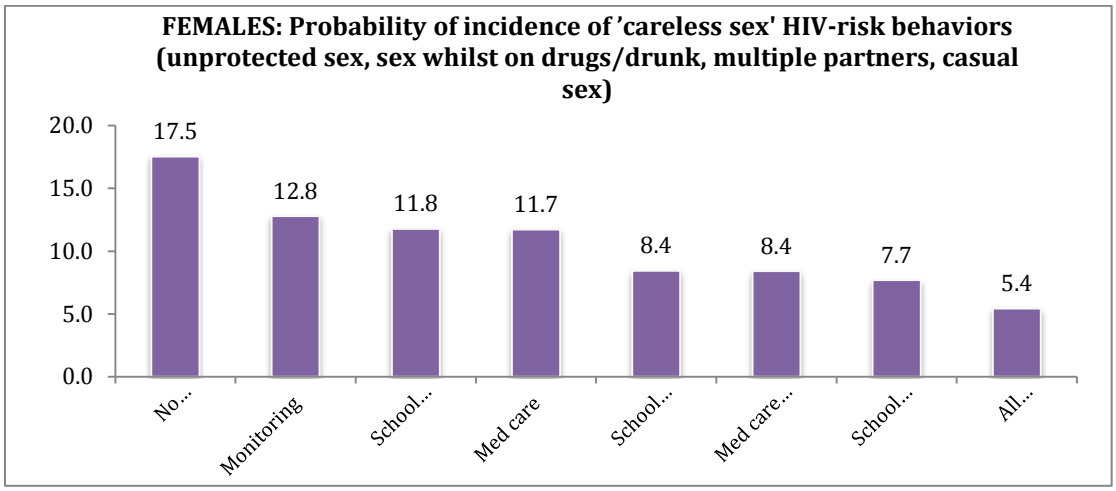
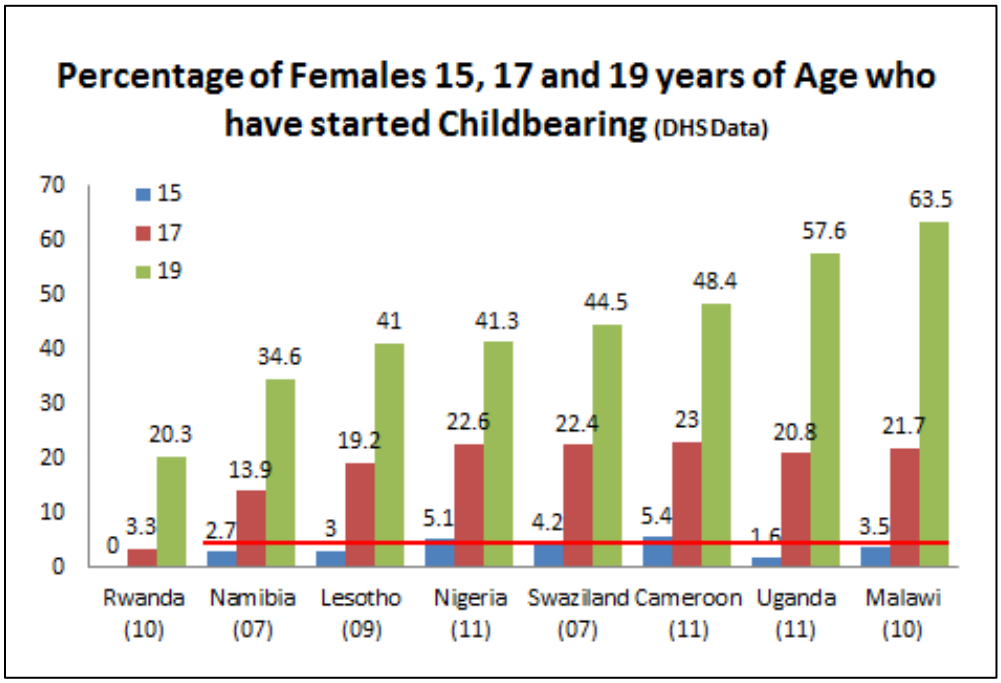
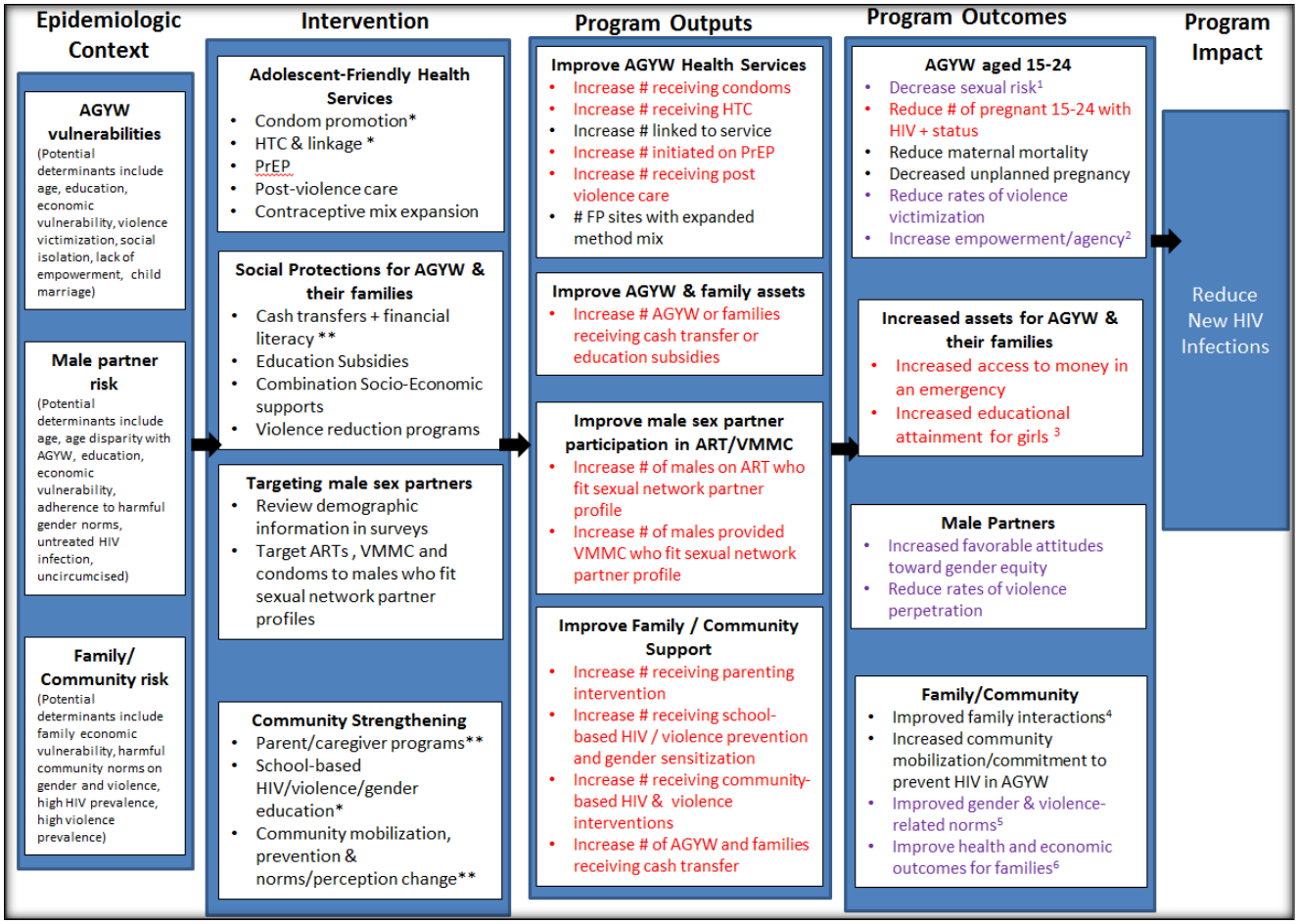


**Figure 11: A substantial percent of females under 20 have begun childbearing in sub-Saharan Africa.**

Data from the most recent DHS analyzed by Rick Olson of UNICEF.



## Figure 12: The DREAMS Logic Model




### Legend: Target populations of interventions

All Interventions are directed towards AGYW, unless otherwise indicated

* = indicate interventions that include male partners

** = indicate interventions include families or communities

### Color codes for data sources

- MER
- DHS, AIS, KIS, or VACS
- Undetermined at this point

### Legend for indicator groupings

[1] Decrease sexual risk

- Increased consistent condom use (disaggregate by type of sex for males and females)
- Reduced sexual risk behaviors (age-disparate sex, multiple partners, transactional sex, early age at first sex)

[2] Increase empowerment/agency (could include 3 or 4 of the following measures)

- Wider range of aspirations
- % of girls with 5+ friends
- % girls pooling resources toward achieving goals
- % girls reporting more time spent socializing with other girls
- % girls with access to supportive individuals or organizations within their community (not girl friends)
- % girls with an older female figure in the community (outside immediate family) in whom they can confide
- % girls accessing trusted sources of information
- % girls who report saying no to sex when they wanted
- % girls speak up to share their views
- % girls feel they are valued by others
- % girls set goals and make plans to achieve them
- % girls exercise choice over life decisions
- % girls believe they have control over their future
- % girls have strong sense of self worth
- Age of first marriage

[3] Increased educational attainment for girls
- Increased school attendance
- Increased school progression

[4] Improved family interactions
- Increased parental monitoring
- Increased positive parent/child interactions

[5] Improved gender & violence-related norms
- Decreased % who believe that men should decide when couple has sex
- Increased % who believe it's wrong for a man to hit or beat wife under all circumstances

[6] Improve health and economic outcomes for families
- Reduced infant mortality
- Reduced food insecurity
- Increased school attendance and completion for children of AGYW

## Table 1: The core package of interventions for DREAMS.

Note: Table 6 lists appropriate programs to implement within each category of the core package; or which relevant guidance should be consulted. Table 3 summarizes elements of the core package that CANNOT be paid for with DREAMS initiative funding.

| **Empower Girls & Young Women and Reduce their Risk** | | | |
|---|---|---|---|
| **Intervention** | Target Groups | Outcomes | Technical Activities |
| **Condom promotion and provision**<br>**(female and male)** | Young women and adolescent girls and their male sexual partners | Reduced transmission and acquisition of HIV | ▪ Generate and/or synthesize local evidence on the key barriers to male and female condom access and utilization<br>▪ Establish or revitalize school-based or school-linked adolescent-friendly sexual and reproductive health (ASRH) services (if capacity exists) to increase access and uptake<br>▪ Focus on improving male and female condom use at first sex and consistent use and availability (e.g. link vulnerable adolescent girls to education, community-based condom outlets and adolescent friendly SRH services)<br>▪ Address national laws, policies, guidelines, or community/social perceptions and norms that may prevent AGYW from accessing condoms.<br>▪ Consider young women's interest in preventing pregnancy. Align with existing USG-funded ASRH and family planning initiatives, if such exist in country (e.g. Family Planning 2020) |

| Empower Girls & Young Women and Reduce their Risk | | | |
|---|---|---|---|
| **HIV Testing and Counseling** | AGYW and their male sexual partners | Earlier diagnosis of HIV infection<br><br>Linkage to appropriate, high impact services | ▪ Generate and/or synthesize local evidence on the key barriers to uptake and access<br>▪ Address barriers to uptake and access among AGYW (e.g., policy, programmatic, and, community/social perceptions and norms)<br>▪ Provide high-quality testing that observes all the 5 C's (confidentiality, informed consent, correct results, counseling, and connection to care)<br>▪ Train service providers in adolescent-friendly service promotion and delivery Link to PEPFAR ACT Initiative<br>▪ Ensure linkages from HTC to other components of the core package<br>▪ Use the existing mix of clinical and community platforms to increase referrals of AGYW and their partners to testing<br>▪ Use information collected on male partners through surveys and/or other analyses to target HTC outreach to men and boys in the community who may be most likely to pose a transmission risk to AGYW<br>▪ Use index patient and/or partner notification strategies to increase uptake and access of HTC within sexual networks of ALHIV |
| **PrEP (only in countries where there is government buy-in and leadership)** | Subsets of young women with exceptionally high risk | Reduce acquisition of HIV | ▪ Target groups at exceptionally high risk (i.e. AGYW who have HIV-positive partners, a recent STI, a violent partner, engage in sex work)<br>▪ Address any regulatory issues in country<br>▪ Reinforce adherence through innovative approaches<br>▪ Provide linkage to support services<br>▪ **NOTE:** See Table 7 for information on what elements can & cannot be funded with PEPFAR DREAMS funds |

| Empower Girls & Young Women and Reduce their Risk | | | |
|---|---|---|---|
| **Post Violence Care** | Young women and adolescent girls who have experienced or are at risk for GBV and/or violence against children (e.g., sexual assault, intimate partner violence, physical violence by parents/ caregivers) | Reduce vulnerability, identify females at risk for HIV and link to prevention | ▪ Develop youth-focused programs to screen for and respond to GBV and VAC in a variety of settings: schools, clubs, clinics, social services<br>▪ Conduct assessments to understand the factors related to violence victimization for local AGYW, including those that promote or prevent them from seeking post-violence care<br>▪ Ensure coordinated efforts and integration where feasible between GBV and OVC sponsored child protection interventions<br>▪ Train service providers in adolescent-friendly violence screening and post-violence care (74)<br>▪ Provide youth-friendly post-violence care, including access to emergency contraception where legal<br>▪ Develop standardized, two-way referral systems linking all health and social service delivery points<br>▪ Use evidence-based parenting interventions to decrease risk of physical abuse from caregivers (PICT, Triple P, Safe Care)<br>▪ **NOTE:** See Table 7 for information on what elements can & cannot be funded with PEPFAR DREAMS funds |

| Empower Girls & Young Women and Reduce their Risk | | | |
|---|---|---|---|
| **Expand and improve the contraceptive method mix** | AGYW | Reduce unmet needs for FP | ▪ Increase contraceptive method mix available to AGYW, with a focus on increasing access to long-acting reversible contraceptives and increasing dual method protection.<br>▪ Align with existing family planning initiatives (e.g. Family Planning 2020, USAID Office of Population and Reproductive Health)<br>▪ Address national laws, policies, guidelines, or community/social perceptions and norms that may prevent AGYW from accessing contraception.<br>▪ Train service providers in adolescent-friendly service promotion and delivery, and ensure that providers are comfortable providing a wide range of contraceptive methods.<br>▪ Ensure linkages to other components of the core package<br>▪ Maximize existing platforms/ for distribution (e.g. ART clinics, family planning clinics and other potential adolescent-friendly SRH services)<br>▪ **NOTE:** See Table 7 for information on what elements can & cannot be funded with PEPFAR DREAMS funds |

| Empower Girls & Young Women and Reduce their Risk | | | |
|---|---|---|---|
| **Social asset building** | AGYW | Increase in social capital; Reduce social isolation; increase agency and empowerment among AGYW | Social asset building should be part of a core package of services that builds "protective assets" including economic and educational assets<br><br>Tailor recruitment strategies to access highly vulnerable and hardest to reach girls (E.g., adolescent domestic workers)<br><br>Hold regular meetings in small groups in safe public spaces where participants receive social support, information, and services (and/or links to services such as health care)<br><br>Focus on building sustainable individual protective assets such as self-esteem, problem-solving abilities, confidence, and social networks that support increased education and economic participation,<br><br>Link socially isolated girls both to higher-status adult female mentors who can serve as advocates on their behalf and to community institutions and services.<br><br>Ensure that these programs support high impact DREAMS interventions (e.g., PrEP, cash transfers) through promotion of and linkage to those services. |

| **Mobilize the Community for change** | | | |
|---|---|---|---|
| **Intervention** | Target Groups | Outcomes | Technical Activities |
| **School- based HIV and violence prevention** | AGYW and boys in schools and communities | Increase knowledge, skills, agency; reduce number of sexual partners, frequency of sex, unprotected sex; increase male and female condom use; delay sexual debut; reduced violence victimization and perpetration | ▪ Work with the education sector and appropriate ministries to provide evidence-based, medically accurate and age-appropriate HIV/AIDS and sex education, and violence prevention. Note: DREAMS funds should only support scale-up of these programs in the regions of highest prevalence.<br>▪ Integrate HIV and violence prevention curricula in schools where OVC and others have existing programs (i.e. safe schools)<br>▪ Implement evidence-based programs that increase agency for AGYW and shift community norms around gender roles, violence, and the value of girls.<br>▪ Ensure that these programs are matched with other package components to achieve impact<br>▪ Ensure that these programs support high impact DREAMS interventions (e.g., PrEP, cash transfers) through promotion of and linkage to those services.<br>▪ See the resource section of this document for sources of evidence-based curricula and examples of programming. |

| Mobilize the Community for change | | | |
|---|---|---|---|
| **Community mobilization and Norms Change** | AGYW, men & boys, and their broader communities, | Reduce violence victimization; increase agency and empowerment among AGYW; reduce contact with riskier partners | ▪ Implement evidence-based programs to build community cohesion, commitment and collective action for preventing HIV and violence among AGYW, as well as interventions that focus on changing harmful community/social norms that can contribute to HIV and violence risk either directly or indirectly<br>▪ Engage community stakeholders in program design and implementation, including AGYW<br>▪ Engage local, faith-based and traditional leadership as active participants in these activities<br>▪ Foster community level dialogue to identify and address the norms that increase risk for HIV and violence victimization among AGYW<br>▪ Embed norms change and gender-related messaging into existing community-based HIV prevention programs<br>▪ Engage men and boys in community conversations about HIV and violence-related issues: such as gender norms, sexuality, relationships, joint decision making and alcohol use<br>▪ Implement curricula with a participatory learning component that focuses on building skills and a community-level awareness and ownership of HIV risk reduction (e.g. Stepping Stones)<br>Ensure that these programs support high impact DREAMS interventions (e.g., PrEP, cash transfers) through promotion of and linkage to those services. |

| Strengthen the Families | | | |
|---|---|---|---|
| **Intervention** | Target Groups | Outcomes | Technical Activities |
| **Parenting/ Caregiver Programs** | Caregivers of vulnerable adolescent girls | Reduce girls' vulnerability | ▪ Implement parenting programs with demonstrated effects on adolescent HIV risk behaviors and on protection from sexual violence<br>▪ Ensure that these programs support high impact DREAMS interventions (e.g., PrEP, cash transfers) through promotion of and linkage to those services.<br>▪ |
| **Social Protection (Cash Transfers, Educational Subsidy, Combination Socio-Economic Approaches)** | AGYW and their parents/ guardians | Reduce vulnerability, reduce transactional sex, increase agency | ▪ Test and implement conditional or unconditional cash transfers to females 15-24 and/or their families, with attention to possible adverse consequences<br>▪ Use combined economic and social empowerment approaches, with a preference for savings-based economic empowerment interventions (i.e., savings groups)<br>▪ Assess feasibility and sustainability concerns<br>▪ Extend existing social protection programs for children to older AGYW (18-24), using non-HKID funding<br>▪ Ascertain what host country government is already implementing and leverage, build on, or scale up these services<br>▪ Focus educational subsidy programs on secondary school enrollment and retention for vulnerable girls<br>▪ **NOTE:** See Table 7 for information on what elements can & cannot be funded with PEPFAR DREAMS funds |

| Decrease Risk in Sex Partners of AGYW | | | |
|---|---|---|---|
| **Intervention** | Target Groups | Outcomes | Technical Activities |
| **Characterization of male partners to target highly effective interventions (ART, VMMC)** | AGYW and their sexual partners | Better targeting of HIV prevention, care and treatment to males who are the potential sex partners of AGYW | • Develop methods for collecting information on the sexual relationships of AGYW to characterize the "typical" male partners of AGYW in the community (will vary by country)<br>o Use data from existing surveys whenever possible (e.g. AIDS Impact Survey, Behavioral Surveillance Survey, VACS)<br>o Create new surveys<br>o Other methods for characterization (e.g., sexual network analysis, phylogenetic testing) *if already underway.* However, DREAMS funds should not be used to start new projects using these methods.<br>• Provide information to treatment, VMMC, male and female condom promotion and HTC programs so they can increase focus on males most likely to be the sources of infection for young women and girls in the community |

## Table 2: Recommended activities to support sustainability of DREAMS

| Sustaining Investments for AGYW | | | |
|---|---|---|---|
| **Intervention** | Target Groups | Outcomes | Technical Activities |
| **Leverage Domestic Program and Service Delivery Platforms for AGYW** | Domestic program implementers | Cost containing and savings for AGYW core interventions | ▪ Implement and manage AGYW interventions and social protection activities (cash transfers, educational subsidies, etc) through existing local structures, programs, and service delivery platforms and leverage funds from non-health and private sectors |
| **Ensuring Political Will and an Enabling Policy and Legal Environment for AGWY** | Policy-makers, civil society, and local leaders | Reduced barriers and obstacles to AGYW programming<br><br>Continuation of AGYW programming post initiative | ▪ Create an enabling policy and legal environment<br>• Engage senior USG diplomats in securing firm, upfront political commitment from partner government towards achieving the initiative's goals<br>• Incorporate into national plans as a priority for achieving the End of AIDS in 2030 the virtual elimination of new HIV infections among in adolescent girls and young women<br>• Develop and ensure enforcement of progressive national policies and laws that support evidence-based prevention activities targeting AGYW as well as policies relating to secondary school attendance, child marriage, trafficking, and gender-based violence<br><br>▪ Engage civil society in the advocacy, planning, implementation, and monitoring of programs and services geared to AGYW, in particular at the community level<br><br>▪ Institutionalize effective AGYW core interventions |

## Table 3: Criteria for evidence of effectiveness for the core package of interventions

| Evidence of Effectiveness | Quality of Evidence: **A**. High quality evidence | **B**. Moderate quality evidence | **C**. Low quality evidence |
|---|---|---|---|
| **1**. Consistently showed effectiveness | A1 | B1 | C1 |
| **2**. Largely but not consistently showed effectiveness | A2 | B2 | C2 |
| **3**. Mixed beneficial and ineffective or harmful results | A3 | B3 | C3 |
| **4**. Consistent ineffective or harmful results | A4 | B4 | C4 |

[A] Three or more experimental trials, meta-analyses, and/or several high quality quasi-experimental studies coupled with evidence from observational studies

[B] 1-2 experimental studies or high quality quasi-experimental studies coupled with evidence from observational studies

[C] Observational data only, or only one quasi-experimental study and few observational studies

**Table 4: Level of evidence and outcomes for the core package of interventions**

| Empower Girls and young women and reduce their risk | | | | |
|---|---|---|---|---|
| Intervention | Biologic Outcomes | Biologic Outcomes - Evidence | Behavioral Outcomes | Behavioral Outcomes - Evidence |
| Condoms (female and male) | Most data are from male condoms | A1 | | |
| PrEP | HIV incidence | A2 | | |
| Post-Violence Care (PEP) | HIV acquisition | B2 | | |
| Post- Violence Care, beyond PEP (trauma focused counseling) | | | Reduced trauma symptoms, functional impairment, depression | A2 |
| Post- Violence Care, beyond PEP (advocacy/case management) | | | Decreased physical abuse by intimate partners; higher quality of life and social support; less difficulty obtaining community resources | B2 |
| Post- Violence Care, beyond PEP (parenting programs) | | | Decreased physical abuse by caregivers | B3 |
| Post- Violence Care, beyond PEP (short-term emergency housing) | | | | Prudent Practice |
| HTC | | Prudent Practice | | Prudent Practice |

| | | | | |
|---|---|---|---|---|
| ↑ Contraceptive Mix (in countries with generalized epidemics) | | Prudent Practice | | |
| Social asset building | | | Increased social support, increased engagement in VCT | Prudent Practice |
| Mobilize the Community for Change | | | | |
| Intervention | Biologic Outcomes | Biologic Outcomes - Evidence | Behavioral Outcomes | Behavioral Outcomes - Evidence |
| School-Based HIV Prevention & Violence Prevention | Pregnancy, STIs | B3 | Reduced number of sexual partners; reduced frequency of sex and unprotected sex; increased male and female condom use; delayed sexual debut; reduced violence victimization and perpetration | A3 |
| Community Mobilization/ Norms Change | | Prudent Practice | Decreased social acceptance of violence; decreased violence victimization | B3 |
| Strengthen the Families | | | | |
| Intervention | Biologic Outcomes | Biologic Outcomes - Evidence | Behavioral Outcomes | Behavioral Outcomes - Evidence |
| Parenting/Caregiver Programs | | | Increased male and female condom use; delayed sexual debut | A3 |

| | | | | |
|---|---|---|---|---|
| | | | | |
| Unconditional Cash Transfers | HIV prevalence, HSV incidence | B1 | Decreased involvement with age-disparate sex, multiple partners, transactional sex; delayed sexual debut | B1 |
| Conditional Cash Transfers- Education | HIV prevalence, HSV incidence | B2 | Decreased childbearing; delayed sexual debut | B2 |
| Education subsidy (uniforms, fees, adult mentors) | | | Decreased school dropout; delayed sexual debut | B3 |
| Combination Socio-Economic Approaches | | | Decreased involvement with age-disparate sex, multiple partners, transactional sex; decreased childbearing; increased male and female condom use | B1 |
| Decrease Risk in Sex Partners of AGYW | | | | |
| Intervention | Biologic Outcomes | Biologic Outcomes - Evidence | Behavioral Outcomes | Behavioral Outcomes - Evidence |
| ART (Male Partners) | HIV incidence | A1 | | |
| VMMC (Male Partners) | HIV incidence | A1 | | |

**Table 5. Interventions that should NOT be included in DREAMS proposals**

| Intervention | Justification |
|---|---|
| Important Interventions excluded due to the specific mandate of this initiative | |
| ARVs for PMTCT for young mothers | DREAMS funds should be used to encourage the most vulnerable pregnant females 15-24 to attend ANC and be tested for HIV. However, treatment or prophylaxis for those girls or young women found positive should be funded through existing PMTCT programs and not the DREAMS initiative. |
| HIV Care and Treatment for girls and young women | DREAMS funds should be used to test vulnerable girls and young women for HIV. Those identified in HTC programs as HIV positive should be actively linked to care and support. However, DREAMS funds should not be used to fund ART for these patients; those funds should come from existing PEPFAR programs or other sources. |
| HIV Care and Treatment for male sexual partners of girls and young women. | DREAMS funds may be used to identify and test the partners of vulnerable girls and young women for HIV. Those identified in HTC programs as HIV positive should be actively linked to care and support. However, DREAMS funds should not be used to fund ART for these patients; those funds should come from existing PEPFAR programs or other sources. |
| Voluntary medical male circumcision (VMMC) for male sexual partners of girls and young women. | DREAMS funds may be used to identify and test the partners of vulnerable girls and young women for HIV. Those identified in HTC programs as HIV negative should be actively linked to HIV prevention programs, including VMMC. However, DREAMS funds should not be used to fund VMMC service delivery for these men; those funds should come from existing PEPFAR programs or other sources. |

| Interventions that should NOT be done because of lack of evidence or negative impacts | |
|---|---|
| Treatment for Schistosomiasis | There is no evidence at this point that treatment for *Schistosomiasis* prevents HIV infection. |
| Abstinence-only or peer led sexual education | Both of these types of sex education interventions have little to no evidence of efficacy and have been shown (in some cases) to have negative effects on young people's risky sexual behaviors. |
| **Packages limited to** HTC; behavior change counseling; and condom promotion and provision | Several high-quality studies (CAPRISA 008, VOICE, FEMPREP) offered counseling, HTC and condoms as their standard of care in the control arm and still saw high incidence rates in this population. |
| Conditional cash transfers for STI reduction, knowledge of HIV status and safe sex practices | High-quality studies demonstrate inconsistent outcomes (75) (76) and instances of adverse effects such as an increase in sexual activity and risky sexual behavior when providing cash transfers to men to practice safe sex (77). |
| Credit-based approaches to economic strengthening (standalone, not in combination with social empowerment approaches) | Lower-quality studies demonstrate inconsistent outcomes, including instances of adverse effects. |
| Income-based approaches to economic strengthening (standalone, not in combination with social empowerment approaches) | Lower-quality studies demonstrate inconsistent outcomes, including instances of adverse effects. |
| Stand- alone youth centers | Numerous studies have shown that youth centers do not decrease HIV risk |

## Table 6: Additional Resources for Implementing the Core Package of Interventions

| Empower Girls & Young Women and Reduce their Risk | | | |
|---|---|---|---|
| Core Package Category | **Required Intervention Components** | **Flexibility in specific program model?** | **Intervention Resources** |
| **Condom promotion and provision (female and male)** | -Follow standard PEPFAR guidance | ✓ | 1. Programmatic Considerations for Condoms as a Structural Level Intervention- http://www.cdc.gov/hiv/prevention/programs/condoms/<br>2. AIDSTAR-One: Behavioral Interventions: Comprehensive Condom Use Programs- http://www.aidstar-one.com/focus_areas/prevention/pkb/behavioral_interventions/condom_use<br>3. UNFPA: Condom Programming for HIV Prevention: an Operations Manual for Programme Managers- http://www.unfpa.org/sites/default/files/pub-pdf/condom_prog2.pdf |

| | | | |
|---|---|---|---|
| **HIV Testing and Counseling** | -Follow standard PEPFAR guidance for quality and ensure 5 C's (consent, confidentiality, counselling, correct test results, connection/linkage to prevention, care and treatment) | ✓ | 1. WHO HTC Consolidated Guidelines- http://www.who.int/hiv/pub/guidelines/arv2013/clinical/testingintro/en/<br>Adolescent-specific guidelines (section 5.1.4.4)- http://www.who.int/hiv/pub/guidelines/arv2013/clinical/en/<br>2. AIDSTAR-One: HIV Testing and Counseling http://www.aidstar-one.com/focus_areas/hiv_testing_and_counseling |
| **PrEP (only in countries where there is government buy-in and leadership)** | -Daily, oral, fixed-dose combination of Tenovofir disoproxil fumarate (TDF) and Emtricitabine (FTC) (TDF alone can be considered an alternative regimen if resources are limited) | | 1. PrEP best practices, research and clinical guidelines CDC- http://www.cdc.gov/hiv/prevention/research/prep/<br>AIDS Vaccine Advocacy Coalition (AVAC)- http://www.prepwatch.org/home |
| **Provide services for survivors of Gender-Based Violence (GBV)** | -Minimum package of post-GBV care as outlined by PEPFAR MER indicator (see #1 in Intervention Resources) | ✓ | 1. PEPFAR MER Indicator for GBV- https://www.pepfarii.net/Project-Pages/collab-22/SitePages/Home.aspx<br>2. Trauma focused counseling- http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/TFCBT_General.pdf<br>3. Advocacy (Case Management) for survivors of violence- http://psychology.msu.edu/cap/Documents/Two%20year%2 |

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|---|---|---|---|
| | | | 0followup%20CAP%20JCCP.pdf<br>4. The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs- http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_Report_PEPFAR_PRC_TechConsiderations.pdf<br>5. Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines- http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/ |
| **Expand and improve the contraceptive method mix** | -Access to a wide range of effective methods including short-acting pills and injectables and longer acting methods (LARCs)<br>-Counseling and instruction on condom use and dual method protection | ✓ | 1. USAID Family Planning Investment Strategy for Women and Girls- http://www.usaid.gov/sites/default/files/documents/1864/fpmp_tech_brief.pdf |
| **Social asset building** | | ✓ | From Research, To Program Design, To Implementation Programming For Rural Girls In Ethiopia: A Toolkit For Practitioners , Population Council 2011. Available online at http://www.girleffect.org/media?id=2997<br><br>Girl-Centered Program Design: A Toolkit to Develop, Strengthen & Expand Adolescent Girls Programs; Population Council 2011. Available online at http://www.girleffect.org/media?id=2995 |

| Mobilize the Community for change | | | |
|---|---|---|---|
| Core Package Category | Required Intervention Components | Flexibility in specific program model? | Intervention Resources |
| **School- Based HIV and violence Prevention** | -Adult-led<br>-Comprehensive (not abstinence-only) | ✓ | 1. School-based HIV prevention<br>UNESCO, International Technical Guidance on Sexuality Education: An Evidence-Informed Approach for Schools, Teachers and Health Educators, 2009- http://unesdoc.unesco.org/images/0018/001832/183281e.pdf<br>2. Community-based HIV prevention<br>Stepping Stones- http://www.steppingstonesintl.org/<br>3. School-based violence prevention<br>IM Power- http://pediatrics.aappublications.org/content/133/5/e1226.full.pdf+html<br>Positive Action- https://www.positiveaction.net/applications/violence-prevention |

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|---|---|---|---|
| **Community mobilization and norms change for HIV and violence prevention** | none | ✓ | 1. Community mobilization<br>SASA!- http://raisingvoices.org/sasa/<br>2. Community-based norms change<br>Coaching Boys Into Men-<br>http://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/<br>Yaari Dosti: Young Men Redefine Masculinity-<br>http://www.popcouncil.org/uploads/pdfs/horizons/yaaridostieng.pdf |
| **Strengthen the Families** | | | |
| Core Package Category | Required Intervention Components | Flexibility in specific program model? | Intervention Resources |
| **Parenting/ Caregiver Programs** | Include skills building component | ✓ | 1. Dilorio, C., et al., *Keepin' it R.E.A.L.!: results of a mother-adolescent HIV prevention program.* Nurs Res, 2006. **55**(1): p. 43-51- http://thenationalcampaign.org/effective-programs/keepin-it-real<br>2. Dilorio C, McCarty F, Resnicow K, et al. REAL Men: A group-randomized trial of an HIV prevention intervention for adolescent boys. Am J Public Health 2007;97:1084–9.- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1874204/pdf/0971084.pdf<br>3. Dancy B, Crittenden K, Talashek M. Mothers' effectiveness as HIV risk reduction educators for their daughters. J Health Poor Underserved 2006; 17:218–39.- http://mtw160-198.ippl.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/v017/17.1dancy.pdf<br>4. Families for Safe Dates- |

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| | | | http://www.sciencedirect.com/science/article/pii/S1054139X1100718X<br>5. PCIT- http://pcit.phhp.ufl.edu/<br>6. Triple P-http://www.triplep.net/glo-en/home/<br>7. Safe Care-http://safecare.publichealth.gsu.edu/ |
| **Social Protection (Cash Transfers, Educational Subsidy, Combination Socio-Economic Approaches)** | | ✓ | 1. Cash Transfers<br>Malawi Cash Transfer Program-<br>http://irps.ucsd.edu/assets/001/503923.pdf<br>2. Combination Socio-Economic Approaches<br>SHARE- http://vaw.sagepub.com/content/18/12/1390<br>IMAGE-<br>http://www.who.int/social_determinants/resources/articles/lancet_pronyk_kim.pdf |

## Table 7: Elements of the core package that cannot be paid for with DREAMS PEPFAR funding

| Core Package Component | Specific element for which PEPFAR DREAMS funding cannot be used |
|---|---|
| PrEP | DREAMS funds should not be used to purchase ARVs used for PrEP programs. Country teams, DREAMS partners and PEPFAR HQ will work together to identify alternate sources of funding to cover this cost.<br><br>DREAMS funding *can* be used for all other aspects of PreP demonstration projects (i.e., training, demand creation, lab tests, outreach, adherence support, etc.) |
| Post Violence Care | DREAMS funds should not be used to purchase emergency contraception (EC), in the case of sexual violence. EC as part of post violence care should be funded through an alternate source. Current programs are funded by USAID (non-PEPFAR funds), UNFPA, or other bilaterals.<br><br>DREAMS funding can be used for all other aspects of post violence care (i.e., lab testing, STI treatment, counseling, referrals, case management, etc.) |
| Expand & improve the contraceptive method mix | DREAMS funds should not be used to purchase contraceptive commodities (with the exception of male and female condoms). Contraceptive commodities are often funded by USAID (non-PEPFAR funds), UNFPA, or other bilaterals.<br><br>DREAMS funding can be used for all other aspects of expanding the contraceptive method mix (i.e., outreach, training service providers, etc.) |

| Core Package Component | Specific element for which PEPFAR DREAMS funding cannot be used |
|---|---|
| Social Protection - cash transfers | Because cash transfer (CT) programs should ideally be part of government-owned poverty-reduction programs, initiation of new cash transfer programs through DREAMS should be done in close consultation with the government, with the intent of identifying new approaches that magnify the impact of these programs.<br><br>The following scenarios are examples of how PEPFAR funds should be used for cash transfer programs:<br><br>(1) expanding (or, in some circumstances, initiating) an appropriate CT intervention in concert with the government, with the expectation that this program will be incrementally transitioned from PEPFAR funds to financing from government or other donors should it prove to be effective.<br><br>(2) using PEPFAR funds to increase access of AGYW and their families to existing CT interventions.<br><br>(3) using PEPFAR funds to improve the effectiveness of an existing CT intervention to achieve PEPFAR outcomes -- for instance, by integrating complementary services/interventions |