

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

Version for use in 2023 planning processes

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Table of Contents

Introduction	3
Adolescent girls and young women – a priority population for HIV prevention.....	3
A differentiated approach.....	3
A complementary tool for decision-making.....	4
Underlying principles	5
Summary of existing guidance	6
A population size estimation tool for young women by level of risk	7
Major platforms for programmes	100
How to prioritise in the context of limited resources	12
Prioritisation matrix	13
Questions and answers on the prioritization matrix	14
Using data in deciding how to reach young women	19
Decision-making: Step by step.....	21
Conclusion	22
References.....	23

Introduction

Adolescent girls and young women – a priority population for HIV prevention

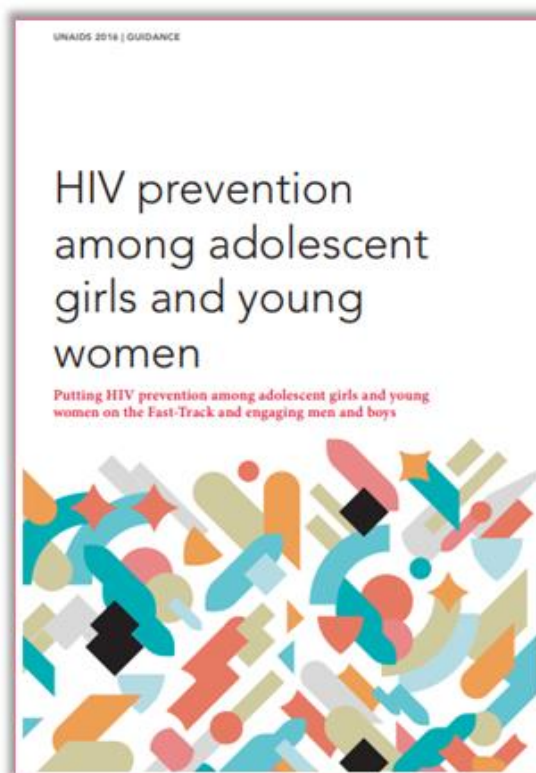
Globally, new HIV infections among adolescent girls and young women (aged 15–24 years) declined by 40% between 2010 and 2021¹ and 250 000 new HIV infections were recorded in 2021, far short of the 2025 target of 50000. In sub-Saharan Africa adolescent girls and young women (aged 15 to 24 years) account for 25% of new HIV infections, despite representing just 10% of the population.² Although a number of comprehensive and vibrant prevention projects are being implemented for adolescent girls and young women through the United States President's Emergency Fund for AIDS Relief (PEPFAR) *DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe)* partnership³ and other national programmes (such as *She Conquers* in South Africa), the response in settings with high HIV incidence still lacks in scale and hence in impact. According to the 2022 Global HIV Prevention Coalition (GPC) country scorecards, dedicated HIV prevention programmes for adolescent girls and young women only exist in a minority of subnational areas with moderate (>0.3%) to high (>1.0%) HIV incidence. Such dedicated HIV prevention programmes are needed for young people and adults to achieve targets set out in the Global AIDS Strategy⁴ and the HIV Prevention 2025 Road Map⁵. This aide focuses on HIV prevention programmes with adolescent girls and young women, which build on broader HIV programmes for young people and adults in these locations, but also require specific actions for adolescent girls and young women.

A differentiated approach

UNAIDS, its cosponsors, The Global Fund⁶ and PEPFAR⁷ consider it a top priority to accelerate HIV prevention programming among adolescent girls and young women. In 2016, UNAIDS introduced guidance⁸ to specifically address development of effective HIV prevention programme packages for reducing HIV incidence among adolescent girls and young women in high incidence settings based on a location-population approach, whereby programming is tailored to specific geographies defined by levels of estimated HIV incidence among adolescent girls and young women. The Global AIDS Strategy 2021-2026 and the HIV Prevention 2025 Road Map set out differentiated targets for HIV prevention with adolescent girls and young women. In addition, UNAIDS developed subnational population size estimates of adolescent girls and young women at higher risk of HIV to inform programmatic focus on those most in need.

There is limited funding available for scaling up effective HIV prevention packages for all priority populations including young women in locations with high HIV incidence. Potentially more new HIV infections could be averted with available resources, however, if the more comprehensive and layered programmes were targeted to adolescent girls and young women at higher risk⁹ and in locations with higher HIV incidence.

Every opportunity should be seized to mobilise additional investment - beyond HIV funding - to address the critical enablers of effective HIV prevention. This includes funding for education including comprehensive sexuality education, social support and protection, sexual and reproductive health and rights (SRHR), the removal of barriers to accessing services such as age of consent laws, as well as for youth-friendly health systems. Therefore, advocacy for high-level policy changes on these enablers and for complementary domestic public and international development funding remains critical for the realisation of impactful comprehensive HIV prevention among adolescent girls and young women.



A complementary tool for decision-making

This decision-making aide – which does not replace more detailed existing programmatic guidance – aims to help countries to prioritise investments into differentiated HIV prevention packages taking into account differences in HIV incidence and vulnerability – and, correspondingly, providing packages that range from only essential to expanded combinations of services. It provides a step-by-step approach to deciding what packages should be provided, by whom, to whom and where, to optimise available HIV funding and complementary funding.

This decision-making aide is a complementary tool and ought to be utilised in conjunction with available technical guidance on HIV prevention interventions such as condom promotion¹⁰, HIV testing services (HTS)¹¹, ARV-based HIV prevention in all its forms¹², or services for key populations¹³ including young key populations. Guidance related to wider programming for adolescent girls and young women is also available from UNESCO¹⁴ (sexuality education), WHO¹⁵ (quality health-care services), UN Women¹⁶ (social protection), and UNFPA (sexual and reproductive health and rights)^{17,18}. Further, early results from the extensive support for combination prevention programmes in high-burden countries through the PEPFAR - DREAMS partnership have now been published and are available as a resource.^{19,20,21}

This document focuses on **adolescent girls aged 15 to 19 years and young adult women aged 20 to 29 years** (as HIV incidence among young adult women aged 25-29 years is also very high in many countries). Since HIV incidence among young adult women aged 25-29 years is also very high in many countries, this age group is included in this guide.* It is further acknowledged that preventing new infections among adolescent girls and young women requires a combination of approaches that also reach out to boys and men (Box 2).

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

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

Beyond that it is important that VMMC coverage is increased in the relevant priority countries, especially among boys and men aged 15-29 years and that targeted actions are undertaken to ensure men are tested, treated and retained in care so as to achieve sustained viral suppression.²² These actions are not covered in detail in this document.

More specifically, *actual* male partners of adolescent girls and young women should be encouraged to get tested and referred for treatment and prevention services. In this context, couples' approaches to HIV prevention can be useful, for example through strengthened male engagement in SRH services as well as related community outreach. At the same time, there is need to consider limitations of this approach for young adolescents and potential risks such as intimate partner violence in the context of couples testing. Constructive male engagement can support good health outcomes for men, women and children. At the same time, women should always be consulted about whether and how they wish their partners to be involved and male partner engagement should never be a condition to accessing services. Elements of demand generation and invitations of male partners can often also happen as part of HIV prevention programme activities for adolescent girls and young women.

* Age groups are indicative and should follow country data on HIV incidence. Adolescent girls and adult women outside those age groups should not be excluded from dedicated programmes for adolescent girls and young women when these programmes meet their HIV prevention needs – and they should also be reached through broader HIV prevention, testing and treatment programmes.

Underlying principles

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

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

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

Adhering to these principles requires actions from stewards and implementers of HIV programmes - including national AIDS coordinating bodies, country health and community systems – and other sectors. It also requires contributions from HIV financing and other sources. Table 2 in this document provides further detail.

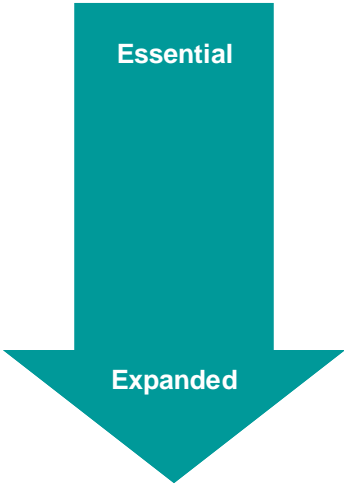
Summary of existing guidance

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

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

To address this challenge, additional guidance for decision-making is needed, which is summarized in the following pages. In this approach, essential HIV prevention packages would be offered in all locations (while expanded packages would be offered in locations with high HIV incidence in line with 2025 targets (Table 1). In this logic, HIV prevention financing for adolescent girls and young women would provide for the expanded packages in few selected locations where HIV incidence is very high, and for essential packages where HIV incidence is moderate. Where additional domestic resources can be mobilized, packages could be expanded.

Table 1: Rationale of differentiated packages

HIV incidence levels in a location (new HIV infections among young women aged 15-24 per 100 person/years*)			
Incidence category	Incidence range	Regions including locations in these incidence categories	Service packages for adolescent girls and young women
Low	(<0.3)	Many subnational areas in west and central Africa, some in eastern Africa, virtually all areas outside Africa	
Moderate	(0.3 – <1.0)	Few subnational areas in western Africa, some in Central Africa, many in eastern and southern Africa	
High	(1.0 – 3.0)	Several specific subnational areas in southern Africa	
Very high	(3.0 and higher)	No subnational areas with very high HIV incidence as of 2022, but very high HIV incidence persists in subpopulations such as young women with non-regular partners in few locations in southern Africa and young women selling sex in several locations across the continent	

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

In practice, this guide primarily applies to sub-Saharan Africa, because outside this region, HIV incidence only exceeds 0.3% among young women within key populations (including young women who sell sex, who inject drugs and young transgender women) and therefore in other regions HIV prevention will primarily focus on young women within key populations. Even within Africa, in 2021 there were no subnational areas where HIV incidence among all young women was uniformly very high (exceeding 3%). However, among young women selling sex, HIV incidence remains *very high* across many countries in Africa, and among young women with non-regular or multiple partners, HIV incidence remains *high* in several countries, particularly in southern Africa.

A population size estimation tool for young women by level of risk

To better understand HIV incidence among young women at different levels of risk *within* districts,[†] UNAIDS has developed a population size estimation tool. In line with the Global AIDS Strategy 2021-2026 and its differentiated targets, the tool disaggregates HIV incidence and population sizes by age, sex, location and risk category. The tool distinguishes four categories of risk:

- Not sexually active
- Sexually active, one cohabiting partner
- Non-regular sexual partner(s)
- Young women within key populations [‡]

In addition to these categories, countries can consider other context-specific vulnerability factors[§] in their planning as outlined in the 2016 programming guide.⁸ The subnational estimates from the tool can be the starting point for establishing the size of the population at risk.

Figures 3 and 4 provide outputs from the tool to illustrate why differentiated programming is important.

Data in Figure 3 show that in this district

- The HIV incidence rate is higher among young women 20-29 (Figure 3a), because most young women in this age group are sexually active (Figure 3b).
- HIV incidence among 15-19-year-olds is lower (Figure 3a) because fewer young women in this age group are sexually active (Figure 3b), however, those relatively few adolescents 15-19 who are sexually active experience relatively high HIV incidence rates (Figure 3e).
- HIV incidence rates are highest among young women selling sex (Figure 3e).
- The absolute number of new infections is largest among other young women with non-regular partners (Figure 3d), because of larger population size (Figure 3c).
- As a result, in this specific district, programmatic focus would be on young women within key populations because of high incidence rates and other young women with non-regular partners because of large numbers of new HIV infections.

The pattern found in Figure 3 is quite common in southern Africa (in particular, Botswana, Eswatini, Lesotho, Namibia, South Africa). In these countries, a large proportion of young women is unmarried, but sexually active, which explains the large proportion of new HIV infections among young women with non-regular partners.

[†] The tool for subnational population size estimates was prepopulated with Spectrum and NAOMI estimates as well as other population size and survey data. The prepopulated tool can be obtained through the Global HIV Prevention Coalition Secretariat (hivpc@unaids.org).

[‡] In the tool, the number of young women from key populations is based on the estimated number of young women selling sex. Young women engaging in transactional sex are included in the category of nonregular partners.

[§] In reaching adolescent girls and young women, other behavioural, biological and structural factors can be considered, such as engaging in transactional sex, history of STIs, being out of school, orphanhood, and exposure to violence. For a more comprehensive list, see UNAIDS 2016 Guidance 'HIV prevention among adolescent girls and young women: Putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys'.

Figure 3: Example of a district population size estimate in southern Africa (illustrative)

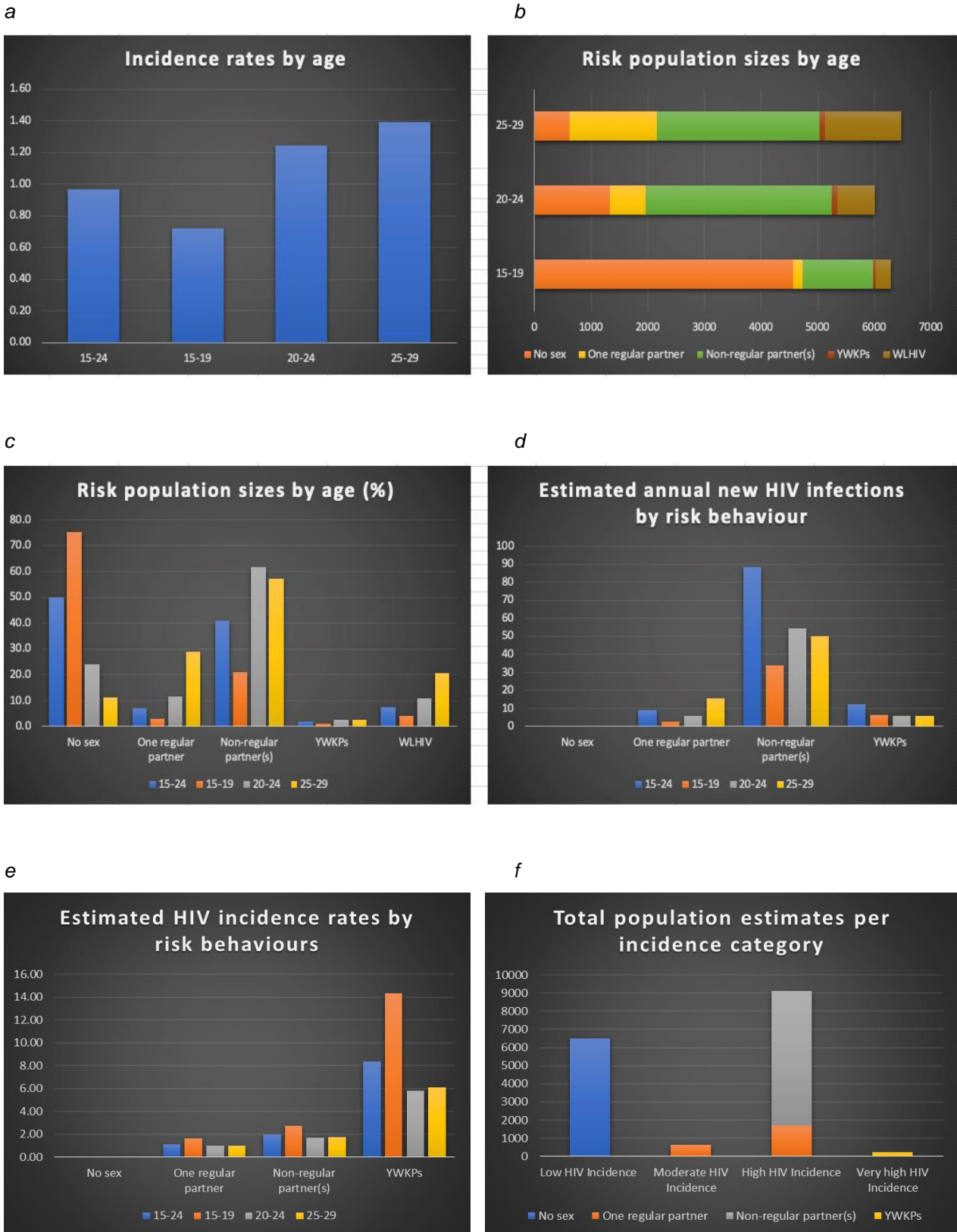


Figure 4 shows that in this country

- There is an almost eight-fold difference in HIV incidence among young women (15-24) between different districts ranging from 0.05 (low) to 0.38 (moderate).
- Young women selling sex experience *very high* HIV incidence in several districts and *high* HIV incidence in other districts.
- HIV incidence among young women with non-regular or multiple partners is low or moderate in all districts. HIV incidence among young women with one partner is low in all but five districts, where incidence is moderate. However, the population size of these groups is larger, as is the number of young women living with HIV.
- Therefore, in absolute numbers, new HIV infections are distributed between different groups: approximately 750 among young women selling sex, 1300 among young women with non-regular partners and another 1600 among women with one regular partner.

Programmatically and for optimal allocation of prevention resources, there is need to consider variation by geography and by risk category:

- o Prevention responses among young women selling sex will have great value for money by focusing on a relatively small population of less than 40 000 young women with high to very high HIV incidence.
- o To achieve incidence reduction targets at population-level, there is also need to reach other young women, but this is potentially much more resource-intensive, because of their large population size of two million.
- o Hence, there is need to focus efforts on adolescent girls and young women with at least moderate HIV incidence rates. These include young women with non-regular partners in about half the districts of the country and in five districts with highest HIV incidence rates also young women with regular partners.
- o In other areas in this country example, essential services such as condoms, testing and treatment would also be available and promoted including through SRH services, but more resource-intensive interventions should remain focused on populations and areas with higher HIV incidence.
- o Since there are several subpopulations quite close to the threshold of 0.3%, the country could consider, if small adjustments to the thresholds would make the country specific approach more coherent.

Figure 4. National summary of district estimates for young women 15-24 (illustrative example from south-eastern Africa)

Geography	Population sizes by behaviour (F15-24)						Estimated new HIV infections				Estimated HIV incidence rates						
	Country	No sex	Regular partner	Non-regular	YWKPs	All F15-24	F15-24/HIV	No sex	Regular partner	Non-regular	YWKPs	All F15-24	No sex	Regular partner	Non-regular	YWKPs	All F15-24
District 1		11950	12865	4057	364	29530	295	0	11	5	7	23	0	0.09	0.13	1.81	0.08
District 2		18763	20370	7683	569	48308	922	0	33	18	16	67	0	0.16	0.24	2.84	0.14
District 3		15638	12474	7540	430	36869	788	0	24	21	14	59	0	0.19	0.28	3.20	0.16
District 4		11838	11649	4801	350	29061	423	0	15	9	8	33	0	0.13	0.19	2.42	0.12
District 5		13710	15098	4413	410	34129	499	0	20	9	10	39	0	0.13	0.19	2.47	0.11
District 6		34654	31592	13496	996	81706	968	0	36	22	22	80	0	0.11	0.17	2.17	0.10
District 7		705	580	449	21	1798	44	0	1	1	1	3	0	0.19	0.28	3.07	0.17
District 8		14886	13314	6224	411	35959	1123	0	40	28	17	85	0	0.30	0.45	4.25	0.24
District 9		39038	51233	12931	1203	105462	1057	0	44	16	22	82	0	0.09	0.13	1.80	0.08
District 10		18283	21543	8679	552	49829	771	0	28	16	13	58	0	0.13	0.19	2.40	0.12
District 11		15799	18552	5117	469	40209	271	0	11	4	6	21	0	0.06	0.08	1.31	0.05
District 12		38449	44741	11922	1126	96942	703	0	30	12	17	59	0	0.07	0.10	1.50	0.06
District 13		22203	25339	11614	670	60861	1036	0	34	22	16	72	0	0.13	0.19	2.42	0.12
District 14		70047	94422	33793	2315	202661	2084	0	80	41	40	161	0	0.08	0.12	1.74	0.08
District 15		23903	35741	12539	835	73934	915	0	37	18	17	71	0	0.10	0.14	1.99	0.10
District 16		40896	42425	17616	1180	103147	1030	0	38	23	21	82	0	0.09	0.13	1.82	0.08
District 17		32963	29431	18494	912	83382	1581	0	46	42	25	113	0	0.16	0.23	2.71	0.14
District 18		49196	53312	33749	1509	142604	4838	0	158	146	61	364	0	0.30	0.43	4.01	0.26
District 19		51569	57028	34482	1829	148892	3983	0	108	93	55	256	0	0.19	0.27	3.02	0.18
District 20		27881	41253	21540	1181	93739	1884	0	58	42	28	128	0	0.14	0.19	2.41	0.14
District 21		27162	36424	24678	1108	92628	3257	0	86	81	37	204	0	0.24	0.33	3.34	0.23
District 22		25476	30912	24897	1003	86104	3816	0	89	99	37	225	0	0.29	0.40	3.72	0.27
District 23		17555	22057	10531	620	52831	2069	0	57	38	23	119	0	0.26	0.36	3.69	0.23
District 24		19534	20447	13691	676	56146	1798	0	51	48	24	122	0	0.25	0.35	3.52	0.22
District 25		5261	5297	3514	173	15051	806	0	23	22	9	54	0	0.44	0.64	5.03	0.38
District 26		15020	14809	10950	499	48405	2127	0	53	56	22	131	0	0.36	0.51	4.40	0.32
District 27		22057	21510	13116	712	59460	2066	0	65	57	29	151	0	0.30	0.44	4.06	0.26
District 28		6605	6837	3688	223	17740	386	0	12	10	7	29	0	0.18	0.26	2.99	0.17
District 29		30557	31261	22761	1036	89791	4177	0	102	105	43	250	0	0.33	0.46	4.14	0.29
District 30		24795	29312	12580	844	69653	2122	0	66	41	29	136	0	0.23	0.32	3.45	0.20
District 31		13356	13328	8227	439	36506	1157	0	30	27	15	72	0	0.23	0.32	3.39	0.20
District 32		6641	7133	2968	216	17364	405	0	13	8	7	28	0	0.18	0.27	3.07	0.16
District 33		39770	38287	25386	1298	109523	4782	0	140	137	59	336	0	0.37	0.54	4.55	0.32
Total		806161	910577	448126	26178	2245223	54181	0	1639	1317	756	3713	0	0.18	0.29	2.89	0.17

Source: Tool for estimating the population size of people at risk of acquiring HIV in settings with high HIV incidence. Geneva, 2022.

Major platforms for programmes

To make programmes simpler and more scalable, it is proposed to define the most important platforms for delivering HIV prevention programmes among adolescent girls and young women. Figure 5 proposes to prioritise action through three platforms working together:

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

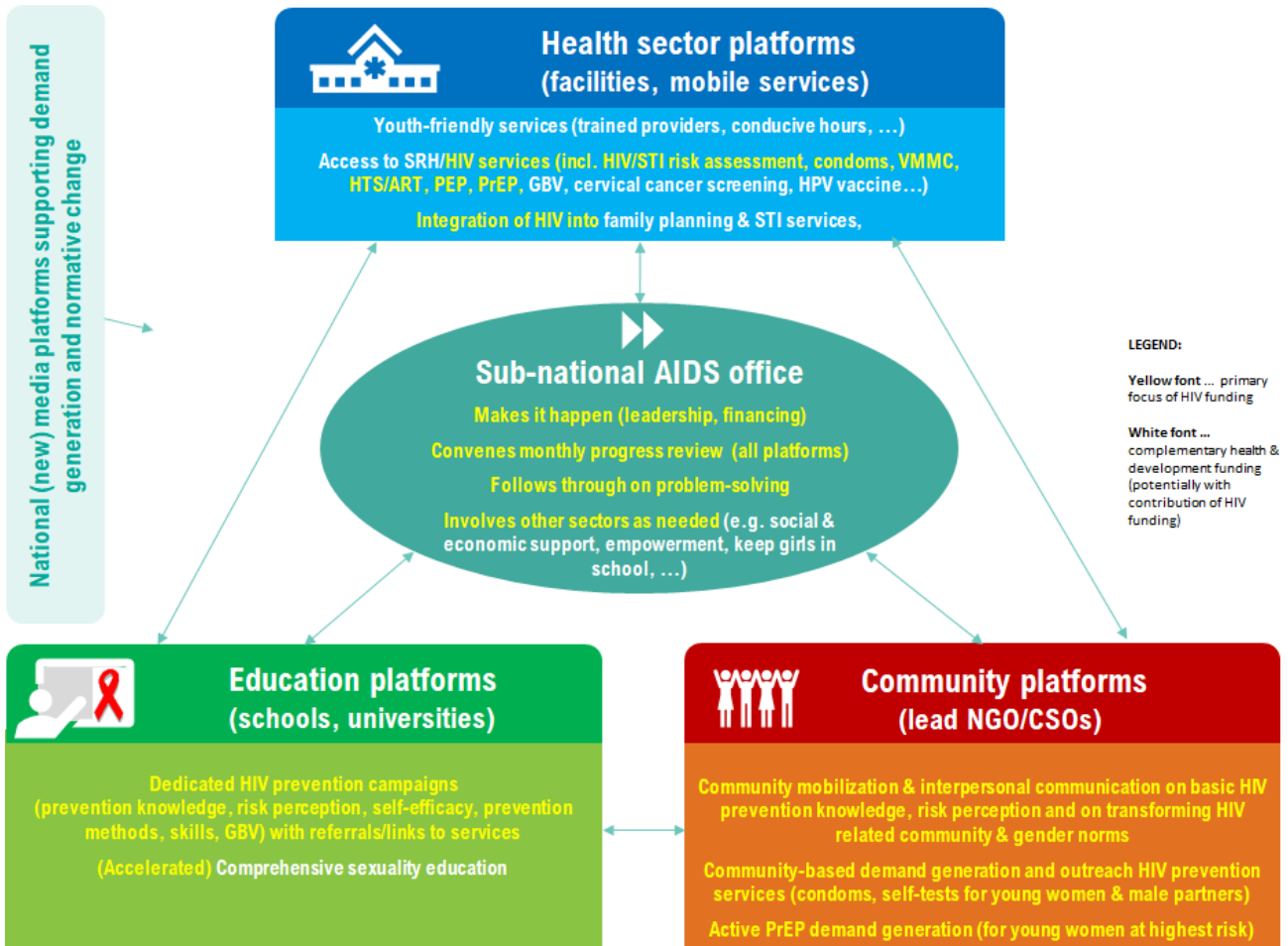
Figure 5 illustrates the key platforms and their collaboration. Arrows highlight the importance of referral between the different sectors. For example, community-based demand generation should refer adolescent girls and young women to youth-friendly, person-centred and non-judgmental SRH/HIV services. At the same time, young women who are accessing contraceptive services and are at increased risk of HIV/STIs may require community support in mobilizing their partners for HIV prevention, testing and treatment as part of broader efforts to change gender and community norms. Another example is referrals made from school-based HIV programmes to services provided by the health sector and through community platforms (e.g. condom provision, self-testing, and prevention counselling). There are several other platforms where HIV prevention can be integrated such as social protection, gender-based violence services, workplaces and others. In the context of limited resources, not all of these platforms can be fully funded through HIV prevention programmes, but local AIDS coordination offices or implementers of community outreach can provide essential prevention services and demand generation through some of these platforms.**

The role of community organisations is critical to reach young women out-of-school and young adult men. Therefore, scaled community outreach needs to be at the centre of prevention investment in communities with high HIV incidence. A strengthened community outreach platform in settings with high HIV incidence is critical in fulfilling multiple functions in communicating about HIV prevention, generating demand for prevention, testing and treatment, making referrals, supporting consistent use/adherence, advocating with gatekeepers and addressing underlying social and gender norms. Virtual platforms play an increasing role and depending on the community context can be an important channel for engagement, outreach and demand generation. Specific guidance on planning for these is available.²³

In the health sector, other SRH/HIV services – in particular contraceptive services and HIV testing services - provide a critical under-utilized platform for providing strengthened HIV prevention services. In the education sector, many countries have adopted comprehensive sexuality education (CSE), which in settings with very high HIV incidence can be complemented with other, more direct HIV prevention communication in schools and other education institutions – for example, short and simple campaigns on the risk of age-disparate sex showed promising effects in two trials.^{24,25}

** In practice, this could mean, for example, that HIV funding in a country will be not be sufficient and therefore not be used to establish stand-alone Gender Based Violence (GBV) centres at scale, but community-based prevention communication can integrate specific messages on GBV when discussing safe sex negotiation and condom use, or GBV services can integrate communication on different HIV prevention options, like condoms, PEP and PrEP, and make them available.

Figure 5: Essential delivery platforms for scaling up programmes for adolescent girls, young women and male partners



Effective collaboration of the three platforms will require active response management to drive the programme and ensure alignment, for example of community demand generation and service accessibility. Where a local AIDS coordination office exists, this office would typically be well placed to perform this leadership function in driving HIV prevention among young women. While this could be linked to broader coordination – on HIV, health promotion, young people’s health or youth development –, broader coordination cannot replace the specific leadership needed for HIV prevention among young women in settings with high HIV incidence. The local AIDS coordination office could be supported in elements of this coordination function by specific implementing partners such as a lead NGO in the field.

Additionally, the engagement of adolescent girls and young women as an integral part of subnational management and implementation should be planned for from the onset including by involving qualified young adult women as professional staff in the management of programmes.

How to prioritise in the context of limited resources

There are resource constraints for HIV prevention in all countries with moderate to high HIV incidence. Therefore, the HIV response cannot finance all support that adolescent girls and young women require for their full development and well-being. This implies that it is important to understand:

- 1) what critical services and support adolescent girls and young women need;
- 2) who is responsible for providing which type of service and support;
- 3) which institutions should finance, which type of service and support.

The main purpose of this decision-making aide is to provide more specific guidance on how to focus HIV prevention investments for adolescent girls and young women. This does not necessarily mean that other priorities are less important, but it requires answering specific additional questions:

- Which components of HIV prevention are a higher priority to be funded from the following available resources – domestic or international: HIV financing or other health and development financing?
- How should HIV prevention packages vary between locations with different levels of HIV incidence given available resources?
- What platforms should be used to deliver the interventions and how can these be implemented at scale with high quality?

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

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

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

In addition, it is important to note that in all settings, young women within key populations are at particularly high risk. Programmes for key populations, for which ample other guidance exists, deserve high priority in all settings and require specific approaches to reach young women within these key populations. In addition, programmes for young women in settings with high HIV incidence as described in this guide should be open to and provide for non-judgmental access and participation of young women from key populations.^{††}

^{††} Considering limited HIV prevention funds, it is not viable to use HIV prevention resources to fund broader health, education and social protection gaps among adolescent girls and young women in settings with low and moderate HIV incidence. For young women within key populations and other subpopulations with very high HIV incidence, some essential health, education and social protection gaps may need to be met through HIV resources. However, even in locations with high HIV incidence, it is impossible to fund these services from HIV prevention resources for all young women. At what scale such support is feasible in a specific country depends on the country's budget envelope. Only once HIV prevention programme essentials are fully covered at scale, expanding use of HIV prevention funding into broader health, education and social protection activities will be viable. Otherwise, there is a risk that the high cost of broader investments for a few locations is achieved at the expense of depriving large numbers of adolescent girls and young women from access to programme essentials.

Prioritisation matrix

The **first part of the prioritisation matrix** (Table 2) focuses on HIV programme investments that should be informed by the level of HIV incidence. For this purpose, countries can first use HIV incidence at district level.

Through **health platforms**, some essential interventions should be routinely offered to all adolescent girls and young women in all locations with moderate and high HIV incidence: HIV/STI risk assessment, HIV risk reduction counselling and testing, active provider-initiated condom distribution and promotion. For subpopulations at higher risk and locations with high HIV incidence, additional services can be provided routinely. In line with this, more advanced STI diagnosis could be offered everywhere to adolescent girls and young women at high risk, but as a routine offer to all sexually active women only in locations with high incidence. The degree to which HIV/STI services can be integrated into contraceptive services could also be varied by HIV incidence levels, which is described in more detail in another document²⁶. The same logic applies to the level of HIV testing followed by ART referral for male partners. For subpopulations with very high incidence, PrEP should be routinely offered through all SRH/HIV service delivery points. For subpopulations with high HIV incidence, PrEP should be widely available in all facilities and actively offered to individual adolescent girls and young women at higher risk (for example with a history of STIs or with a partner with unknown HIV status). In settings with low and moderate HIV incidence, young women at highest risk, in particular young women key populations could be offered or referred to PrEP.

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

Through **community platforms**, active community mobilization on HIV prevention should take place in all communities with high incidence and selected settings in areas with moderate HIV incidence. In communities with high incidence, community-based demand generation and outreach for HIV prevention services should be scaled up to reach virtually all adolescent girls and young women (15-29), specifically those out-of-school, as well as men 20-34, while an approach focused on young women at higher risk is recommended for other locations. The more resource-intensive structured interpersonal communication interventions (following tested models such as Stepping Stones, SASA! and SHARE) will likely require even more focus and could primarily be scaled up in all communities with high incidence. Active PrEP demand generation for sexually active adolescent girls and young women should be done community-wide for subpopulations with very high HIV incidence. In communities with high HIV incidence active demand generation for PrEP should still be done for young women at higher risk (also see Table 3). In all other settings, PrEP demand creation would primarily focus on key populations including young women from key population communities. Additional social support interventions including economic support, social asset building²⁷ and education assistance should be paid from other development funding, whenever possible. HIV funding is commonly insufficient in such areas, but in communities with high HIV incidence dedicated HIV prevention funding could be used to support specific elements of social support for particularly vulnerable young women at highest HIV risk.

The **second part of the prioritisation matrix** describes services which should be provided to all adolescent girls and young women in all locations regardless of HIV incidence levels. In order to implement these actions, countries should rely on other resources from complementary health and development funding (beyond the resources allocated for the HIV response).

To optimally allocate resources, there will likely be a large difference in per capita investments between settings based on the level of HIV incidence. This is because the number of young women at high risk varies between these settings. In settings with moderate HIV incidence, per capita investments will be lower than in settings with high HIV incidence, because the limited resources can be focused on the smaller proportion of young women at higher risk. Decisions need to be made at country-level considering available funding.

Table 2. Prioritization Matrix

PART I. HIV programmes (high priority for HIV funding)				
HIV incidence	Health sector	Community	Education sector	Multisectoral action & coordination
(by location)	HIV programmes for all priority populations (which also benefit adolescent girls and young women)			
Low (less than 0.3%)	<ul style="list-style-type: none"> HIV testing and treatment services, PEP, prevention of vertical transmission of HIV as part of maternal health, PrEP only for individuals at exceptionally high risk within key populations or discordant couples or in other exceptional individual circumstances Male & female condoms and lubricants, VMMC for adolescent boys and men (in relevant priority countries), basic national HIV information (prevention and treatment), risk reduction communications including new & social media 	<ul style="list-style-type: none"> Action to address HIV-related rights, stigma and discrimination HIV programmes including trusted community outreach platforms for key populations (including AGYW within key populations) 	<ul style="list-style-type: none"> HIV integrated in education policies and curricula. <i>(HIV funds only if not funded through education sector)</i> 	<ul style="list-style-type: none"> Multisectoral HIV policy development and coordination between health, community, education, gender, social protection, financing and other sectors
HIV prevention programmes for adolescent girls and young women				
Moderate (between 0.3 and 1%) All of the above PLUS	<ul style="list-style-type: none"> HIV/STI risk assessment and risk reduction counselling HIV testing services including self-testing Active condom and lubricant distribution & promotion 	<ul style="list-style-type: none"> Community outreach (interpersonal and virtual) addressing HIV prevention knowledge, risk perception and related social norms, demand generation and outreach services including condoms, self-testing, referrals <i>(focus on popular opinion leaders and high-risk venues frequented by AGYW and men 20-39 at higher risk of HIV)</i> 	<ul style="list-style-type: none"> Dedicated school-based HIV prevention campaigns (knowledge, risk perception, methods, skills, GBV) linked to services (condoms, testing, referrals) in selected schools & tertiary institutions <i>(HIV funds only if not funded through education sector)</i> 	<ul style="list-style-type: none"> Subnational AIDS Office leads regular prevention programme review & problem-solving (that includes programmes with adolescent girls and young women), multi-sectoral coordination and referral systems between different sectors
High (1.0% and more) All of the above PLUS	<i>Expand the focused action above (in orange) to routine offer</i>	<i>Expand activities above to all AGYW & men 20-39</i>	<i>Expand activity above to all schools & tertiary institutions</i>	<i>Hold dedicated AGYW prevention programme reviews</i>
	<ul style="list-style-type: none"> Availability and provider-initiated offer of PrEP services <i>(focus on AGYW with casual or multiple partners, history of STIs and in transactional sex)</i> 	<ul style="list-style-type: none"> Active PrEP and PEP demand generation and community outreach services <i>(focus on settings frequented by AGYW at higher risk)</i> 	<ul style="list-style-type: none"> Accelerated introduction of comprehensive sexuality education <i>(HIV funds only if not funded through education sector)</i> 	<ul style="list-style-type: none"> Full-time HIV prevention focal point at subnational level to drive action and accountability
	<ul style="list-style-type: none"> <i>Expand demand generation and active provider-initiated offer of PrEP services to routine offer for subpopulations with very high HIV incidence exceeding 3% and ^{##}</i> 	<ul style="list-style-type: none"> Structured interpersonal communication on HIV prevention and related social norms, e.g., scalable (shorter) versions of Stepping Stones, SASA!, SHARE <i>(focus on locations with higher prevalence of risk factors)</i> 	<ul style="list-style-type: none"> Keep girls in-school / education assistance <i>(Other funding/ HIV funds only in exceptional cases for most vulnerable AGYW at high risk of HIV)</i> 	<ul style="list-style-type: none"> Social support and asset-building - e.g. safe spaces, mentoring and economic empowerment <i>(focus on most vulnerable AGYW at high risk of HIV)</i>
PART II. Other enablers and synergies (typically other funding than HIV)				
All locations (not guided by HIV incidence)	<ul style="list-style-type: none"> Access to integrated SRHR (including family planning, gender-based violence, cervical cancer screening, HPV vaccine and other STI services) including legal and policy support Youth-friendly health systems (trained providers, conducive hours, destigmatized care for adolescent girls and young women ...) 	<ul style="list-style-type: none"> Out of school comprehensive sexuality education 	<ul style="list-style-type: none"> Access to primary and secondary education Comprehensive sexuality education (CSE), school health programmes, non-discrimination in schools, intersections to GBV 	<ul style="list-style-type: none"> Social support and economic empowerment of vulnerable adolescents Cash transfers, economic empowerment

Legend Routine offer for all AGYW in the area Focus on specific groups of AGYW Highly focused on AGYW at highest risk

^{##} See Table 3 on next page for additional information on PrEP relative to HIV incidence among sub-populations of young women.

In applying Table 2 above, countries can use HIV incidence rates for AGYW by district.

Table 3 below shows the logic of expanding packages in simplified form for individual-level interventions such as PrEP or face-to-face outreach. These interventions can be focused more precisely by using HIV incidence rates from the population size estimation tool, which is further disaggregated by sexual risk behavior and 5-year age groups.^{§§}

Table 3: Scaling up individual interventions contributing to HIV impact***

HIV incidence rate in the subpopulation (by age, sex, geography and behaviour)	Interventions to be delivered at scale for the specific subpopulations (with the respective HIV incidence rates)
Low (less than 0.3%)	+ HTS & condoms available + Partner services for all AGYW with HIV + ART (all PLHIV)
Moderate (between 0.3% and 1%)	+ Demand generation for essential combination prevention above (virtual/ media) + PEP
High (between 1% and 3%)	+ Interpersonal (face-to-face) outreach (demand & services)
Very high (more than 3%)	+ PrEP

Scale up everything above plus

Provide access to additional choices such as PrEP to individuals at higher risk within the sub-population (focused offer)

In line with Table 3, HIV impact among subpopulations with low and moderate HIV incidence will primarily result from testing, treatment and condoms. This would be mostly accompanied by demand generation in the virtual space and media. All these approaches can be scaled up even in resource limited contexts.

Scaled PrEP offers should be considered, if HIV incidence in a subpopulation of young women (by geography, age and risk) exceeds 3%. Such a subpopulation could be young women 15-29 with non-regular partners in a specific district. For example, HIV incidence in a district could be 1.8% for all young women and 3.1% for young women with non-regular partners and this would call for intensive demand generation among all young women with non-regular partners. With HIV incidence below 3% among young women with non-regular partners one would not aim for utilization of PrEP among all young women in this group. A good portion of young women with a non-cohabiting, non-marital partner may have a fairly stable relation with a single boyfriend or be comfortable in negotiating and using condoms. Hence, active promotion of PrEP utilization could be further focused on a subgroup of women with a recent history of STIs, with multiple partners or engaging in casual or transactional sex. In addition, PrEP could be offered to women actively demanding PrEP more widely.

Current experience across PrEP programmes for young women show low continuation on PrEP. So, a more flexible approach to using PrEP needs to be considered with support for stopping and restarting PrEP and use PEP for someone who has stopped PrEP. PrEP services for young women should always provide PEP with

^{§§} Estimated HIV incidence rates disaggregated by risk behaviour provide a more granular understanding and should therefore be used wherever it is possible and appropriate. For specific health sector interventions such as PrEP and related demand generation, applying the disaggregated estimates will be appropriate as not all young women in a specific district will need PrEP and PrEP efforts can be better informed by HIV incidence levels for subgroups such as young women who sell sex and other young women at higher risk. For school-based interventions, however, this would not be possible or desirable, and HIV incidence levels for the geographical area should be applied. For community interventions, both options can be applied. For outreach to young women at higher risk and demand generation in specific high-risk venues such as bars, focus can be determined based on disaggregated estimates. For other activities reaching all young women, it would be more appropriate to apply HIV incidence by geography alone. The granular HIV prevention targets in the HIV Prevention 2025 Road Map and Global AIDS Strategy 2021-2026 also describe, for which interventions targets should be set based on geography alone and for which behaviour and geography should be combined.

*** The table - deliberately - does not go into the various complementary sexual health, education and other services to show the logic of core HIV prevention programme elements, as those were covered in Table 2.

information on how to use PrEP and PEP. Furthermore, contraceptive services, including emergency contraception should always be provided along with PrEP for young women.

In principle, elements of this logic could be applied to programmes for young women selling sex. However, it is recommended that programming for this population follows the specific HIV prevention targets for sex workers and specific implementation tools for sex worker programmes and WHO Consolidated Guidelines.

Questions and answers on the prioritization matrix

Question	Answer
The matrix is very complex. How can its guidance be summarized in a few sentences?	In locations with low HIV incidence , there should be access to HIV testing and treatment, condoms for all priority populations including adolescent girls and young women as well as dedicated programmes for key populations. Groups of adolescent girls and young women with moderate HIV incidence between 0.3% and 1% should have access to all of the above. In addition, other essential HIV prevention programme elements including provider-initiated HIV counselling, testing and condom promotion and PEP should be provided to <i>all</i> adolescent girls and young women accessing services. Community demand generation and other health, education and community interventions will be required for young women at higher risk within these communities. Groups of young women with high HIV incidence exceeding 1 % should receive all of the above plus intensive outreach and demand generation for prevention services for all and PrEP for those at higher risk. Communities with very high HIV incidence exceeding 3% should receive all of the above plus provider-initiated PrEP offers for all and – for the most vulnerable in these settings also special social support and empowerment. In most settings, very high incidence only affects key populations and full key population packages with special attention to young women key populations should be provided. Decisions need to be contextualized to the country realities. Essential health, education and social services should be available everywhere, but they should be funded from sources other than HIV financing, whenever possible.
How can we avoid that an approach based on risk differentiation becomes stigmatizing?	A key challenge in the differentiated approach to programming that underlies this table is to avoid that differentiation by risk becomes stigmatizing and a barrier to service uptake. Rather than solely relying on individual level risk assessments, priority can be given, whenever possible, to understanding risk based on known factors and patterns at community level. Therefore, the primary level of differentiation in this table for all interventions is by HIV incidence by geography. In other words, the level and comprehensiveness of HIV prevention efforts corresponds with HIV incidence in the area, an approach that does not stigmatize individuals. In addition, for several elements of programmes, implementation can be differentiated by other community level factors. For example, community outreach can be concentrated on specific areas within the district where sexual risk is expected to be higher such as bars, towns, mines, factories, commercial farms, other workplaces, transport corridors or, increasingly virtual dating spaces. If these places are not known, there should be community level risk assessment or mapping. For some services, basic individual level understanding of risk is, however, required. For example, to provide differentiated person-centred HIV prevention in a health care setting and offer PrEP it will be helpful to understand whether a young woman is sexually active, whether she lives with her partner, whether she has non-regular partners, or symptoms of STIs. A basic and quick risk assessment can clarify these questions but must be carried out in a sensitive, empathetic and non-invasive way by a trained provider.
What does ‘routine offer’ and ‘focused’	Routine offer in this table means that there should be an active initiative from health care or community-level providers in offering the service. The frequency of such routine offers will vary between different interventions, locations and age groups based on context specific programmatic guidance. Focused offer stands

<p>offer stand for in these tables?</p>	<p>for approaches that reach a subpopulation of young women within the subnational area or only specific settings (locations) frequented by young women at higher risk. Within populations such as young women with non-regular partner(s), an offer may be further focused on those at highest risk, for example those with multiple partners, history of STIs and transactional sex. The table provides specific suggestions on how to frame the focus for different interventions.</p>
<p>How does this matrix apply to young women from key populations who are often at highest risk?</p>	<p>Programmes for young women from key populations should be prioritized based on HIV incidence in the specific key population (or a proxy for it), even in settings where HIV incidence in the overall population is low (as indicated in part I of the matrix). Programmes should follow the existing guidance for HIV prevention with sex workers^{13,28} and young key populations.^{29,30} Given the very high HIV incidence rates among young women who sell sex in Africa, the most comprehensive prevention packages (including elements such as community outreach and PrEP) should be made available for young women who sell sex in all contexts in Africa. Special consideration also needs to be given to young women who do not formally identify as sex workers but sell sex and young women engaging in transactional sex.³¹ There should be country specific analysis to decide which adolescent girls and young women can be better reached through key population programmes or other programmes for adolescent girls and young women. For example, adolescent girls and young women who start meeting men in the same bars as sex workers, but do not (yet) identify as sex workers may be reachable through peer outreach workers from the key population programme if they are trained to engage adolescent girls and young women. At the same time, community outreach programmes for other young women need to be particularly sensitive and equipped to support young women engaged in transactional sex and selling sex. Referrals between programmes are also important to best meet individual needs of adolescent girls and young women.</p>
<p>Why are vulnerability factors other than age, sex, location and risk behaviour (such as orphanhood, being out of school and experiencing GBV) not part of the risk differentiation in the global targets and the subnational estimates?</p>	<p>A number of vulnerability factors can play an important role but the degree to which they are associated with HIV is more contextual compared to the more direct factors of age, sex, location, risk behaviours or being part of a key population. Among other reasons, this is why the risk differentiation in the global targets primarily reflect location and behaviour. For the same reason, the new Population Size Estimation Tool also considers age, sex, location and behaviour and also because universal quantitative assumptions on the role of other vulnerability factors on HIV incidence cannot be made as their association with HIV incidence varies between settings. However, information on other vulnerability factors is important to consider in country and subnational level planning (see Table 3).</p>
<p>How can we know about risk behaviours at subnational level, when surveys are not representative at this level?</p>	<p>The UNAIDS tool for subnational population size estimates builds on survey data from population-based surveys. As this data is often not representative at subnational level, small area estimation modelling is applied to estimate the level of risk behaviours at a subnational level. Small-area estimation models use survey data at a fine spatial scale, in this example survey cluster locations assigned to districts, and smooth across these uncertain estimates, borrowing information from neighbouring areas to improve estimation. Although small-area estimation modelling gives us a better understanding of subnational risk behaviours, these modelled estimates need to be interpreted with some caution given the wide uncertainty around an individual estimate. Results can be further refined at country level. For further information on this question, contact UNAIDS for the user guide on the population size estimates tool.</p>
<p>How can complementary funding from non-HIV sources be secured for funding enablers?</p>	<p>Domestic and international financing of HIV responses is too limited to cover broader social, health and education outcomes for adolescent girls and young women in most cases. However, advocacy could also aim at ensuring that international development financing in social, health and education sectors is increasingly planned in a way that it supports adolescent girls and young women's health and well-being.</p>

	<p>Advocacy could also support increasing domestic investment into health, education and social protection with a particular focus on young women considering a range of health, social and economic benefits for such investments.</p> <p>Integrating work on specific social enablers into HIV prevention programmes for young women can be done at low to moderate cost, for example advocacy to address social and gender norms related to HIV transmission can be integrated into community outreach with local leaders. Advocacy at national level can address policy barriers such as age of consent laws and contribute to a more enabling environment. As outlined in key populations programme guidance, addressing policy and legal barriers is particularly important in programmes with young women from key populations.</p>
<p>How does the differentiated approach to risk reflect that risk changes over time? For example, people become sexually active or start or stop having non-regular partners.</p>	<p>People will always transition into and out of risk categories for different reasons. The population size estimates disaggregated by risk are based on percentages obtained from surveys and provide a proxy for the number of people in a specific risk category at any given point in time. Therefore, these numbers should normally not change substantially at population-level, even though individuals move in and out of risk categories. However, there may be exceptional circumstances when numbers change temporarily, for example caused by seasonal labor or seasonal travel. Local planning should reflect such information.</p> <p>Lives of individual young women also constantly change and their level of risk may change. This is why it is important not just to rely on a detailed once off assessment of risk of an individual. It is essential for HIV prevention programmes to be present in settings and locations where risk occurs to engage young women who are new in these settings early on. It is also important to use contacts of young women with the health system and community outreach to sensitively explore whether there are changes in risk.</p>
<p>What should countries do if other essential health, education and social protection gaps exist? Can HIV prevention funding cover these?</p>	<p>Considering limited HIV prevention funds, it will not be viable, in most settings, to use HIV prevention resources to fund direct delivery of broader health, education and social protection programmes among adolescent girls and young women in settings with low and moderate HIV incidence. Even in locations with high HIV incidence, it will not be possible to fund these services from HIV prevention resources for all young women. For young women within key populations and other subpopulations with very high HIV incidence, some essential health, education and social protection gaps may need to be met through HIV resources in exceptional circumstances if other resources are not available. At what scale such support is feasible in a specific country depends on the country's budget envelope and remains a country-led decision. Once HIV prevention programme essentials are fully covered at scale, expanding use of HIV prevention funding into broader health, education and social protection activities might be viable for a (small) proportion of young women, for whom successful prevention outcomes make such support indispensable. However, there is a risk that the high cost of broader investments for a few locations is achieved at the expense of depriving large numbers of adolescent girls and young women from access to programme essentials.</p>
<p>What about men?</p>	<p>Men in high HIV burden settings have lower access to testing, lower treatment coverage and are therefore significantly less likely to be virally suppressed than women – hence increasing access to testing and ART will not only benefit them but reduce HIV infections in AGYW. Partner services for all positive AGYW should be offered in all settings and can be considered for all AGYW in high incidence settings.</p>

Using data in deciding *how to reach* young women

After population sizes and differentiated packages have been established, it is important for programmes to further analyze how adolescent girls and young women can actually be reached. Detailed guidance on analysis of other vulnerability factors and programme options is available elsewhere^{8,32}. This section just describes how to translate population size estimates into viable programmatic targets and strategies to reach young women, while also considering other vulnerability factors. Population size numbers based on age, behaviour and location are critical for planning and designing packages but on their own are not sufficient to find and reach adolescent girls and young women at higher risk. This is why, in designing interventions other data need to be used. The type of data that is most helpful will vary slightly between countries, and between urban and rural settings.


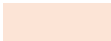

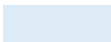


Table 4 provides an example of a district level analysis that links population size estimates to other data on potential service access platforms and other vulnerability factors. For this purpose the table uses data from a district in southern Africa shown in Figure 3 with HIV incidence that is *very high* among young women selling sex and *high* among young women with non-regular partners. In this table, the population size estimates in the upper part are from the population size estimation tool. In the lower part of the table these numbers are broken down into numbers of adolescent girls and young women reachable in different settings. In the example below, 7414 adolescent girls and young women with non-regular partners and high HIV incidence need to be reached through different platforms. Based on survey data on contraceptive use in the country, it might be known that 54% of adolescent girls and young women with non-regular partners access contraceptive services. This means that 4000 young women with non-regular partners might be using contraceptive services during a calendar year and could be reached through this platform. As shown in this example, completing this table requires using and triangulating other data available through surveys or local records. Ideally, to facilitate this process, such tables should be prepopulated at national level and refined locally at subnational level.

In using this information for planning, it is important to decide first which young women need to be reached. This can be based on the upper part of the table with the population sizes by HIV incidence. For subgroups of adolescent girls and young women with very high HIV incidence and those with high HIV incidence, it will be important to reach them through several channels. In doing so, it will be important to note that there will be overlaps. For some interventions like demand generation, this may not be a problem as it reinforces messages, while for other interventions such as accessing prevention commodities or more intensive community courses, local decisions on the most appropriate channel will be needed. For groups of adolescent girls and young women with moderate HIV incidence, it might not be possible to reach them through all channels and there will be need to prioritize which young women can be reached through which channel in line with the agreed packages, available resources and young women's preferences.

Table 4: Using other data in planning how to reach adolescent girls and young women at higher risk of HIV. Example of a table for use at subnational level (using data from the district in southern Africa from Figure 3)

	No sex	One regular partner	Non-regular partners	Young women key pops	Total	Data source
Population sizes by age						
15-19	4,566	176	1,242	45	6,029	As per population size estimation tool
20-24	1,329	632	3,288	104	5,353	
25-29	624	1,530	2,883	98	5,135	
Total	6,519	2,338	7,413	247	16,517	
Population sizes by incidence category						
Low HIV Incidence	6,518	-	-	-	6,518	As per population size estimation tool
Moderate HIV Incidence	-	632	-	-	632	
High HIV Incidence	-	1,706	7,414	-	9,120	
Very high HIV Incidence	-	-	-	248	248	
Total	6,518	2,338	7,414	248	16,517	
Other population sizes for planning where to reach adolescent girls and young women						
	No sex	One regular partner	Non-regular partners	Young women key pops	Total	
In school	3,877	81	807	-	4,765	As per district education office records
In tertiary institutions	81	76	207	-	364	
Out of school (see for platforms below)	2,561	2,181	6,399	248	11,389	
Reachable through contraceptive services	-	1,800	4,000	220	6,020	Local estimates based on survey and service data
Reachable through STI services	-	50	300	50	400	
Reachable through ANC/MNH services	-	200	100	10	310	
Reachable through GBV services	70	100	250	25	445	
Lower-income households/ neighborhoods	2,607	935	2,966	160	6,668	Local estimates based on social protection data
Orphaned (15-19)	200	100	250	10	560	
Other highly vulnerable adolescents (15-19)	200	100	250	10	560	
Attending bars and other entertainment venues	200	200	1,500	200	2,100	Local estimates based on total population in specific towns and areas, number of bars, and data on internet access
In sex work venues (brothel, street venues ...)	-	-	100	150	250	
In workplaces at higher risk (mines, farms, ...)	400	200	1,200	70	1,870	
Living in higher-risk areas (towns, major roads ...)	600	500	2,000	200	3,300	
Using online dating apps	300	100	1,500	100	2,000	
Reachable through online outreach	1,000	100	1,500	60	2,660	

Legend:

	Focus of sex worker programme
	Focus of AGYW community outreach
	Focus of AGYW community outreach + social support
	Focus of HIV prevention in health care settings
	Focus of online outreach
	Basic in-school prevention

Decision-making: Step by step

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

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

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

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

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

This information can be obtained using existing survey or (implementation) research results from the country or subnational area or through rapid assessments at subnational level. The information can be used to further define the population of young women to be reached with different programme components.

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

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

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

Step 6: Define a simple management mechanism for the HIV prevention component to reflect the focus on delivery of core results with the required geographical coverage, intensity and quality. Local governments would typically convene the management mechanism. Depending on the context of the country, this

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

stewardship role could be with a local AIDS coordination office through a staff member who is dedicated to HIV prevention, including adolescent girls and young women.

Step 7: In line with the defined HIV prevention packages, clearly define the role of the different delivery platforms (in particular health services, schools, community platforms), and develop a simple delivery system. Having several organizations implementing HIV prevention for one population in one district will never be scalable and sustainable. For example, in one district one non-governmental organisation (NGO) or civil society organisation (CSO) could be designated to implement all community-level HIV prevention among adolescent girls and young women. Such an organization should have the capacity to implement at scale, actively involve young women (including as staff and champions) and collaborate closely with the local AIDS office, health facilities, schools and other partners operating in the area.

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

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

Conclusion

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

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