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Janet Fleischman and Katherine Peck¹

Executive Summary

The data are stark and incontrovertible: In eastern and southern Africa, girls account for 80 percent of all new HIV infections among adolescents, and HIV/AIDS is the leading cause of death for girls aged 15–19. With 7,000 girls and young women aged 15–24 infected every week,² the goal of an AIDS-free generation cannot be achieved without a dramatic new approach to this population. After years of neglect, a global convergence is emerging around the urgency of going beyond biomedical interventions to address the social and economic factors driving HIV risk for adolescent girls and young women. Whether this new attention can catalyze reductions in new HIV infections represents a fundamental challenge for controlling the AIDS epidemic.

In a major shift, the President’s Emergency Plan for AIDS Relief (PEPFAR) launched a new initiative on World AIDS Day in December 2014, in partnership with the Bill & Melinda Gates Foundation and the Nike Foundation, to significantly reduce new HIV infections in adolescent girls and young women. With \$210 million and highly ambitious goals, the DREAMS (Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe) Partnership aims to address HIV risks for adolescent girls and young women in high-burden “hot spots” in 10 countries in eastern and southern Africa by identifying where these young women are being infected, what is putting them at risk, and how to target programs accordingly. The partnership’s goal is to reduce incidence in high-burden areas by 25 percent in two years, and by 40 percent in three years. Whether these targets are attainable or simply aspirational remains to be seen, but they represent a determined effort to do things differently.

DREAMS builds on a growing global focus on the needs of girls and young women. Education for girls is receiving heightened attention, from Nobel Peace Prize winner

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² According to the Joint United Nations Program on HIV and AIDS (UNAIDS) Gap Report, there are between 6,500 and 8,400 new infections on average per week. See “The Gap Report,” UNAIDS, 2014, http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf.

Malala Yousafzai to First Lady Michelle Obama; world leaders, including The Elders,³ are speaking out against child marriage; the first U.S. government strategy was developed by the Obama administration in 2012 to respond to gender-based violence; faith-based organizations are extending their work on orphans and vulnerable children (OVCs) to include economic skills and financial literacy; and the issues of reproductive health and family planning are highlighted by the global platforms of Family Planning 2020 (FP2020) and the Beijing Declaration and Platform for Action (Beijing+20). Just as U.S. engagement on women and girls was accelerated during Hillary Clinton's tenure as secretary of state, public support from civil society and government leaders around the world has generated new determination to address the needs of women and girls, although the resources have yet to match the rhetoric.

Ambassador Deborah Birx, the U.S. global AIDS coordinator, recognizes the importance of this moment of global attention, calling it “an incredible, compelling time to make a huge difference.” She also made it clear that success in controlling the global HIV pandemic demands such action: “Even if we do everything we’re doing right now, the number of young women at risk will be increasing every year—it will outdistance our ability to meet their service needs. . . . We can’t mobilize the resources needed if we continue with this rate of new infections. We have to meet their needs in a unique and different way.” She continued: “There’s no right answer—if we had it, we’d be doing it. . . . We can’t worry about failing spectacularly, or we won’t do the hard things.”⁴

As exciting and laudable as this new attention is, the challenges are daunting, especially given the imperative to show significant impact within a short, two-year timeline. Herein lies the biggest vulnerability of DREAMS—success fundamentally rests on shifting political, social, and cultural norms, legal practices, and economic realities that are notoriously slow and difficult to change. We have long known that girls and young women have represented a glaring gap in the AIDS response, largely because their risks are linked to social and economic factors, and there is no biomedical “magic bullet.” Effective interventions must go beyond the health sector; new approaches are needed to address the structural drivers that directly and indirectly increase girls’ HIV risk, including poverty, gender inequality, sexual violence, and lack of education.⁵ Basic HIV prevention messages such as A-B-C (abstinence, be faithful, use condoms) are too often not within a girl’s power to control. Preventing HIV in adolescent girls and young women in high-prevalence

³ The Elders was founded by President Nelson Mandela, and includes former UN secretary general Kofi Annan, former U.S. president Jimmy Carter, and former first lady of South Africa Graça Machel. See “Child marriage,” The Elders, February 2015, <http://theelders.org/child-marriage>.

⁴ CSIS interview with Ambassador Deborah Birx, Washington, D.C., February 12, 2015.

⁵ “Social Protection Programmes Contribute to HIV Prevention,” Policy Brief, UNAIDS, January 2015, <http://strive.lshtm.ac.uk/system/files/attachments/Social%20protection%20programmes%20contribute%20to%20HIV%20prevention%20brief.pdf>.

settings means empowering them with social protection and safe spaces, education and economic skills, and access to family planning and reproductive health.⁶

In a time of increasingly limited global resources for HIV/AIDS and partisan gridlock in Washington, it is all the more notable that PEPFAR is now making adolescent girls and young women such a high priority. Yet if DREAMS is to gain traction, it will require strong host-country commitment at all levels as well as a dynamic political strategy, which means U.S. ambassadors and U.S. country teams have to be fully on board. Most importantly, DREAMS will require country buy-in to have an impact.

This paper examines how adolescent girls and young women have become a priority focus in the fight against global HIV/AIDS, the approaches that have proven effective and the evidence generated, and the gaps and challenges that remain. We offer in the paper examples of the kinds of innovative programs, varied entry points, and new strategies that may be used to reach adolescent girls and young women in key geographic hot spots. To provide a view of the broader landscape of activity in this area, we also lay out the other international initiatives that can be expected to complement and expand upon the DREAMS Partnership. Finally, we highlight key challenges relating to how DREAMS will operationalize and measure impact, how to bring sufficient scale and sustainability to these programs, and the importance of targeting and engaging adolescent girls and young women for more-effective program design and implementation.

Background

While the number of new HIV infections and AIDS-related deaths is declining globally,⁷ this progress masks pockets of high prevalence in key populations, including 15- to 24-year-old adolescent girls and young women in eastern and southern Africa, who are infected at rates two to five times higher than boys their age. While some of these girls and young women were infected perinatally, that is, at birth from their HIV-infected mothers, many were infected through sexual transmission. The gap in addressing girls in the HIV responses is not a new discovery, but recent data has raised the profile of this issue.

An article coauthored by the executive directors of the United Nations Children's Fund (UNICEF) and UNAIDS puts the situation in stark relief: "More than 250,000 15 to 19-year-olds were newly infected with HIV in 2013—and they are overwhelmingly girls . . . Girls are more vulnerable to HIV because they are more vulnerable generally—to violence, including sexual violence, forced marriage and trafficking. They are far less

⁶ Annabel Erulkar, *Building the Assets to Thrive: Addressing the HIV-related vulnerabilities of adolescent girls in Ethiopia*, Population Council, 2014, 1, http://www.popcouncil.org/uploads/pdfs/2014PGY_BuildingAssetsThrive.pdf.

⁷ UNAIDS, "The Gap Report," 8–9.

likely than boys to have the information they need to protect themselves, but even if they have that information, they may not be empowered to use it.”⁸

Reasons for the new global focus include:

- *Attention to data:* Researchers in eastern and southern Africa have produced data that clearly demonstrate the alarming, disproportionate burden of HIV among adolescent girls and young women. Studies in certain rural areas of South Africa have found that young pregnant women are infected at phenomenally high rates: 18.6 percent of 17- to 18-year-olds, 25.4 percent of 19- to 20-year-olds, 32.8 percent of 21- to 22-year-olds, and 44.8 percent of 23- to 24-year-olds.⁹
- *Alarming demographics and the youth bulge:* The “youth bulge”¹⁰ has made Africa the world’s youngest continent. In 2010, 70 percent of the region was under the age of 30.¹¹ This youth bulge has profound social, economic, health, and political implications. Parallel to this shift has been rising urbanization, which means that Africa’s urban centers are swelling with young populations. High rates of HIV infection concentrated within a rapidly growing youth population risks overwhelming current interventions to stop the epidemic.
- *Failure to address structural drivers:* Adolescent girls and young women face a lethal mix of legal, economic, and social factors—known as structural drivers—that interact to affect behavior and decisions on sexual partners.¹² These factors include gender inequality and gender roles, lack of livelihood options, and stigma and discrimination, which reduce the benefits conferred by protective factors such as education, economic assets, and legal protection. Structural drivers also lead to early, coerced, and intergenerational sex; transactional sex; child marriage; and gender-based violence and exploitation. The drivers also interfere with girls’ and young women’s ability to use and adhere to biomedical prevention technologies.

⁸ Antony Lake and Michel Sidibé, “To end the AIDS epidemic, start focusing on adolescents,” UNAIDS, February 17, 2015, http://www.unaids.org/en/resources/presscentre/featurestories/2015/february/20150217_oped_all-in.

⁹ Salim S. Abdool Karim, “State of the Art: Epidemiology and Access” (presentation at Twentieth International AIDS Conference, AIDS2014, Melbourne, Australia, July 2014), <http://pag.aids2014.org/session.aspx?s=2013#4>.

¹⁰ Justin Yifu Lin, “Youth Bulge: A Demographic Dividend or a Demographic Bomb in Developing Countries?,” Let’s Talk Development (World Bank blog), January 5, 2012, <http://blogs.worldbank.org/developmenttalk/youth-bulge-a-demographic-dividend-or-a-demographic-bomb-in-developing-countries>.

¹¹ “Regional Overview: Youth in Africa,” United Nations Economic Commission for Africa and United Nations Programme on Youth, <http://social.un.org/youthyear/docs/Regional%20Overview%20Youth%20in%20Africa.pdf>.

¹² See “Drivers,” *Strive*, London School of Hygiene & Tropical Medicine, <http://strive.lshtm.ac.uk/drivers>.

- *Limitations of new biomedical approaches/trials:* Biomedical interventions are evolving incrementally in the development of female-controlled preventions, such as microbicides and pre-exposure prophylaxis (PrEP),¹³ but the results of recent biomedical trials have been sobering. While PrEP has proven highly effective in preventing infection if regularly used, results from the VOICE (Vaginal and Oral Interventions to Control the Epidemic) study demonstrated low daily adherence among roughly 5,000 young, unmarried South African women for oral or vaginal antiretroviral Tenofovir products.¹⁴ ¹⁵ The limited adherence to this and other biomedical methods highlights the need to pursue a more holistic approach that includes longer-acting tools that require less ongoing adherence, such as injectables and implants, and finding ways to engage with girls and young women to support greater adherence.
- *PEPFAR 3.0—goal of epidemic control:* In its efforts to deliver on the promise of an AIDS-free generation, in 2014 PEPFAR launched what it called “PEPFAR 3.0.”¹⁶ This was a new effort to focus on doing “the right things in the right places at the right time.” Built upon the five action agendas of impact, efficiency, sustainability, partnership, and human rights, this strategy prioritizes programming for those with the greatest risk and greatest need, with a particular focus on children, adolescent girls, and key populations. The idea is to target geographic hotspots with the highest disease burden.

DREAMS—Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe

At the White House event for World AIDS day on December 1, 2014, PEPFAR announced a new two-year initiative called DREAMS, a \$210 million public-private partnership with the Bill & Melinda Gates Foundation and the Nike Foundation. DREAMS will focus on a core package of multisectoral interventions to address HIV risk and seek to provide multiple interventions in key geographic “hot spots.” The idea is to identify where adolescent girls and young women are being infected, the factors putting them at risk, and how to target programs accordingly. According to the DREAMS concept note, “These interventions, from a variety of sectors, when scaled

¹³ Pre-exposure prophylaxis (PrEP) is a preventive ARV treatment for people at high risk of HIV infection. If used consistently, it has proven highly effective in preventing HIV infection.

¹⁴ Jeanne M. Marrazzo et al., “Tenofovir-Based Preexposure Prophylaxis for HIV Infection among African Women,” *New England Journal of Medicine*, February 5, 2015, <http://www.nejm.org/doi/full/10.1056/NEJMoa1402269>.

¹⁵ Qualitative interviews from the VOICE trials uncovered that many women hid the products out of fear of stigma, as many were concerned with being falsely labeled as HIV positive for taking the preventive treatment. There were also fears about adverse side effects, as well as the toxicity of the drug, and a lack of social support for study participation. Michael S. Saag, “Preventing HIV in Women—Still Trying to Find Their VOICE,” *New England Journal of Medicine*, February 5, 2015, <http://www.nejm.org/doi/full/10.1056/NEJMe1415750>.

¹⁶ “PEPFAR 3.0: Controlling the Epidemic—Delivering on the Promise of an AIDS-Free Generation,” Department of State, <http://www.pepfar.gov/documents/organization/234744.pdf>.

and targeted to the most vulnerable adolescent girls have the potential to change the course of the global HIV epidemic.”¹⁷

DREAMS has set extremely ambitious goals—a 25 percent reduction in HIV incidence among adolescent girls and young women in the target areas in two years, and a 40 percent reduction in three years. PEPFAR officials emphasize that these are not national targets, but focused on specific high-incidence areas.

The partnership will concentrate on the most vulnerable subgroups of 15- to 24-year-old females in each country context,¹⁸ for example: girls whose parents have HIV or have died of AIDS; those engaged in cross-generational or varying types of transactional sex¹⁹; those married as adolescents; those who have experienced gender-based violence; those who are food insecure; and those who are mobile or whose partners are mobile. The initiative will cover up to 10 high-burden countries in eastern and southern Africa.²⁰

PEPFAR will contribute the bulk of the funding at \$180 million, reallocated from the FY2014 budget. Programs will focus on critical assets for girls and building on PEPFAR’s programs, platforms, infrastructure, and relationships. The Bill & Melinda Gates Foundation will provide \$25 million to support both evaluation and program implementation. The Nike Foundation will provide \$5 million for technical expertise in girl-centered strategies, program design, and communications.

DREAMS is expected to begin implementation in a highly accelerated timeframe, with the launch meeting held with country teams in January 2015 in South Africa, and country plans to be submitted for review in April and May 2015. PEPFAR country teams are expected to implement all aspects of the core package, although they can request an exemption.²¹ Importantly, the chiefs of mission are expected to be directly

¹⁷ “Working Together for an Aids-Free Future for Girls,” PEPFAR, Bill & Melinda Gates Foundation, and Nike Foundation, <http://www.pepfar.gov/documents/organization/234747.pdf>.

¹⁸ According to DREAMS guidance: “Although the objective 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).” See “Preventing HIV in Adolescent Girls and Young Women: Guidance for PEPFAR Country Teams on the DREAMS Partnership,” PEPFAR, 2015, 9.

¹⁹ Transactional sex refers to the exchange of sex with men for material gains and basic survival needs. Girls and women who exchange sex for money or favors may not necessarily identify themselves as sex workers. See “Violence against Women and HIV/AIDS: Critical Intersections—Intimate Partner Violence and HIV/AIDS,” Global Coalition on Women and AIDS and World Health Organization, Information Bulletin Series, Number 1, <http://whqlibdoc.who.int/unaid/2004/a85591.pdf?ua=1>.

²⁰ According to UNAIDS, there are over 5,000 new HIV infections a week among young women aged 15–24 years in 10 countries alone in east and southern Africa, representing the bulk of new infections within this population globally.

²¹ According to DREAMS guidance: “With the exception of PrEP, PEPFAR OUs [operating units] participating in the DREAMS Partnership should plan to implement all interventions from each category of the core package. OUs may ‘opt-out’ of an intervention only if justification can be provided on why a particular intervention does not fit their epidemiological, socio-cultural or political context or would be duplicative to an existing intervention easily accessible to the same cohort.” See “Preventing HIV in Adolescent Girls and Young Women: Guidance for PEPFAR Country Teams on the DREAMS Partnership,” PEPFAR, 2015, 9.

engaged in the participating countries; they have signed a letter committing themselves to the project as part of the country planning process.

The DREAMS core package²² will include nontraditional HIV interventions in the social and economic realm with the aim of saturating high-burden areas with programming. The Office of the U.S. Global AIDS Coordinator (OGAC) cites the work of South African researchers, including Lucie Cluver,²³ who has shown that the layering of “cash plus care” (direct cash transfers and social support services) can lead to a reduction in transactional sex, while also helping girls go to school.²⁴ The idea is to create a context in which a girl can more easily manage risks. At the same time, the hope is that these interventions will increase the chances that biomedical and other HIV-related interventions can work, such as information about and access to condoms, PrEP, and reproductive health/family planning services.

Although PEPFAR funds cannot be used for all these activities, the expectation is that other partners will support those programs. For example, PEPFAR is unlikely to support cash transfer programs, pay for the drugs for PrEP demonstration projects, or provide contraceptive commodities other than male and female condoms.²⁵ In addition to the contributions from the Bill & Melinda Gates Foundation and the Nike Foundation, PEPFAR officials hope that other public and private partners will help support these and other interventions. In particular, the DREAMS partners hope that corporate partners will join to create economic opportunities for girls and young women, and that the range of actors involved in services for orphans and vulnerable children, including faith-based organizations, will extend the OVC platform to older girls and young women. For family planning commodities, other bilateral and multilateral partners can play a role, such as the United Nations Population Fund

²² The core package focuses on: 1) adolescent girls and young women, to empower them and to reduce their risk of HIV and violence; 2) their families, to strengthen them economically and their ability to “parent positively”; 3) their sexual partners, to target them for highly effective interventions, such as antiretroviral treatment (ART) and voluntary medical male circumcision (VMMC); 4) their larger communities, to mobilize them for change and to keep girls and women safe from violence. See “Preventing HIV in Adolescent Girls and Young Women: Guidance for PEPFAR Country Teams on the DREAMS Partnership,” PEPFAR, 2015, 7.

²³ Carole Leach-Lemens, “Cash transfers plus care halve HIV risk behaviours in South Africa adolescents,” NAM (National AIDS Manual) AIDSMAP, July 22, 2014, <http://www.aidsmap.com/Cash-transfers-plus-care-halve-HIV-risk-behaviours-in-South-African-adolescents/page/2893215/>.

²⁴ Lucie Cluver et al., “Cash Plus care: social protection cumulatively mitigates HIV-risk behaviour among adolescents in South Africa,” *AIDS* 28, suppl. 3 (2014): S389–S397, <http://www.youngcarers.org.za/assets/pdfs/Cluver-L-Orkin-M-Boyes-M-Sherr-L-2014-Cash-plus-care-social-protection-cumulatively-mitigates-HIV-risk-behaviour-among-adolescents-in-South-Africa.-AIDS-.pdf>.

²⁵ According to the COP Guidance for 2014, “As part of comprehensive care for HIV and AIDS, field teams are expected to prioritize opportunities to use PEPFAR funds to support voluntary family planning and reproductive health (FP/RH) services. These services must meet an HIV prevention, treatment, or care purpose and/or link PEPFAR-funded activities with FP/RH activities funded from separate U.S. government accounts or other non-U.S. government sources of funds. As in years past, PEPFAR funds may not be used to purchase family planning commodities; however, male and female condoms can be purchased using PEPFAR funds.” See “Country Operational Plan (COP) Guidance: FY 2014,” PEPFAR, November 8, 2013, 88, <http://www.pepfar.gov/documents/organization/217765.pdf>.

(UNFPA) and the U.S. Agency for International Development’s (USAID) Office of Population and Reproductive Health.²⁶

Many observers believe that this could be a transformational moment; others fear that the goals are too ambitious and that there aren’t enough proven interventions to build upon. Whether the strategy of concentrating on key geographic areas where the epidemic is raging in girls and young women, rather than developing national-level programs, will succeed also remains to be seen. To implement this degree of geographic targeting will require a level of granularity of data that not all acutely affected countries possess. “Maybe it’s overly ambitious,” says Michele Moloney-Kitts, director of Together for Girls. “But there are lots of opportunities—it’s a chance to do things differently.”²⁷

Illustrative Interventions beyond the Health Sector

The disproportionate impact of HIV on girls and young women stems from a range of factors linked to gender inequality and human rights abuses that result in lack of access to education and reproductive health care, gender-based violence, child marriage, and discriminatory policy and legal environments. Addressing these factors, which go beyond biomedical interventions, is key to the DREAMS core package.

The core package of interventions assembled for DREAMS stems from a widespread recognition of the shortcomings of a strictly biomedical approach to prevention. Its concept of layered, multisector programming looks to empower girls with awareness, assets, and tools, enabling them to protect themselves from the risk of HIV infection. According to the DREAMS guidance for PEPFAR country teams:

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

²⁶ USAID’s Office of Population “graduates” countries from funding once they have reached a certain threshold for family-planning-related indicators. This phased graduation takes into account a country’s total fertility rate, modern contraceptive prevalence rate, and additional indicators related to equity and method mix. See Jane T. Bertrand, “USAID Graduation from Family Planning Assistance: Implications for Latin America,” Population Institute and Tulane University, October 2011, http://www.populationinstitute.org/external/files/reports/FINAL_LAC_Report.pdf. However, there may be limitations on what can be provided in countries such as South Africa, which have “graduated” from U.S. family planning assistance.

²⁷ CSIS telephone interview with Michele Moloney-Kitts, January 30, 2015.

comprehensive packages of social, economic and biomedical interventions to both reduce girl's vulnerability to HIV and increase their agency.²⁸

At this writing, implementation of DREAMS has not yet begun. However, the following represent some leading entry points for prevention of HIV infection among adolescent girls and young women, as well as some illustrative interventions.

Preventing Gender-based Violence (GBV)

A global body of research shows strong and complex links between GBV and HIV for girls and young women. Violence is both a risk factor for HIV acquisition and a consequence of being infected; threats of violence present barriers for girls seeking health information and services or other social support, and complicates their situation once infected.

The link between violence and HIV in girls and young women sheds light on the complex dynamics that will have to be addressed. Compared to older women, adolescent girls ages 15 to 19 are at greater risk for experiencing physical and sexual abuse: studies in 81 countries found that some 30 percent of girls age 15–19 have experienced intimate partner violence,²⁹ and one in four report that their first sexual experience was forced.³⁰ Research also shows that a high percentage of these experiences is with older men, who are more likely to be infected with HIV than younger men.³¹ Sexual violence leads to an increase in HIV-related risk behaviors,³² and girls who experience violence are up to three times more likely to develop HIV or other sexually transmitted infections.

The **SASA! Study** in Uganda examined the impact of a community mobilization program to prevent violence against women.

The program employed local activists to foster dialogue surrounding power and gender in their communities. A follow-up survey documented a 64 percent decrease in physical violence among women, as well as a decrease in the acceptability of intimate partner violence among women and men. SASA! showed that a structured community mobilization intervention has the power to change harmful gender norms and reduce violence against women.

See Tanya Abramsky et al., "Findings from the SASA! Study: A cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda," *BMC Medicine* 2014, 12:122, <http://www.biomedcentral.com/1741-7015/12/122>.

²⁸ "Preventing HIV in Adolescent Girls and Young Women: Guidance for PEPFAR Country Teams on the DREAMS Partnership," PEPFAR, 2015, 5.

²⁹ "Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence," WHO, London School of Hygiene and Tropical Medicine, and South African Medical Research Council, 2013, 17, http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf?ua=1.

³⁰ "Transforming Data Into Action: Together for Girls Stakeholder report 2013–2014," Together for Girls, 8, <http://www.togetherforgirls.org/wp-content/uploads/Together-for-Girls-2013-2014-Stakeholder-Report.pdf>.

³¹ Judith Bruce, "Violence against Adolescent Girls: A Fundamental Challenge to Meaningful Equality," Population Council, 2011, http://www.popcouncil.org/uploads/pdfs/2012PGY_GirlsFirst_Violence.pdf.

³² Together for Girls, 2015 Stakeholder Meeting.

Cash Transfers

Young women's risks of HIV infection are closely linked to their social and economic situation, particularly lack of education and economic dependence on men. Together, gender and economic inequities drive a number of HIV-related risk behaviors, including transactional sex, age-disparate and intergenerational relationships, and inability to negotiate safer sex.³³

There are many avenues for addressing the link between poverty and HIV, including cash transfers, food support, educational subsidies, and child grants. Unconditional cash transfers, that is, direct cash payments to individuals or families with no designation of how the money should be spent, have proven effective in reducing HIV-related risk behaviors³⁴ and HIV prevalence³⁵ among adolescent girls.

Cash transfers can also include conditionalities to improve uptake of social services. The majority of conditional cash transfers for young women include a requirement that the girl attends school, aiming to reduce poverty-related barriers to education and improve prospects for financial security in the long term.³⁶ Schooling can significantly reduce young women's HIV-related vulnerabilities; better-educated women are more likely to "delay marriage and childbearing, [. . .] earn better incomes and have greater decision maker power within relationships."³⁷

The **Zomba cash transfer trial** examined whether a cash transfer program could reduce risk of sexually transmitted infections in young, unmarried women. The trial provided cash transfers to nearly 3,800 girls and their families in Malawi. After 18 months, girls enrolled in the study had a 64 percent lower HIV prevalence and 77 percent lower HSV-2 prevalence than girls who had not received the transfers. The trial demonstrated that cash transfer programs can reduce HIV and HSV-2 infections in adolescent girls in low-resource settings.

See S. Baird et al., "Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: A cluster randomized trial," *Lancet* 2012; 379: 1320–29.
<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2961709-1/abstract>.

³³ "Discussion Paper: Cash Transfers and HIV Prevention," United Nations Development Program (UNDP), October 17, 2014, <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/discussion-paper--cash-transfers-and-hiv-prevention.html>.

³⁴ A recent South African study demonstrated the effects of cash plus care services on a suite of HIV-related risk behaviors, including transactional sex, age-disparate sex, past-year initiation of sexual activity, unprotected sex, multiple sexual partners, casual sex, sex while using alcohol or drugs, and pregnancy. See Cluver et al., "Cash plus care: social protection cumulatively mitigates HIV-risk behaviour among adolescents in South Africa."

³⁵ S. Baird et al., "Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: A cluster randomized trial," *Lancet* 2012; 379: 1320–29.
<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2961709-1/abstract>.

³⁶ "Discussion Paper: Cash Transfers and HIV Prevention," UNDP.

³⁷ Audrey E Pettifor et al., "Keep Them in School: The Importance of Education as a Protective Factor against HIV Infection among Young South African Women," *International Journal of Epidemiology* 37.6 (2008): 1266–73, March 18, 2015, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2734068/>.

Improving Access to Integrated HIV-Family Planning Services

A range of barriers fuels high levels of unmet need for family planning and reproductive health services among adolescent girls.³⁸ Improving access through innovative delivery mechanisms, such as in-school services and family planning-HIV integration, can help to reduce these barriers. Integrating family planning into HIV services helps prevent new HIV infections by reducing unintended pregnancies, thereby preventing mother-to-child-transmission (PMTCT).³⁹ Similarly, integrating HIV services into family planning, reproductive health, and maternal and child health programs helps provide information and services to prevent HIV infection in women and girls.

Creating Safe Spaces/Building Social Assets

The absence of safe community spaces for adolescent girls—locations where they are respected and can develop skills, friendships, and support networks—is a major factor contributing to social isolation, as they are often removed from their families and network of friends. The safe spaces model, pioneered by the Population Council, has proven to be a valuable tool in addressing the HIV-related vulnerabilities of adolescent girls. This approach seeks to create a comfortable environment in which girls engage with their peers in weekly, mentor-led sessions about health and livelihoods,⁴⁰ and can serve as a platform for a variety of community-based interventions.

The **CAPRISA school-based SRH study** looked to evaluate the value of a school-based platform for accessing services.

The program piloted a tiered system of sexual and reproductive health (SRH) services, including in-school information sessions, on-site counseling and testing for HIV, and referrals. Over 8,800 students received SRH information and over 4,100 students accessed on site testing and counseling for HIV. This showed that high school students are receptive to school-based SRH services. Community engagement, especially of adolescents themselves, is key to understanding challenges in access.

See J. Frohlich et al., “Meeting the sexual and reproductive health needs of high school students in South Africa: Experiences from rural KwaZulu-Natal,” *South African Medical Journal* 104, no. 10 (May 16, 2014): 687–90, <http://www.samj.org.za/index.php/samj/article/view/7841/6459>.

³⁸ A review from the International Center for Research on Women (ICRW) identified numerous demand-side factors including gendered roles and expectations, stigma around adolescent sexuality, and limited decisionmaking power. Supply-side constraints included accessibility issues, including a lack of awareness of services, inconvenient operating hours, and cost, as well as quality issues, such as incompetence of providers, stockouts, and lack of privacy. See Suzanne Petroni, “Lessons Learned from Sexual and Reproductive Health Programming,” Presentation at DREAMS Planning Workshop, Johannesburg, South Africa, January 26, 2015.

³⁹ The four pillars of PMTCT are: prevention of HIV in women; prevention of unintended pregnancies among women; prevention of HIV transmission from a woman to her infant; and care and support for HIV-infected women, their infants, and their families.

⁴⁰ Judith Bruce, Miriam Temin, and Kelly Hallman, “Evidence-based Approaches to Protecting Adolescent Girls at Risk of HIV,” AIDSTAR—USAID, March 2012, http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_GenderSpotlight_AdolescentGirls.pdf.

The proven benefits of social networks to overall health and wellbeing are a key motivator of the safe-spaces approach. At the critical period of adolescence, girls are less likely than boys to have a strong social network and corresponding protective assets. This is especially true for married adolescent girls, out-of-school girls, and girls living away from their families, who are viewed as particularly vulnerable populations.

Child brides are subject to heightened HIV-related vulnerabilities.⁴¹ For adolescent girls, marriage often signifies the start of frequent and unprotected sexual activity, and in many countries signifies increased risk of HIV infection. Intergenerational marriages often result in adolescent brides with husbands 20 to 30 years their senior, with age compounding preexisting gender inequities and power dynamics. Early marriage also leads to increased social isolation for adolescent girls.

Gender-based economic disparities contribute significantly to adolescent girls' vulnerability to HIV. High-risk sexual behavior is often driven by economic inequality: as young women are dependent on men for financial security, they are either unwilling or unable to negotiate safer sex. Relationships are often formed with older men, who are more likely to have greater resources, and more sexual partners.⁴² Numerous studies have documented the need for money or the desire for material goods as a primary motivator among adolescent girls for engaging in sexual activity.⁴³ Low income is associated with earlier sexual debut, more sexual partners, decreased condom use, and higher likelihood of nonconsensual sex and trading sex for money, goods, or services.

Meseret Hiwott was a mentoring program designed to reduce social isolation of married adolescent girls and build knowledge around sexual and reproductive health. The program encouraged married adolescents to interact with girls their own age and learn about gender equity, positive health behaviors, self-esteem, power dynamics, and financial literacy.

Enrolled girls were more likely to use family planning, receive counseling and testing for HIV, and receive assistance from husbands with housework.

See Annabel Erulkar, "Building the assets to thrive: Addressing the HIV-related vulnerabilities of adolescent girls in Ethiopia," Population Council, 2014, http://www.popcouncil.org/uploads/pdfs/2014PGY_BuildingAssetsThrive.

Other National and International Initiatives

This global momentum includes a number of other initiatives focused on HIV in adolescents, evidence of an alignment of interests, especially among PEPFAR, UNICEF, UNAIDS, UNFPA, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. But many other groups are active in the area of empowering adolescent girls and young

⁴¹ Erulkar, "Building the Assets to Thrive," *Population Council*.

⁴² Kim Ashburn, Ann Warner, and Sara Friedman, "Can Economic Empowerment Reduce Vulnerability of Girls and Young Women to HIV?," *ICRW*, 2010, <http://www.icrw.org/sites/default/files/publications/Can-Economic-Empowerment-Reduce-Vulnerability-Girls-Young-Women-HIV.pdf>.

⁴³ *Ibid*.

women, improving their access to education and economic assets, and responding to gender-based violence: bilateral donors, such as the United Kingdom and the Nordic countries; multilateral organizations, such as the World Bank; public-private partnerships, such as Together for Girls; and a range of national and international nongovernmental organizations (NGOs). It is still unclear how these numerous initiatives will intersect, and how they will translate the focus on women and girls into tangible results.

All In!

In late 2014 to early 2015, the United Nations launched a new initiative called “All In!,” a platform for action to end HIV in adolescents. In addition to UNICEF, UNAIDS, and UNFPA, All In! was joined by WHO, PEPFAR, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the MTV Staying Alive Foundation, and youth movements.⁴⁴ It is expected to include 25 countries, representing 90 percent of AIDS-related deaths and 85 percent of new infections among adolescents.

All In! concentrates on four central pillars: improving data and epidemiology; strengthening national plans for focus on adolescents; fostering innovation in new technologies and approaches to engage this population more effectively; and advocating for evidence, policy, and resources. Finally, All In will seek to engage and mobilize young people as agents of change.

At a high-level meeting in Nairobi in February 2015, world leaders called for a new global target to reduce AIDS-related deaths among adolescents by 65 percent and to cut new HIV infections by 75 percent in the next five years. The high-level representation included the executive directors of UNICEF, UNAIDS, and UNFPA, as well as the president of Kenya.

Global Fund to Fight AIDS, Tuberculosis, and Malaria

The Global Fund’s documents and strategies recognize that gender inequalities are a major driver of the HIV epidemic, but it has recently intensified its focus on adolescent girls and young women. Since the Global Fund’s role involves working with countries to develop and own their HIV response, this focus on girls and young women should help the Global Fund to work across government ministries beyond health to include education, economic and social development, and agriculture.

An area of particular promise involves cash transfers or cash incentives to keep girls in school and to prevent HIV infection. According to the Global Fund’s executive director, Ambassador Mark Dybul, the link between education and health is critical,

⁴⁴ “Leaders from around the world are All In to end the Aids epidemic among adolescents,” UNAIDS, February 17, 2015, http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/february/20150217_PR_all-in.

and has the potential to have significant impact on both health and development outcomes: “This is the first time we have data that obliges us to fully link education and health. . . . That to me is one of those huge switches you almost never get.”

As part of this new focus, the Global Fund is seeking to collect and analyze age and gender disaggregated data to strengthen its understanding of and response to adolescent girls and young women.

High-Level Task Force for Women, Girls, Gender Equality, and HIV for Eastern and Southern Africa

The task force was launched at the 16th International Conference on AIDS and STIs in Africa, and grew out of the 2010 Global Task Force’s Agenda for Accelerated Country Action on Women, Girls, and HIV.⁴⁵ Targeting 21 countries, the initiative is cochaired by Sheila Tlou and Michel Sidibé of UNAIDS, and is focused on ways to impact the HIV/AIDS epidemic and address issues contributing to the vulnerabilities of women and girls.⁴⁶

The task force’s mission is to advocate for change on a number of gender-based issues, including child marriage, sex work, transmission of HIV from mother-to-child, and violence against women.⁴⁷ It endeavors to engage leadership at all levels of society, from adolescent girls to heads of state, to highlight areas of progress as well as barriers to success in empowering women and girls. In particular, the task force looks to engage traditional leaders as the custodians of culture, as well as ministries of education and health, working to gain their commitments to ensure comprehensive sexuality education and services.

Key Challenges for Successful DREAMS Implementation

Short Time Frame for Results

A primary challenge in operationalizing the DREAMS partnership involves sustaining efforts beyond the initial two years. The hope is that early gains will attract additional donors, but for that to happen, quick and impressive results will need to be demonstrated through the core package of interventions. A longer time horizon will undoubtedly be needed to demonstrate impact, which may pose a challenge to maintaining engagement and commitment of donors, governments, and communities.

⁴⁵ “High Level Taskforce to tackle gender inequality,” UNAIDS, December 8, 2011, <http://www.unaids.org/en/resources/presscentre/featurestories/2011/december/20111208uawomen>.

⁴⁶ “Term of Reference: High level Taskforce for Women, Girls, Gender Equality and HIV for the Eastern and Southern Africa Region,” UNAIDS, http://www.unaidsrstes.org/prvs/sites/default/files/high_level_taskforce_for_women_girls_and_hiv_tors_final.pdf.

⁴⁷ “High-Level Taskforce for women, girls and HIV calls for accelerated efforts to protect the rights and wellbeing of young women and girls in South Africa,” UNAIDS, October 31, 2012, <http://www.unaids.org/en/resources/presscentre/featurestories/2012/october/20121031sataskforce>.

Implications for “Hot-spot” Programming

DREAMS’s focus on geographic hot spots is meant to strategically target limited resources. However, shifting resources out of lower-priority areas to these “hot spots” may mean diminished resources and services in some areas to compensate for expansions elsewhere.

Expanding Access to Key Services

In some places, there may be opposition to expanding family planning/reproductive health services and comprehensive sexuality education to 10- to 24-year-olds, as well as to offering PrEP.⁴⁸ In addition, PrEP may pose specific challenges due to the continued exclusion of adolescents from biomedical trials.⁴⁹ Closely related, it is widely accepted that early intervention is key in addressing HIV-related vulnerabilities for adolescent girls; nevertheless, 10- to 14-year-olds are generally excluded from programming as it is difficult to do research and collect data within this age group. If DREAMS is to effectively reach 10- to 14-year-olds, it will need to address major structural issues—for example, ethical and legal barriers to working with underage populations⁵⁰—while also working to reach other especially vulnerable populations, including young sex workers and married adolescents.

Operationalizing a Multisectoral Approach

While we know that a multisectoral approach is needed for this population, comprehensive interventions are not easy to operationalize and connect strategically. Engagement from a wider range of government ministries—including finance, education, justice, and women’s affairs—will be critical. There is a need to determine if it is possible to create a minimum package of multisectoral interventions that can reduce risk of HIV infection for this population.

Data and Measurement for the Learning Agenda

DREAMS will have to develop ways to define and measure progress, and to address the lack of costing data in these programs. Given the difficulties of counting and

⁴⁸ PrEP is part of the core package for DREAMS, but is not required.

⁴⁹ PrEP is unlikely to be available to those under 18. In addition, given difficulties with enrolling underage participants due to ethical frameworks for research, major trials such as VOICE have focused exclusively on adult females 18 years or older, meaning that there is limited knowledge of the drug’s efficacy among younger girls. The need to develop products and interventions that can address the unique vulnerabilities of adolescent girls warrants their inclusion in PrEP trials, which will require revisiting ethical and legal frameworks for biomedical research. See Quarraisha Abdool Karim and Rachel Dellar, “Inclusion of Adolescent Girls in HIV Prevention Research: An Imperative for an AIDS-free Generation,” *Journal of the International AIDS Society* 17 (2014), <http://www.jiasociety.org/index.php/jias/article/view/19075>.

⁵⁰ WHO is producing new guidance on ethical research in children.

collating disaggregated data from integrated platforms, proxy indicators will be necessary to track, monitor, and capture successes and failures.

Establishing Country Buy-in/Ownership

Given the kind of social and political change envisioned by DREAMS, progress will hinge on buy-in from national, provincial, district, and community leaders, yet these are precisely the leaders who have too often been complacent or, even worse, resistant in the face of the alarming threats faced by adolescent girls and young women. DREAMS programs will have to contribute to shifting political, social, and cultural norms, legal practices, and economic realities in order to address the risk of HIV for girls and young women.

Given the disappointing experience with the Obama administration's Global Health Initiative (GHI) established in 2009,⁵¹ DREAMS may also face challenges in motivating U.S. embassies to cooperate. If PEPFAR can point to progress in the initial two-year pilot phase, ongoing commitment and resources will be necessary to incorporate the interventions into Country Operational Plans (COPs), enlist new donors, and expand the scale of the program. Meanwhile, in key countries like South Africa, PEPFAR is transitioning out of its central role in HIV financing, with progressively reduced U.S. resources and leverage going forward.

Recommendations/Policy Options

At a time when global funding for the AIDS crisis has leveled off, the recent surge in attention to preventing HIV in adolescent girls and young women is remarkable. The DREAMS Partnership has set forth highly ambitious goals in a short timeframe, and success will require sustained commitments and new approaches if real impact is to be achieved.

A realistic roadmap is necessary to ensure a comprehensive, coordinated response and sustained financial commitments from international donors, national governments, implementing partners, and affected communities. To make these goals attainable and not simply aspirational, the United States should adopt a longer-term plan that builds on these policy options:

- Target and involve adolescent girls and young women in the design, implementation, and monitoring of DREAMS. Programs should help build their

⁵¹ The Global Health Initiative, announced by President Obama in May 2009 to promote a more comprehensive U.S. government approach to global health, was effectively ended in July 2012 with the closure of the GHI Office at the State Department. This sudden announcement led to uncertainty at the country level as to how and if the GHI country strategies would be carried forward and whether funding would be available. While in certain countries, GHI galvanized new action and coordination across U.S. government agencies and highlighted an important focus on women, girls, and gender equality, its potential was never realized.

capacity and protective assets, including for younger adolescents ages 10–14, and focus investments to reach those girls and young women at highest risk.

- Demonstrate progress and document what works. Ensure appropriate budgets, plans, and targets that reflect these priorities, and develop indicators to ensure accountability. Support costing studies and dissemination of lessons learned from implementation to inform programing and funding.
- Develop strategies for country buy-in to build locally appropriate and sustainable programs. This means working with different levels of government (local, district, provincial, national) as well as trained female mentors and health-care workers, civil society organizations, women leaders, and faith-based organizations.
- Motivate and reward PEPFAR country teams that accelerate U.S. leadership to drive and coordinate multisectoral programs and incorporate a focus on adolescent girls and young women into U.S. global health diplomacy. Such high-level diplomacy should be undertaken by the leaders of U.S. government agencies and the chiefs of missions in the participating countries.
- Expand public-private partnerships to leverage U.S. investments in adolescent girls, young women, and HIV and to finance a wider range of programs to address their needs. This means seeking out new partners (private sector, UN agencies and other multilateral partners, and national governments), and leveraging other programs and sectors (including economic, financial services, agriculture, and communications).

Conclusion

The emergence of DREAMS and other international partnerships focused on HIV in adolescent girls and young women represent an ambitious effort to go beyond biomedical interventions to address the social and economic factors that put this population at risk of infection. It remains to be seen, however, if these initiatives can demonstrate impact in a short timeframe, and build toward sustainable programs. This is a critical moment to transform a growing global interest in women and girls in a range of sectors into effective HIV programing, and to highlight the results at the July 2016 International AIDS Conference in Durban, South Africa. The conference, being held at the epicenter of South Africa's AIDS epidemic, will provide an important opportunity to take stock of where these efforts are heading, what they require for success, and what lies ahead.



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