



SADC GUIDE TO HIV PREVENTION PROGRAMMES FOR ADOLESCENT GIRLS AND YOUNG WOMEN AND THEIR SEXUAL PARTNERS



SADC HIV GUIDE

THE GUIDE RESULTS FROM A HIGHLY CONSULTATIVE PROCESS INVOLVING ALL SADC MEMBER STATES, UN AGENCIES, DEVELOPMENT PARTNERS AND CIVIL SOCIETY ORGANIZATIONS

© UNFPA



CONTENTS

Acknowledgement	
1. Introduction and background	3
2. Defining adolescent girls and their male partners	5
3. Steps to designing an HIV prevention programme for adolescent girls and young women and their male partners/Guidance framework	7
STEP 1: Know your epidemic	7
STEP 2: Identify the determinants of HIV	9
STEP 3: The package of HIV prevention interventions	10
STEP 4: Set the targets	12
STEP 5: Measure progress toward achieving the targets	13
Conclusion	15
Essential reading	17

ACKNOWLEDGEMENT

The SADC Secretariat wishes to express its sincere gratitude to all stakeholders who provided strategic guidance and valuable inputs in developing the “SADC Guide to HIV Prevention Programmes for Adolescent Girls and Young Women and Their Sexual Partners” including development partners, UN agencies, civil society and young people.

Specifically, the Secretariat would like to thank experts from all Member States representing Ministries responsible for Health and HIV and AIDS, and national AIDS Authorities who reviewed and enriched the document during different consultative forums.

This work would not have been possible without the financial and technical assistance from UNFPA, and UNAIDS through their Regional Offices for East and Southern Africa.

We wish to also acknowledge the role played by young people in sharing their experiences and also proposing concrete steps to addressing the challenges they face. Similarly, we wish to thank Prof Olive Shisana for capturing views of different stakeholders and compiling a guide that will assist Member States to accelerate HIV programming for young people especially Adolescent Girls and Young women.

The commitment of the following experts who coordinated the entire process of the development of the Guide is also highly appreciated: Alphonse M. Mulumba (SADC Secretariat), Innocent Modisaotsile (UNFPA), Malviya Alankar (UNAIDS).

QUICK LOOK

DESPITE A STEEP DECLINE IN AIDS-RELATED DEATHS BETWEEN 2010 AND 2017, NEW HIV INFECTIONS HAVE DECLINED BY ONLY 16%, REACHING 1.8 MILLION IN 2017

© UNFPA



1. INTRODUCTION AND BACKGROUND

In 2016, member states of the United Nations and stakeholders, including civil society, faith-based organizations, networks of people living with HIV, networks of key populations, international organizations and foundations, adopted the United Nations Political Declaration on Ending HIV and AIDS. It set ambitious targets to reduce new HIV infections by 75 per cent by 2020, and reducing new infections among adolescent girls and young women to below 100,000 new infections per year. To achieve this goal, the Political Declaration called for 90 per cent of people at risk of HIV infection, including all young people in high-prevalence settings, to have access to comprehensive HIV prevention services.

Despite a steep decline in AIDS-related deaths between 2010 and 2017, new HIV infections have declined by only 16 per cent, reaching 1.8 million in 2017. Close to half of these new infections occurred in 14 high-burden countries located in Eastern and Southern Africa, the majority of which are in the Southern Africa Development Community (SADC) region.

Recognizing the urgency to fast-track the reduction of new HIV infections, SADC, with the support of the UNAIDS Regional Support Team for Eastern and Southern Africa (UNAIDS RST-ESA) and the United Nations Population Fund, East and Southern African Regional Office (UNFPA ESARO), have developed this Guide.

The Guide results from a highly consultative process involving all SADC member states, UN agencies, development partners and civil society organizations. It was reviewed at the meeting of National AIDS Council Directors and technical experts from SADC, held on 2 to 4 October 2017 in Johannesburg, South Africa.

Purpose of this Guide

- i) To define a package of interventions that can be implemented by SADC member states to ensure that 90 per cent of adolescent girls and young women (AGYW) and their male partners at risk of HIV infection have access to comprehensive combination HIV prevention services in order to fast-track the reduction of new HIV infections to below 100,000 by 2020.
- ii) To provide a methodology for member states to define targets aligned with those defined in the 2016 Political Declaration and to measure the extent to which HIV prevention programmes are meeting the needs of AGYW and their male partners and reducing new HIV infections.

Who is the Guide for?

This Guide is intended for programme managers working in National AIDS Councils and Ministries of Health, Education, Gender and Youth that are implementing programmes addressing the needs of adolescent girls and young women.

How to use this Guide

This Guide uses a step-wise approach that programme managers can follow when designing programmes to reduce the risk of HIV among AGYW and their male partners. The Guide aims to enable a common understanding of what is meant by AGYW and their male partners. It proposes a package of interventions, principles for setting national and subnational targets against which to measure progress, and indicators to monitor programme performance.

The steps are briefly described below:

STEP 1: Know your epidemic

Map the prevalence and the levels of new HIV infections and deaths, disaggregated by geography, age and gender, to identify geographic areas and people who are most at risk of HIV infection, in order to focus efforts in reaching those most at risk.

STEP 2: Identify the determinants of HIV

Identify the biological, behavioural, social, cultural and structural factors that place AGYW and their male partners at risk of HIV.

STEP 3: Identify the package of interventions

Proposes a package of evidence-based, combination HIV prevention interventions that uses a layering approach. The proposed package of interventions is informed by the intensity and resources required, linked to the level of HIV incidence in a particular geographic area.

STEP 4: Set the targets

Outlines the principles that programme managers should consider when setting targets to prevent new HIV infections among AGYW at national and subnational level.

STEP 5: Measure progress toward achieving the targets

Recommends relevant indicators for measuring progress in achieving the goal of reducing new HIV infections amongst AGYW and their male partners.

Limitations

This Guide does not attempt to summarize the evidence regarding the risk factors that place people at risk of HIV infection as these are well documented. It does not include the standard operating procedures on how to implement specific interventions to prevent new HIV infections.

QUICK LOOK

NEW HIV INFECTIONS AMONG AGYW AND THEIR MALE PARTNERS ARE MUCH HIGHER THAN AMONG ADOLESCENT BOYS AND YOUNG MEN THEIR OWN AGE

© UNFPA



2. DEFINING ADOLESCENT GIRLS AND THEIR MALE PARTNERS

Adolescent girls and young women are defined as persons aged 10 to 24 years. New HIV infections among AGYW are much higher than among adolescent boys and young men their own age. Therefore, it is crucial to identify the male partners of AGYW, because reducing new infections among AGYW can only be effective if those who expose them are included in interventions.

Not all adolescent girls and young women and their male partners are at risk of HIV infection. Those most at risk include those who:

- are in sero-discordant relationships;
- are involved in age-disparate relationships;
- engage in multiple sexual relationships, which may or may not be concurrent;
- pay for sex (usually males);
- are HIV-positive (males and females);
- use contraceptives and have sex without condoms; and
- engage in transactional sex (older males and younger females or older females and younger males).

QUICK LOOK

THE FRAMEWORK IS INTENDED TO GUIDE PROGRAMME MANAGERS IN UNDERTAKING EVIDENCE-BASED PROGRAMMES TO REDUCE NEW HIV INFECTIONS AMONG AGYW AND THEIR MALE PARTNERS IN THE SADC REGION

© UNFPA



3. GUIDANCE FRAMEWORK

The following framework is intended to guide programme managers in undertaking evidence-based programmes to reduce new HIV infections among AGYW and their male partners in the SADC region:

STEP 1: Know your epidemic

SADC member states can be classified into one of the following HIV incidence categories (per 1,000 population), based on HIV incidence among AGYW as estimated by UNAIDS in 2018:

HIV incidence rates for SADC countries, 2018.

HIV incidence per 1,000 population in 2018	Countries
High Incidence =>3	Lesotho (13.40), Botswana (12.17), South Africa (11.70), Eswatini (11.20), Mozambique (7.56), Zambia (6.03), Namibia (5.61), Zimbabwe (4.62), Malawi (3.80)
Medium incidence 1 to 2.99	Tanzania (2.07), Angola (1.39)
Low incidence <1	Madagascar (0.45), Democratic Republic of the Congo (0.26), Comoros (0.02), Mauritius (N/A), Seychelles (N/A)

Source: UNAIDS, <http://aidsinfo.unaids.org/>¹

The HIV epidemic in countries, as in the SADC region, is not homogenous. Programme managers need to understand where new infections are increasing and who is most at risk by analysing their epidemic, drawing upon UNAIDS estimates and population-based surveys, to determine the following:

- Levels of new HIV infections and HIV prevalence at national and subnational level disaggregated by age, gender, marital and socioeconomic status.
- Estimated AIDS-related death rates using national vital statistics.
- An analysis of the geographic burden of HIV to identify high-burden areas and hotspots, using geospatial clustering (hotspots) of HIV infections and associated risk factors within subnational areas, in order to target interventions to the areas most at risk.

Case study: Geospatial mapping, South Africa

When undertaking geospatial mapping, programme managers should identify the subnational HIV incidence and prevalence estimate. In this case study from South Africa, the analysis started with provinces and subsequently analysed the next level (districts) and then the local authority. Within each district or local authority, areas were further disaggregated by urban or rural areas. At each level, the population was disaggregated by age groups, sex and socioeconomic level to determine who is most at risk of HIV infection. This analysis allows programme managers to identify, within local authority areas, the hotspots of those most at risk and to plan interventions and allocate resources to fast-track the response in these areas.

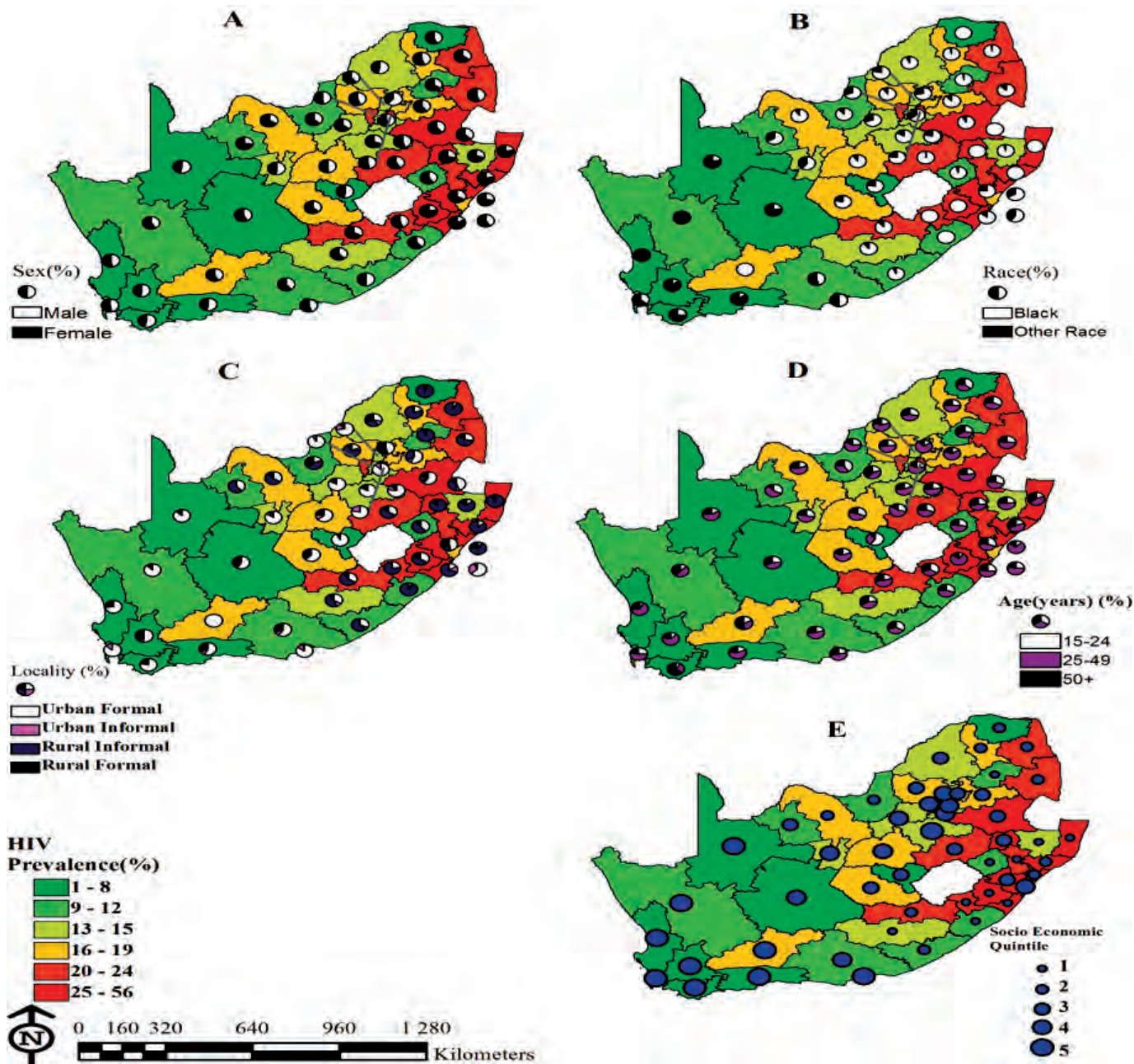


Figure 2: Thematic maps of distribution of HIV prevalence and demographic determinants across districts in South Africa (Wabiri, et al, 2016).

- Map A** shows sex ratio; where females preponderate, the HIV prevalence is high. Therefore, focusing on females and migration of males from the area is important.
- Map B** shows HIV is higher in predominantly black areas, suggesting that black women should be a target for HIV prevention interventions (when considered with Map A).
- Map C** shows that informal rural and urban areas are heavily burdened and deserve to be prioritized.
- Map D** shows that persons aged 25 to 49 and young people aged 15 to 24 carry a disproportionate burden of HIV in high-burden districts.
- Map E** reveals that the HIV prevalence is highest in poor economic areas.

STEP 2: Identify the determinants of HIV

Once the geographic areas and the populations most at risk of HIV infection have been identified, programme managers should attempt to understand the biological, behavioural, sociocultural and structural risk factors that increase the vulnerability of AGYW and their male partners to HIV infection.

Data and analysis of these risk factors may be found within national health information systems, population-based HIV impact assessment studies, modelling by UNAIDS using the spectrum model, sentinel surveys and demographic and health surveys, among others.

Structural drivers of HIV

Change first sentence to read: Socioeconomic and cultural factors are the structural drivers that increase the risk of HIV infection for AGYW. They include poverty, gender inequality, lack of education, unemployment, toxic concepts of masculinity, gender-based violence, and harmful traditional practices such as female genital mutilation and early marriage.

Economic dependence, power inequalities and fear of abuse prevent girls from refusing sex and negotiating condom use. Sexual violence increases HIV risk directly through forced and unprotected sex, exposure to multiple sexual partners, and genital trauma. Intimate partner violence correlates with higher HIV incidence, especially in settings of high prevalence. Keeping girls in school, especially through secondary level, lowers their vulnerability to HIV infection. Girls leave school owing to a range of issues including menstrual health, unintended pregnancy, and a lack of value of female education. Programme managers should look at the factors that cause girls to drop out and review laws and policies to ensure that girls complete their schooling.

Interventions that address some structural drivers include keeping girls in school, providing microfinance and livelihood opportunities for AGYW, and strengthening women's social autonomy. Since these interventions seek to change established sociocultural norms that underpin gender inequality, boys and men, traditional leaders, health staff and law enforcement officials must be involved.

Biological determinants of HIV

HIV prevention programmes should emphasize the biological determinants that increase the risk of young women to HIV, including acute HIV infection in male partners with high semen viral load, the presence of certain sexually transmitted infections (STIs), and low levels of male circumcision.

Female biological susceptibility

AGYW are at higher risk of HIV acquisition as HIV passes more easily through the cells of the vaginal lining because the surface area of the vagina is larger compared to the penis. The high level of activation of the immune cells in the female genital tract also increases the biological risk of acquiring HIV (Pomerants, et al, 1988; Dellar, Dlamini and Karim, 2015 cited in UNAIDS 2016 Guidance).

Male biological susceptibility

In 2007, consistent and compelling evidence led WHO and UNAIDS to recommend the scale-up of medical male circumcision (MMC) as an additional HIV prevention intervention in 14 priority countries, of which 10 are in the SADC region.

The package of services to be offered as part of MMC include HIV testing services, STI screening, safe sex social and behavioural communication, condoms, and changing gender norms and attitudes. Nearly 12 million men have been circumcised in the period 2010 to 2017 in the 10 priority countries in the SADC region.

It is estimated that one new HIV infection is averted for every 80 circumcisions performed from 2008 to 2017. UNAIDS has identified male circumcision as a crucial intervention to achieve the 2020 global target of fewer than 500,000 new HIV infections annually (a 75 per cent reduction from 2010)².

STIs

The presence of certain STIs such as herpes simplex 2, trichomonas, and vaginitis increases the risk of HIV among AGYW.

New evidence shows that women with an inflammation of the vagina owing to an overgrowth of *Prevotella bivia* bacteria were nearly 13 times more likely to be infected with HIV than those with lower levels of these bacteria. The presence of *Prevotella bivia* also significantly reduces the effectiveness of PrEP (CAPRISA, 2016). Many women are not aware that they have this overgrowth of *Prevotella bivia* bacteria and yet this is a treatable risk factor (Schwebke, et al, 2015). Wider health screening and data collection are needed to ensure routine reporting on women who present *Prevotella bivia*.

Ministries of Health should strengthen their Health Information Systems to track data on STIs disaggregated by age, gender and type of STIs and to improve contact tracing. All persons who report with STIs should be offered HIV testing as the presence of an STI does increase the risk of contracting HIV.

Lack of knowledge of serostatus and HIV treatment by male partners

Women are more vulnerable to HIV infection when their male sexual partners living with HIV do not test and know their status, and do not access treatment, therefore exposing women to high viral loads. Ensuring that male partners test for HIV and are initiated on early treatment reduces the risk of sexual transmission of HIV (Grinsztejn et al, 2014, and Anglemyer, Horvath, and Rutherford, 2013). Studies show that people who do not know their serostatus are 3.5 times more likely to transmit the virus than those who are HIV-positive and aware of their status (Marks, Crepaz, and Janssen, 2006).

² WHO. 2018. WHO Progress Brief: Voluntary Medical Male Circumcision for HIV-prevention.

Behavioural determinants of HIV

Knowledge of HIV prevention among young people

Programme managers should examine the extent to which AGYW correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. This data enables programme managers to assess the extent to which comprehensive sexuality education and national HIV prevention education and communication campaigns are having the desired impact. This data can be complemented with qualitative studies with AGYW, parents and educators to understand why gaps persist and how to strengthen programme implementation.

Multiple and concurrent sexual partnerships

Concurrent sexual partners and the inconsistent use of condoms within these relationships increases the risk of HIV. Programme managers should analyse the rates of multiple sexual partnerships, drawing upon population-based surveys or, where this data is not available, it should be included into national population-based surveys. The analysis of the data should take into account the type of partner (i.e. spouse, casual, etc.), number of sexual partners, and the age of the partner in the past 12 months or ever. This analysis will also enable programme managers to discern the extent to which multiple partners are age disparate.

Transactional sex

Transactional age-disparate sex are relationships where men, and sometimes women, with economic means engage in sexual relationships with younger women or men in exchange for money or material goods. AGYW may engage in these relationships out of the desire or peer pressure related to acquiring consumer goods or due to sheer poverty. There may or may not be a large age disparity between the partners. Both partners in these relationships, especially AGYW, are vulnerable to HIV acquisition, as these relationships are often characterized by concurrent sexual relationships and sex without condoms, where the wealthier partner uses his or her economic power to influence the decisions of the younger partner.

The prevalence of transactional sex can be measured by asking participants in population-based surveys if they have ever given or received gifts, goods, services or money in exchange for sex. Analysing this data in relation to the age of the sexual partner can also shed light on the proportion of transactional sexual relationship that are also age-disparate. Qualitative studies can also shed further light as to the factors that drive transactional sex.

Condoms

Condoms are the only method that prevents HIV, STIs and unintended pregnancies. Inconsistent condom use in concurrent, transactional or age-disparate sexual relationships place all partners at risk of HIV. The indicator of condom use at last sex with a non-regular partner is used to measure behavioural risk of HIV. Programme managers should also analyse condom data in relation to the type of sexual relationships (including multiple sexual partnerships and concurrent partnerships). Programme managers should also note the potential for respondent bias, where respondents may give answers considered socially correct.

STEP 3: The package of HIV prevention interventions

The table below provides a recommended package of combination HIV prevention interventions that programme managers can use to design an appropriate and effective response. The primary focus of any prevention programme is to prevent new infections and to ensure that no one is left behind. However, the intensity of the intervention and the investment required may not be the same everywhere.

It is recommended that programme managers adopt a layering response and define the package of HIV prevention interventions in relation to the geographic areas with high levels of new HIV infections. Programme managers should ensure that organizations and networks of young people are meaningfully engaged in prioritizing, designing, implementing, monitoring and evaluating interventions.

National interventions to be implemented in all areas	<ol style="list-style-type: none">1. Access to client-centred integrated SRH/HIV services (contraceptives, maternal health, including PMTCT, STIs, VMMC, HTS, and ART, including adherence).2. Distribution and promotion of male and female condoms and lubricants.3. National HIV communications (SBCC, demand generation, social media).4. Keep girls in school through a variety of incentives.5. Age-appropriate comprehensive sexuality education for youth in educational settings (primary, secondary and tertiary) and out-of-school youth.
Medium to high HIV incidence districts of 0.3 to 1.99	Over and above the national package of interventions include: <ol style="list-style-type: none">1. Targeted interpersonal SBCC programmes using evidence-based approaches with linkages to SRH/HIV commodities and services.2. Community outreach and demand generation for services targeting AGYW and their male partners (condom distribution, HTS, prevention counselling).3. Sexual and gender-based violence.
Extremely high HIV incidence 2.0+	Over and above national interventions and those in medium to high districts, include: <ol style="list-style-type: none">1. Access and adherence to PrEP.2. Intensive targeted community outreach efforts.3. Conditional cash transfers with incentives for AGYW.

The following provides a brief description of some of these interventions:

Access to client-centred integrated SRHR, HIV services

Providing client-centred services means that programme managers should create an enabling environment, remove the barriers for access to integrated services for adolescents and key populations, and ensure that healthcare workers are trained to provide services that are respectful and address the health needs of all clients.

The provision of client-centred integrated SRHR, HIV and GBV services means that all SRHR (family planning, STIs, etc.) and HIV (HTS and ART) service delivery points should provide clients with a comprehensive integrated package of SRHR, HIV and SGBV services that are designed to meet their needs.

Voluntary medical male circumcision programmes should be implemented to ensure that 90 per cent of adolescent boys and young men aged 10 to 29 years are circumcised. VMMC services should reinforce messages on partner reduction and condom use, and integrate STI screening, HTS and referral to treatment for those in need.

The provision of quality client-centred integrated SRHR, HIV and SGBV services allows to use every opportunity to enable all people to prevent unintended pregnancies, HIV and STIs, while providing quality care and treatment to secure their health and well-being.

Distribution and promotion of male and female condoms and lubricants

Based on global modelling, it is estimated that condoms have averted approximately 50 million new HIV infections since the onset of the HIV epidemic (UNFPA, WHO and UNAIDS 2015).

Programme managers should adopt a total market approach to the promotion and distribution of male and female condoms. This approach recognizes that government and donor-procured condoms should be targeted to those most in need and who cannot afford to buy condoms. Programme managers should analyse which outlets are most appropriate to distribute government and donor-procured condoms, such as formal and informal drinking establishments (bars and taverns), garages, shops, military barracks and prisons, so that people can access condoms where needed. Socially marketed condoms should be targeted to those who have some means to pay for condoms, while commercial condoms should be available for those who can afford to buy them. Socially marketed and commercial condoms should be available through filling stations, shops, pharmacies, upmarket bars, taverns and hotels.

Governments should strengthen supply chain management systems so that condom distribution is tracked to the last mile. Condom programmes should be supported with demand creation campaigns with greater intensity in areas where people are at higher risk of HIV infection.

Social and behavioural communication

Social and behavioural communication (SBC) is an evidence-informed participatory intervention designed to address the behaviours that put people at risk of HIV infection and to generate demand for services and commodities, such as condoms. The development of an SBC intervention draws upon the evidence derived through the “Know your epidemic step” and the identification of the determinants of HIV. It uses qualitative data to get a deeper understanding of audience perceptions.

Informed by theories of social and behavioural change, mass media, marketing and community participation, SBC works in partnership with the audience and creative experts to design imaginative and innovative messages through a combination of channels (traditional and social media) to address the biomedical, behavioural, social and structural drivers of the epidemic. All SBC should make linkages to service delivery and uptake.

Age-appropriate HIV education and communication

Comprehensive sexuality education programmes for youth in and out-of-school, and social and behavioural communication interventions should aim to increase knowledge of HIV, STIs and unintended pregnancies and to impart skills that will empower people with confidence to adopt and negotiate safer sexual practices with partners and to change their own behaviour (Bandura, 1989).

Community outreach and demand for services

Comprises a range of interventions, including social mobilization to engage with community leaders and structures on key behavioural, social, cultural and gender norms driving the local epidemic. Structured community-based interventions are undertaken by trained community healthcare workers and social mobilizers who facilitate participatory group or individual interventions, using pretested toolkits and approaches to increase knowledge, transfer skills, address the cognitive and emotional barriers and promote the uptake of services. These may be complemented with door-to-door and/or household risk assessments, condom distribution, home-based counselling, and testing and referral and follow-up to services. It may also include setting up adherence clubs for people living with HIV or active follow-up of people living with HIV to ensure adherence to treatment. The intensity of the community outreach required will depend on the severity of the epidemic.

Pre-exposure prophylaxis

Pre-exposure prophylaxis (PrEP) is effective in reducing new HIV infections. When Oral Tenofovir (TDF) and Emtricitabine (FTC) were combined and administered as PrEP against HIV-1 acquisition, it was found to be highly efficacious among women with high adherence levels. The efficacy of TDF was found to be 71 per cent (P=0.002) and of TDF-FTC 66 per cent (P=0.005) in preventing HIV infection (Baeten et al, 2012). A recent study by the Centre for the AIDS Programme of Research in South Africa (CAPRISA) showed that Tenofovir gel PrEP was effective in preventing HIV in women with a healthy lactobacillus dominant vagina when compared to women who did not have lactobacillus vaginal dominance. The study found that *Gardnerella vaginalis*, which dominates the vagina when lactobacillus levels are low, absorbs TDF, thereby reducing the availability of TDF to prevent HIV infection and consequently limiting its efficacy as PrEP against HIV (CAPRISA, 2016).

These findings reinforce that it is essential to integrate PrEP scale-up with sexual and reproductive health services that provide STI and family planning services.

STEP 4: Set the targets

Programme managers should set targets to prevent new HIV infections among AGYW and their male partners guided by the following principles:

A. Align with global targets of the 2016 Political Declaration on HIV and AIDS

National programme managers should set national and subnational targets to reduce new HIV infections, taking into account the targets in the Political Declaration on HIV and AIDS, namely, to reduce new HIV infections by 75 per cent and to reduce annual new HIV infections among adolescent girls and young women to less than 100,000 by 2020.

In 2017, it is estimated that 1.8 million people were infected globally with HIV. Nearly 685,000 or 38 per cent of all new infections took place in the SADC region. Six SADC member states account for 87 per cent or 593,000 of all new infections: South Africa (39.0 per cent), Mozambique (19.0 per cent), Tanzania (9.5 per cent), Zambia (7.0 per cent), Zimbabwe (6.0 per cent), and Malawi (6.0)³.

Globally, 340,000 new infections took place among AGYW aged 15 to 24 years in 2017; of these, 170,000 or half occurred in the SADC region. Six SADC Member States account for 88 per cent of all new infections among AGYW: South Africa (44.0%), Mozambique (17.0%), Tanzania (8.0%), Zambia (7.0%), Malawi (6.0%) and Zimbabwe (5.0%)⁴.

To achieve the global target of reducing new HIV infections among AGYW by 75 per cent by 2020 will require that the SADC region reduces new HIV infections by 113,500 between 2018 and 2020. South Africa would need to reduce new HIV infections among AGYW aged 15 to 24 years by 52,200 in the same period.

Once national targets on preventing new infections have been set, programme managers should cascade these down to the subnational level. To determine priority areas for action, consider the distribution of the epidemic using incidence data, where available, or prevalence data and the population size of the subnational geographic area, while ensuring that no-one is excluded from HIV prevention interventions.

B. Develop, implement, monitor and evaluate a coordinated, comprehensive multisectoral combination HIV prevention plan to ensure that 90 per cent of people at risk of HIV infection access comprehensive prevention services

Programme managers should lead the development of a multisectoral plan that integrates behavioural, biomedical, social and structural drivers. The plan should assign accountability for results in reducing new HIV infections among AGYW and their male partners to various stakeholders.

In developing the plan, programme managers should decide upon the package of combination HIV prevention interventions required and map the various interventions being undertaken so as to build upon existing initiatives and identify and fill gaps in the response.

The development, implementation and oversight of this plan should be carried out through one national coordinating mechanism that brings together all stakeholders, national government departments, civil society organizations, and bilateral and multilateral development partners, and that meets regularly to assess the progress made. The plan should be accompanied by one monitoring and evaluation framework (See Annex A on proposed indicators). The national coordinating structure should be emulated at the subnational level and local government level that will adapt the national plan and the package of interventions required to respond to the local dynamics of the epidemic in their area.

The multisectoral plan should include clear objectives that are specific, measurable, achievable, relevant and time-oriented. It should define the actions to be undertaken to achieve the objectives. Activities should be defined that are doable, whether they will have the desired impact, the time required to undertake the actions, and how the actions and attaining the objectives will contribute towards achieving local, national, regional and global targets.

The multisectoral plan should be costed and advocacy undertaken with Ministries of Finance and international development partners to support its implementation.

C. Strengthen national systems to fast-track the prevention of new HIV infection and to ensure linkages to treatment, care and support

Programme managers in Ministries of Health should prioritize investing in the national health systems to deliver quality integrated SRHR/HIV services, drawing upon the six core components, or “building blocks” of healthcare systems as articulated by the World Health Organization (WHO):

(i) service delivery; (ii) health workforce; (iii) health information systems; (iv) access to essential medicines; (v) financing; and (vi) leadership/governance (WHO, 2010). Increasingly, a seventh building block is added, namely, strengthening linkages between community and facility, and the generation of demand for health services. Ministries of Health should ensure that services are client-centred and designed to meet the needs of AGYW and their male partners. This includes ensuring that appropriate service delivery standards are set and met in providing integrated contraceptive, HIV and STI services for AGYW, and that integrated VMMC services are provided to their male partners with linkages to treatment where need be.

Similarly, programme managers in Ministries of Education should make sure that Comprehensive Sexuality Education is included in the curriculum and strengthen the quality of delivery to ensure that core essential topics are included and taught early (before sexual debut). Educators (teachers) should be capacitated to not only transfer knowledge but to also build the skills of young people in managing relationships, condom negotiation and their rights to access SRHR/HIV services without fear of stigma and discrimination. Mechanisms should be put in place to link students with services in their local communities and to ensure that all youth have access to condoms and contraceptives to protect their health and well-being.

Programme managers in the Ministries of Youth should be at the forefront of efforts, in partnership with Ministries of Health, to define programme interventions and to mobilize resources to reduce the vulnerability to HIV infection of out-of-school-youth in areas with high HIV incidence.

³ UNAIDS. AIDSinfo.org. Note figures rounded off to closest .5%.

⁴ Ibid. Note figures rounded off to closest .5%.

Programme managers in Ministries of Health, gender, police and law enforcement should coordinate efforts to reduce the risks of harmful practices, in particular sexual violence and intimate partner violence, child marriage and female genital mutilation.

Ministries of Finance should allocate appropriate resources to enable full implementation of the plan. The investment in adolescent girls and young women will allow governments to reap the demographic dividend through a healthy and productive youthful population that can contribute towards national development.

D. Use efficient, effective and innovative solutions

Planners should aim to deliver programmes that are efficient and effective in reducing new HIV infections. This may include adapting programmes that have demonstrated impact in the national context, as well as trying innovative responses that are monitored and evaluated to determine their success.

Innovative responses are often disruptive. They may be novel ways of programme and service delivery, or may be technologically based and reach much larger numbers of targeted persons. They may be more accessible, scalable, replicable and sustainable (Rotheram, Borum Swendeman and Chorpita, 2012). For example, low-cost internet and cell phone-based interventions make it feasible to deliver messages targeted to specific populations (Ybarra and Bull, 2007).

When planning cellphone and internet-based interventions, programme managers should look at data on the digital gender gap in their country. Women's access to the internet through computers and smart phones is much lower than men's. In Mozambique, just 7 per cent of women use the internet. The disparity limits women's ability to get health information online.

Systematic reviews and meta-analyses show that there are no differences in the efficacy of computer-based delivered interventions (including mHealth and eHealth programmes) and human-delivered interventions, but that the former cost less to deliver and allow for better customization of content and more flexible means of delivery (Noar, Black and Pierce, 2009).

E. The plan should be resourced with human, equipment and financial resources commensurate with the scale required to curb new infections

Programme managers should ensure that resources, including financial, human and commodities, are allocated to support the package of interventions. While prioritizing investments in the geographic areas with the highest risk of infection, investments must continue in national prevention interventions in areas with low to moderate levels of new HIV infections, so that new infections are not reduced in a high-burden area only to see an increase in another area.

HIV prevention plans (i) need to be costed to understand the investment required to reduce new HIV infections; (ii) need resource mapping to determine how much and where current domestic and international resources are being invested; (iii) require identification of gaps to be addressed with the mobilization of local resources; and (iv) require sustainability plans developed with partners to ensure a smooth transition to domestic resources should funding priorities and focus areas change. All partners should participate in costing the plan.

STEP 5: Measure progress toward achieving the targets

The final step is to identify the relevant indicators to measure progress in achieving the set targets for reducing new HIV infections among AGYM and their sexual partners.

Indicators are defined as "standardized measures that can be used to report on the burden of disease, health status, or behavioural traits in a given population and describe or measure programme activities" (WHO, CDC, UNAIDS, FHI 360, 2017).

The UNAIDS Global AIDS Monitoring 2017 Guide and the 2017 Bio-Behavioural Survey Guide (WHO, CDC, UNAIDS, FHI 360, 2017) are the most useful sources for developing, adapting, and/or monitoring indicators of progress toward the 2016 United Nations Political Declaration on HIV and AIDS.

SADC member states should agree upon a common set of indicators to allow for comparisons across countries, to measure whether the programme is having the desired impact, to show progress over time, and to encourage accountability for both national and donor resources.

Annex A proposes some indicators that can be considered by SADC in relation to the desired impact of the programme (reducing new HIV infections) and the outputs relating to the proposed package of interventions as defined on page 12.

Programme managers should carry out periodic evaluations of programme interventions to determine whether they are having the desired impact or whether they need tweaking and/or adjustments. Programme managers should also undertake operational research to inform programme design.

QUICK LOOK

THIS GUIDE HAS CLARIFIED THE TARGET POPULATION OF AGYW AND IDENTIFIED THE STEPS TO BE TAKEN TO REDUCE NEW HIV INFECTIONS IN SADC COUNTRIES

© UNFPA



CONCLUSION

This Guide has clarified the target population of AGYW and identified the steps to be taken to reduce new HIV infections in SADC countries. The suggested five steps are:

- (1) Know your epidemic;
- (2) Identify the determinants of HIV;
- (3) Identify the interventions;
- (4) Set the targets; and
- (5) Measure progress toward achieving the targets.

The Guide includes principles to be considered in setting targets. Each country will need to take into consideration its own resource-base, expertise and context when developing its own plan at national and subnational level, where applicable. Finally, a list of essential reading materials is suggested.

QUICK LOOK

EACH COUNTRY WILL NEED TO TAKE INTO CONSIDERATION ITS OWN RESOURCE-BASE, EXPERTISE AND CONTEXT WHEN DEVELOPING ITS OWN PLAN AT NATIONAL AND SUBNATIONAL LEVEL, WHERE APPLICABLE

© UNFPA



ESSENTIAL READING

Agha, S., Kusanthan, T., Longfield, K., Klein, M. and Berman, J., 2002. Reasons for non-use of condoms in eight countries in sub-Saharan Africa. *Washington, DC: Population Services International*.

Amin, S., Austrian, A., Chau, M., Glazer, K., Green, E., Stewart, D., and Stoner, M. (2013). Adolescent Girls Vulnerability Index: Guiding Strategic Investment in Uganda. New York: Population Council.

Anglemyer, A., Horvath, T. and Rutherford, G., 2013. Antiretroviral therapy for prevention of HIV transmission in HIV-discordant couples. *Jama*, 310(15), pp.1619-1620.

Auvert, B., Taljaard, D., Lagarde, E., Sobngwi-Tambekou, J., Sitta, R. and Puren, A., 2005. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. *PLoS medicine*, 2(11), p.e298.

Baeten, J.M., Donnell, D., Ndase, P., Mugo, N.R., Campbell, J.D., Wangisi, J., Tappero, J.W., Bukusi, E.A., Cohen, C.R., Katabira, E. and Ronald, A., 2012. Antiretroviral prophylaxis for HIV prevention in heterosexual men and women. *New England Journal of Medicine*, 367(5), pp.399-410.

Balkus, J.E., Nair, G., Montgomery, E.T., Mishra, A., Palanee-Phillips, T., Ramjee, G., Panchia, R., Selepe, P., Richardson, B.A., Chirenje, Z.M. and Marrazzo, J.M., 2015. Age-disparate partnerships and risk of HIV-1 acquisition among South African women participating in the VOICE Trial. *Journal of acquired immune deficiency syndromes (1999)*, 70(2), p.212.

Bailey, R.C., Moses, S., Parker, C.B., Agot, K., Maclean, I., Krieger, J.N., Williams, C.F., Campbell, R.T. and Ndinya-Achola, J.O., 2007. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. *The Lancet*, 369(9562), pp.643-656.

Bandura, A., 1989. Human agency in social cognitive theory. *American psychologist*, 44(9), p.1175.

Bandura, A., 1990. Perceived self-efficacy in the exercise of control over AIDS infection. *Evaluation and program planning*, 13(1), pp.9-17.

Brown, W.J. and Redman, S., 1995. Setting targets: a three-stage model for determining priorities for health promotion. *Australian and New Zealand Journal of Public Health*, 19(3), pp.263-269.

CAPRISA: New evidence on why young women in South Africa are at high risk of HIV infection. July 2016, Volume 15, Issue. <http://www.capriska.org/FileHandler.ashx?fid=80838> (accessed 25/9/2017).

The Centre For HIV And AIDS Prevention Studies: Medical Male Circumcision (MMC) in South Africa http://www.sahivsoc.org/Files/Fri_Dino_Rech%20Medical%20Male%20Circumcision.pdf Chersich, M.F. and Rees, H.V., 2008. Vulnerability of women in southern Africa to infection with HIV: biological determinants and priority health sector interventions. *Aids*, 22, pp.S27-S40.

Chersich, M.F., Wabiri, N., Risher, K., Shisana, O., Celentano, D., Rehle, T., Evans, M. and Rees, H., 2017. Contraception coverage and methods used among women in South Africa: A national household survey. *SAMJ: South African Medical Journal*, 107(4), pp.307-314.

Chin, H.B., Sipe, T.A., Elder, R., Mercer, S.L., Chattopadhyay, S.K., Jacob, V., Wethington, H.R., Kirby, D., Elliston, D.B., Griffith, M. and Chuke, S.O., 2012. The effectiveness of group-based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, human immunodeficiency virus, and sexually transmitted infections: two systematic reviews for the Guide to Community Preventive Services. *American journal of preventive medicine*, 42(3), pp.272-294.

Clark, S., 2004. Early marriage and HIV risks in sub-Saharan Africa. *Studies in family planning*, 35(3), pp.149-160.

Cohen, M.S., McCauley, M. and Gamble, T.R., 2012. HIV treatment as prevention and HPTN 052. *Current Opinion in HIV and AIDS*, 7(2), p.99.

Cohen, M.S., Chen, Y.Q., McCauley, M., Gamble, T., Hosseinipour, M.C., Kumarasamy, N., Hakim, J.G., Kumwenda, J., Grinsztejn, B., Pilotto, J.H. and Godbole, S.V., 2011. Prevention of HIV-1 infection with early antiretroviral therapy. *New England journal of medicine*, 365(6), pp.493-505.

Davey-Rothwell, M. A., Tobin, K., Yang, C., Sun, C. J., & Latkin, C. A. (2011). Results of a randomized controlled trial of a peer mentor HIV/STI prevention intervention for women over an 18 month follow-up. *AIDS and Behavior*, 15, 1654-1663.

de Oliveira, T., Kharsany, A.B., Gräf, T., Cawood, C., Khanyile, D., Grobler, A., Puren, A., Madurai, S., Baxter, C., Karim, Q.A. and Karim, S.S.A., 2017. Transmission networks and risk of HIV infection in KwaZulu-Natal, South Africa: a community-wide phylogenetic study. *The Lancet HIV*, 4(1), pp.e41-e50.

DeGue, S., Valle, L.A., Holt, M.K., Massetti, G.M., Matjasko, J.L. and Tharp, A.T., 2014. A systematic review of primary prevention strategies for sexual violence perpetration. *Aggression and Violent Behavior*, 19(4), pp.346-362.

Dellar RC, Dlamini S, Karim QA. Adolescent girls and young women: key populations for HIV epidemic control. *Journal of the International AIDS Society*. 2015;18(2Suppl 1):19408. doi:10.7448/IAS.18.2.19408.

Dehne, K.L., Dallabetta, G., Wilson, D., Garnett, G.P., Laga, M., Benomar, E., Fakoya, A., Baggaley, R.C., Nelson, L.J., Kasedde, S. and Bermejo, A., 2016. HIV Prevention 2020: a framework for delivery and a call for action. *The Lancet HIV*, 3(7), pp.e323-e332.

Dreams Core Package of Interventions.

Dreams Indicator Reference Guide.

Dreams Kenya.

Dreams Lesotho.

Dreams Malawi.

Dream South Africa.

Dreams Swaziland.

Dreams Tanzania.

Dreams Zambia.

Dreams Zimbabwe.

Ellsberg M, Jansen HAFM, Heise L, Watts CH, Garcia-Moreno C, WHO Multi-country Study on Women's Health Domestic Violence against Women Study Team: Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *Lancet* 2008; 371:1165–1172.

ESA Accountability Framework 8 April 2017.

ESA Commitment Final Report Affirmed on 7 December.

ESA Commitment Report Digital: FULFILLING OUR PROMISE TO YOUNG PEOPLE TODAY 2013-2015 Progress Review.

Eloundou-Enyegue, P.M., Meekers, D. and Calvès, A.E., 2005. From awareness to adoption: the effect of AIDS education and condom social marketing on condom use in Tanzania (1993–1996). *Journal of Biosocial Science*, 37(3), pp.257-268.

Evans, M., Risher, K., Zungu, N., Shisana, O., Moyo, S., Celentano, D.D., Maughan-Brown, B. and Rehle, T.M., 2016. Age-disparate sex and HIV risk for young women from 2002 to 2012 in South Africa. *Journal of the International AIDS Society*, 19(1).

UNFPA: REGIONAL INTERVENTIONS ACTION PLAN FOR EAST AND SOUTHERN AFRICA 2018-2021.

UNFPA: Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA): FINAL VERSION AFFIRMED 7th December.

Fisher, J.C., Cook, P.A. and Kapiga, S.H., 2010. Alcohol use before sex and HIV risk: situational characteristics of protected and unprotected encounters among high-risk African women. *Sexually transmitted diseases*, 37(9), pp.571-578.

Fonner VA, Armstrong KS, Kennedy CE, O'Reilly KR, Sweat MD (2014) School Based Sex Education and HIV Prevention in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis. *PLoS ONE* 9(3): e89692. <https://doi.org/10.1371/journal.pone.0089692>.

Geldsetzer, P., Bloom, D.E., Humair, S. and Barnighausen, T., 2015. Benefits and Costs of the HIV/AIDS Targets for the Post-2015 Development Agenda. *Copenhagen Consensus, Lowell, MA*, www.copenhagenconsensus.com/sites/default/files/health_perspective_-_geldsetzer_-_hiv.pdf2015.

Global Fund: Global Fund Support towards Adolescent Girls and Young Women HIV Prevention and SRHR for AGYW: Eastern and Southern Africa Regional Consultation. February 1-3, 2017, Windhoek, Namibia.

Global Fund Report Health of Women and Girls: Maximizing Impact through Strategic Investments Improving the Health of Women and Girls: December 2015 Geneva, Switzerland.

Global Fund Adolescent Girls and Young Women in High-HIV Burden Settings: Technical Brief, Geneva, January 2017.

Global Fund: Focus on Education and Health: July 2016 theglobalfund.org.

Global Fund Indicator guidance sheets annex_HIV_sheet_en Exel.

Gile, K.J. and Handcock, M.S., 2010. Respondent-driven sampling: an assessment of current methodology. *Sociological methodology*, 40(1), pp.285-32).

Gray, R.H., Kigozi, G., Serwadda, D., Makumbi, F., Watya, S., Nalugoda, F., Kiwanuka, N., Moulton, L.H., Chaudhary, M.A., Chen, M.Z. and Sewankambo, N.K., 2007. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *The Lancet*, 369(9562), pp.657-666.

Grinsztejn, B., Hosseinipour, M.C., Ribaud, H.J., Swindells, S., Eron, J., Chen, Y.Q., Wang, L., Ou, S.S., Anderson, M., McCauley, M. and Gamble, T., 2014. Effects of early versus delayed initiation of antiretroviral treatment on clinical outcomes of HIV-1 infection: results from the phase 3 HPTN 052 randomised controlled trial. *The Lancet infectious diseases*, 14(4), pp.281-290.

Harling, G., Newell, M.L., Tanser, F., Kawachi, I., Subramanian, S.V. and Bärnighausen, T., 2014. Do age-disparate relationships drive HIV incidence in young women? Evidence from a population cohort in rural KwaZulu-Natal, South Africa. *Journal of acquired immune deficiency syndromes (1999)*, 66(4), p.443.

Halperin, Daniel T and Epstein H., 2004: Concurrent sexual partnerships help to explain Africa's high HIV prevalence: implications for prevention. *The Lancet*, Volume 364 , Issue 9428 , 4-6.

Jewkes RK, Dunkle KL, Nduna M, Shai NJ: Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *Lancet* 2010; 376:41-48.

Kalichman, S.C., Simbayi, L.C., Kaufman, M., Cain, D. and Jooste, S., 2007. Alcohol use and sexual risks for HIV/AIDS in sub-Saharan Africa: systematic review of empirical findings. *Prevention science*, 8(2), p.141.

Kaime, T., 2009. *The African Charter on the Rights and Welfare of the Child: A socio-legal perspective*. PULP.

Kripke, K., Reed, J., Hankins, C., Smiley, G., Laube, C. and Njeuhmeli, E., 2016. Correction: Impact and Cost of Scaling Up Voluntary Medical Male Circumcision for HIV Prevention in the Context of the New 90-90-90 HIV Treatment Targets. *PloS one*, 11(12), p.e0169500.

Kripke, K., Reed, J., Hankins, C., Smiley, G., Laube, C. and Njeuhmeli, E., 2016. Impact and cost of scaling up voluntary medical male circumcision for HIV prevention in the context of the new 90-90-90 HIV treatment targets. *PloS one*, 11(10), p.e0155734.

Kusek, J.Z. and Rist, R.C., 2004. *Ten steps to a results-based monitoring and evaluation system: a handbook for development practitioners*. World Bank Publications.

LaCroix, J.M., Snyder, L.B., Huedo-Medina, T.B. and Johnson, B.T., 2014. Effectiveness of mass media interventions for HIV prevention, 1986–2013: a meta-analysis. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 66, pp.S329-S340.

Li, Y., Marshall, C.M., Rees, H.C., Nunez, A., Ezeanolue, E.E. and Ehiri, J.E., 2014. Intimate partner violence and HIV infection among women: a systematic review and meta-analysis. *Journal of the international AIDS society*, 17(1).

Mah, T.L. & Halperin, D.T. Concurrent Sexual Partnerships and the HIV Epidemics in Africa: Evidence to Move Forward. *AIDS Behav* (2010) 14: 11. <https://doi.org/10.1007/s10461-008-9433>.

Marks, G., Crepaz, N. and Janssen, R.S., 2006. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *Aids*, 20(10), pp.1447-1450.

Marks, G., Crepaz, N., Senterfitt, J.W. and Janssen, R.S., 2005. Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 39(4), pp.446-453.

Ministry of Health: Kenya AIDS Strategic Framework 2014/2015-2018/2019.

Ministry of Health: National Adolescent sexual and reproductive health Policy, 2015.

National Statistical Office (NSO) [Malawi] and ICF. 2017. Malawi Demographic and Health Survey 2015-16. Zomba, Malawi, and Rockville, Maryland, USA. NSO and ICF.

Raffaelli, Marcela, E. Siqueira, A. Payne-Merritt, R. Campos, W. Ude, M. Greco, D. Greco, A. Ruff, and N. Halsey. "HIV-related knowledge and risk behaviors of street youth in Belo Horizonte, Brazil. The Street Youth Study Group." *AIDS education and prevention: official publication of the International Society for AIDS Education* 7, no. 4 (1995): 287-297.

Morris, B.J., Wamai, R.G., Henebeng, E.B., Tobian, A.A., Klausner, J.D., Banerjee, J. and Hankins, C.A., 2016. Estimation of country-specific and global prevalence of male circumcision. *Population health metrics*, 14(1), p.4.

Nalugoda, F., Guwatudde, D., Bwaninka, J. B., Makumbi, F. E., Lutalo, T., Kagaayi, J., Gray, R. H. (2014). Marriage and the risk of incident HIV infection in Rakai, Uganda. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 65(1), 91-98.

Njeuhmeli, Emmanuel, Steven Forsythe, Jason Reed, Marjorie Opuni, Lori Bollinger, Nathan Heard, Delivette Castor et al. "Voluntary medical male circumcision: modeling the impact and cost of expanding male circumcision for HIV prevention in eastern and southern Africa." *PLoS medicine* 8, no. 11 (2011): e1001132.

Noar, S. M., Black, H. G., & Pierce, L. B. (2009). Efficacy of computer technology-based HIV prevention interventions: a meta-analysis. *Aids*, 23(1), 107-115.

Phaswana-Mafuya, N., Shisana, O., Davids, A., Tabane, C., Mbelle, M., Matseke, G., Banyini, M. and Kekana, Q., 2014. Perceptions of sugar mommy practices in South Africa. *Journal of Psychology in Africa*, 24(3), pp.257-263.

Pfeiffer, J., 2004. Condom social marketing, Pentecostalism, and structural adjustment in Mozambique: a clash of AIDS prevention messages. *Medical anthropology quarterly*, 18(1), pp.77-103.

Pettifor AE, Hudgens MG, Levandowski BA, Rees HV, Cohen MS. Highly efficient HIV transmission to young women in South Africa. *AIDS*. 2007 Apr 23;21(7):861-5.

Pomerantz RJ, de la Monte SM, Donegan SP, Rota TR, Vogt MW, Craven DE et al. Human immunodeficiency virus (HIV) infection of the uterine cervix. *Ann Intern Med*. 1988 Mar;108(3):321-7.

Rotheram-Borus, Mary Jane; Swendeman, Dallas; Chorpita, Bruce F.: Disruptive innovations for designing and diffusing evidence-based interventions. *American Psychologist*, Vol 67(6), Sep 2012, 463-476.<http://dx.doi.org/10.1037/a0028180>.

SADC sponsored CSW Resolution 60/2 Programme of Action, 2017 and UNFPA, Harmonizing laws and policies on adolescent sexual and reproductive health in East and Southern Africa, 2016.

Sawers, L. and Stillwaggon, E: Concurrent sexual partnerships do not explain the HIV epidemics in Africa: a systematic review of the evidence. *Journal of the International AIDS Society* 2010**13**:34 <https://doi.org/10.1186/1758-2652-13-34>.

Sedgh, G. and Hussain, R., 2014. Reasons for contraceptive nonuse among women having unmet need for contraception in developing countries. *Studies in Family Planning*, 45(2), pp.151-169.

Schwebke, J.R., Marrazzo, J., Beelen, A.P. and Sobel, J.D., 2015. A phase 3, multicenter, randomized, double-blind, vehicle-controlled study evaluating the safety and efficacy of metronidazole vaginal gel 1.3% in the treatment of bacterial vaginosis. *Sexually transmitted diseases*, 42(7), p.376.

Shisana, O., Risher, K., Celentano, D.D., Zungu, N., Rehle, T., Ngcaweni, B. and Evans, M.G., 2016. Does marital status matter in an HIV hyperendemic country? Findings from the 2012 South African National HIV Prevalence, Incidence and Behaviour Survey. *AIDS care*, 28(2), pp.234-241.

Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Zungu N, Labadarios D, Onoya D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town: HSRC Press.

Tanser, F., Bärnighausen, T., Hund, L., Garnett, G.P., McGrath, N. and Newell, M.L., 2011. Effect of concurrent sexual partnerships on rate of new HIV infections in a high-prevalence, rural South African population: a cohort study. *The Lancet*, 378(9787), pp.247-255.

Tanser, F., Bärnighausen, T., Grapsa, E., Zaidi, J. and Newell, M.L., 2013. High coverage of ART associated with decline in risk of HIV acquisition in rural KwaZulu-Natal, South Africa. *Science*, 339(6122), pp.966-971.

Wabiri, N., Shisana, O., Zuma, K. and Freeman, J., 2016. Assessing the spatial nonstationarity in relationship between local patterns of HIV infections and the covariates in South Africa: A Geographically Weighted Regression Analysis. *Spatial and Spatio-temporal Epidemiology*.

UNAIDS 2014a: Fast-Track: ending the AIDS epidemic by 2030 http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf.

UNAIDS: 20170720 Data Book 2017_en.pdf.

UNAIDS: Global AIDS Monitoring 2017: Indicators for monitoring the 2016 UN Political Declaration on HIV/AIDS, 2016.

UNAIDS 2014: Gender-responsive HIV programming for women and girls. Guidance note. Geneva: UNAIDS; 2014 (http://www.unaids.org/sites/default/files/media_asset/genderresponsiveHIVprogramming_en.pdf).

UNFPA-UNICEF Global Programme to Accelerate Action to End Child Marriage, Indicator Reference Sheet (Indicator Index), August 2017.

UNFPA, WHO and UNAIDS: Position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy. http://www.unaids.org/en/resources/presscentre/featurestories/2015/july/20150702_condoms_prevention#23.

United Nations: 70/266. Political Declaration on HIV and AIDS: On the Fast-track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. A/RES/70/266 22 June 2016.

UNICEF National Survey on Violence against Women.

UNICEF: African charter on the rights and welfare of the child. www.unicef.org/esaro/African_charter_article_in_full.pdf.

Weller, S.C. and Davis-Beaty, K., 2002. Condom effectiveness in reducing heterosexual HIV transmission. *The Cochrane Library*.

World Health Organization, 2012. Programmatic update: antiretroviral treatment as prevention (TASP) of HIV and TB: executive summary.

WHO, CDC, UNAIDS, FHI 360. Biobehavioral survey guidelines for Populations at Risk for HIV. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

World Health Organization, 2010. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. World Health Organization.

WHO, Human Reproductive Programme: The importance of sexual and reproductive health and rights to prevent HIV in adolescent girls and young women in eastern and southern Africa: Evidence brief WHO/RHR/17.05 © World Health Organization 2017.

World Health Organization, Joint United Nations Programme on HIV/AIDS (2011) Progress in scale-up of male circumcision for HIV prevention in eastern and southern Africa: focus on service delivery—2011. Geneva: World Health Organization. World Health Organization, Joint United Nations Programme on HIV/AIDS 2011 Progress in scale-up of male circumcision for HIV prevention in eastern and southern Africa: focus on service delivery—2011 Geneva World Health Organization.

WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key populations. Geneva: World Health Organization (WHO); 2014 (<http://www.who.int/hiv/pub/guidelines/keypopulations/en/>, accessed 8 September 2016).

WHO: tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations: supplement to the 2014 consolidated guidelines for HIV prevention, diagnosis, treatment and care for key populations, WHO Document Production Services, Geneva, Switzerland, July 2015.

World Health Organization, 2012. Making health services adolescent friendly: Developing national quality standards for adolescent friendly health services.

Ybarra, M. L., & Bull, S. S. (2007). Current trends in Internet- and cellphone-based HIV prevention and intervention programs. *Current HIV/AIDS Reports*, 4(4), 201-207.

Zembe YZ, Townsend L, Thorson A, Ekström AM (2012) Predictors of Inconsistent Condom Use among a Hard to Reach Population of Young Women with Multiple Sexual Partners in Peri-Urban South Africa. *PLoS ONE* 7(12): e51998. <https://doi.org/10.1371/journal.pone.0051998>.



This report was supported by UNFPA and UNAIDS



Ensuring rights and choices for all