THE GLOBAL FUND MEASUREMENT FRAMEWORK FOR ADOLESCENTS GIRLS and YOUNG WOMEN PROGRAMS

Contents

List of Abbreviations

AGYW	Adolescents Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
CRG	Community Rights and Gender
DHIS	District Health Information Systems
DREAMS	Determined, Resilient, Empowered, AIDS-free Mentored, and Safe
EPP	Estimation and Projection Package
GBV	Gender Based Violence
GF	Global Fund
HIV	Human Immunodeficiency Syndrome
HTS	HIV Testing Services
KPI	Key Performance Indicator
MECA	Monitoring Evaluation and Country Analysis
M&E	Monitoring and Evaluation
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Response
PHIA	Population Based HIV Impact Assessment
PreP	Pre-exposure prophylaxis
SRHS	Sexual Reproductive Health Services
TERG	Technical Evaluation Reference Group
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VAC	Violence Against Children
VMMC	Voluntary Male Medical Circumcision

I. Background and Purpose

The Global Fund Strategy 2017–2022, "Investing to End Epidemics", has committed to scaling-up programs to support adolescent girls and young women (AGYW) in 13 countries. The 13 AGYW countries are Botswana, Cameroon, Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. The goal is to reduce new HIV infection among females 15-24[1] by 58% by 2022. This is a pooled target from all the 13 countries based on the Goals model, which assumes an equal incidence trajectory in adults and 15 – 24 year olds. The Global Fund's Strategic Key Performance Indicator 8 (KPI 8) measures new HIV infections among this group to demonstrate progress in addressing gender and age disparities in health.

According to UNAIDS report[2], the estimated number of new HIV infections among AGYW in sub-Saharan Africa in 2015 was 450,000. "The United Nations (UN) Political Declaration on Ending AIDS adopted in June 2016 calls for reducing new HIV infections to fewer than 500 000 per year by 2020, and it sets a specific target to reduce new HIV infections among adolescent girls and young women aged 15 to 24 years to fewer than 100 000 by 2020".

To this end, the Global Fund supports delivery of evidence-informed package of interventions for HIV prevention, treatment and care and support among AGYW outlined in the Global Fund technical brief for adolescents girls and young women in high-HIV burden settings. A robust Monitoring and Evaluation system is required to track progress of these interventions and to know how these programs are benefitting the AGYW.

This framework is aligned to the Global Fund's modular framework, which details programmatic modules for HIV, TB, and Malaria and corresponding core list of indicators (including those for AGYW) upon which countries build their funding requests. As part of the accountability framework, AGYW focus countries are required to include these indicators with respective targets in their performance frameworks based on planned AGYW activities.

The Technical Evaluation Reference Group (TERG) thematic review report of the "implementation of Gender-Responsive Programming at Country Level" provides three key recommendations for strengthening AGYW M&E systems;

- *Recommendation 9a: Develop tools that offer practical advice on implementing programs for AGYW and promote peer-to-peer exchange*
- *Recommendation 9b: Support initiatives to strengthen country capacity for monitoring progress on AGYW program implementation. –building country capacity for monitoring progress*
- *Recommendation 9c: Provide more substantial and specific guidance to countries on the development of performance frameworks for AGYW-focused grants*

[1] The Global Fund's technical brief for AGYW in high burden settings defines AGYW as females aged 10-24 and emphasizes the importance of tailoring the response to the specific needs of five-year age groups (10-14, 15-19 and 20-24) within the population of AGYW (Global Fund, Technical Brief on AGYW, Jan, 2017).
[2] UNAIDS 2016 Guidance HIV prevention among adolescent girls and young women.

In addition to the above recommendations, one of the lessons learnt from the two year implementation of PEPFAR'S DREAMS (Determined, Resilient, Empowered, AIDS-free Mentored, and Safe) project is "the need for a robust system to identify most vulnerable girls" (quoted from meetings with PEPFAR teams).

Together with the Global Fund technical brief for AGYW in high burden settings, this measurement framework is timely in responding to these recommendations and lessons learnt by outlining key requirements for setting up robust M&E system for AGYW programs. It provides guidance to Global Fund supported countries focusing on AGYW and the Global Fund Country Teams to strengthen their M&E systems and ensure accountability for the Global Fund investments in AGYW programs.

The measurement framework will support programs to effectively measure progress towards reducing new HIV infections among AGYW through strengthened data systems for measuring routine, outcome and impact indicators. The measurement framework identifies critical steps needed to ensure programs target and reach the most at risk AGYW with needed interventions. This approach has a potential of increasing efficiencies in use of available AGYW resources.

The proposed measurement framework is based on the overall Global Fund framework for data use for action and improvement [3], which emphasizes the need for strengthening country data systems, analytical capacity, program monitoring, in country reviews, evaluations, and data use. It is intended to help countries build resilient and sustainable systems for monitoring and evaluation of the AGYW programs and ensure available data is analyzed and used for program improvement.

The **purpose of AGYW measurement framework** is to provide operational guidance for strengthening monitoring and evaluation systems and processes for AGYW programs and ensuring a consistent approach for data collection, analysis and use across countries implementing these programs. Much still remains to be done for **community level M&E systems** since many of the AGYW behavioral, structural and some biomedical interventions are delivered at the community level. Countries may need support from in-country and international partners to develop and strengthen existing community and health facility M&E systems and to manage these programs and obtain desired results. In addition, for monitoring and evaluation of services delivered both at health facility and community, the focus should be to support improvement of existing national data systems to provide relevant age disaggregated data on AGYW programs.

The framework supports establishment of strong AGYW M&E systems that will enable generation and reporting of quality data and provide a platform for programs to make evidence informed decisions around;

- Targeting and reaching the most at risk AGYW
- Successful layering of interventions (providing different and needed interventions)
- Quality delivery/implementation of interventions
- Achievement of targeted program coverage at local and national level
- If selected interventions and investments deliver value for money

[3] The Global Fund Strategic Framework For Data Use For Action and Improvement (2017-2022) Draft 18 May 2018

– Progress made towards impact and the degree of reduction in new HIV infections among females 15-24 years in the AGYW focus countries

AGYW focus countries should adapt the proposed guidance according to their context and maturity of their M&E systems. It is intended to be used for all new grants focusing on AGYW and the existing grants undergoing revisions.

II. Key Principles

The measurement framework for AGYW is based on the following principles that underpin the effective implementation of this framework in countries and at the Global Fund.

Box 1 - Key principles

1. **Country Ownership**: The Global Fund remains fully committed to country ownership and seeks to strengthen country systems and capacities.
2. **Alignment and harmonization** with Technical partner international guidance
3. **Strengthen, build on and align with existing in-country systems, processes and events**. Avoid creation of parallel systems, processes and new requirements
4. **Partnership**: Work with technical and other partners to leverage technical, financial and political strengths, with mutual accountability centred on country outcome
5. **Learning and adaptability**: continuously adjust and refine the policies, guidelines and approach based on learning and emerging needs to achieve value for money

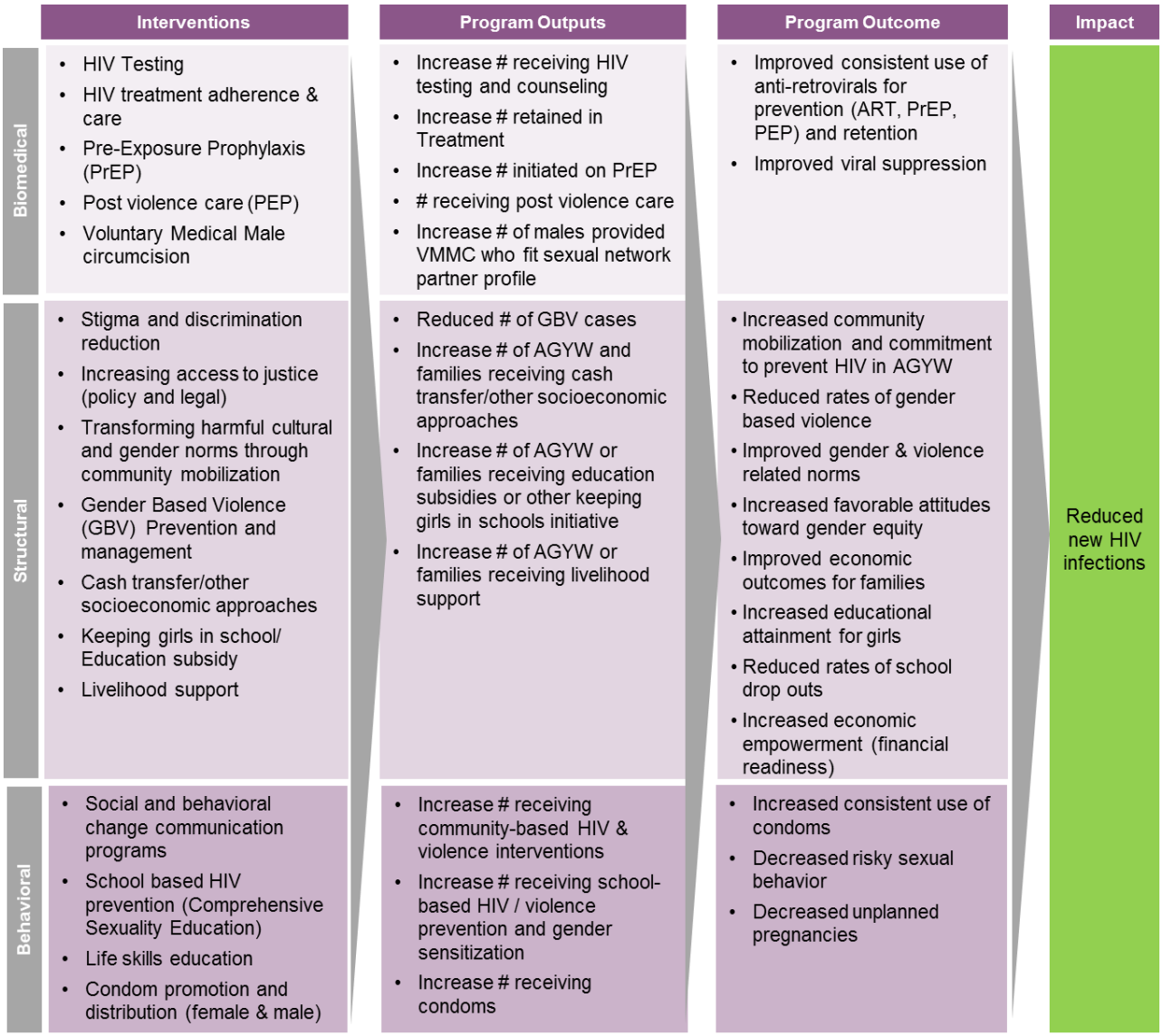
III. M&E framework for programs targeting Adolescents Girls and Young Women

This document proposes the input-activity-output-outcome framework that has been largely agreed and commonly used. This reflects indicators used at different levels to measure results achieved as well as what goes into the program or project. **The theory of change** is that if AGYW receive biomedical, behavioral and structural HIV prevention interventions then that will lead to positive outcomes that will lead to reductions in new HIV infection among this group all programmatic, financial and political assumptions holding true. Specifically, implementation of behavioral, biomedical and structural interventions lead to specific outputs such as AGYW receiving education subsidies, life skills education etc. If these outputs are meaningful and achieved among the intended populations, the program or project is likely to have positive effects or outcomes in the medium to long term, such as increased use of condoms, increased school attendance, increased adherence to ART, later age at first sex among the AGYW. These positive outcomes should lead to a reduction in new cases of HIV infections.

Figure 1 below shows the different biomedical, behavioral and structural AGYW interventions outlined in Global Fund's Technical brief for AGYW and adapted from UNAIDS guidance on AGYW programs. In addition, the figure illustrates the pathway through which these interventions lead to a reduction in new HIV infection. Essentially, effective monitoring and evaluation systems are necessary to support implementation of AGYW programs, to track service uptake, desired outcomes and impact of the

interventions. Table 1 and 2 below include a list of coverage and outcome indicators related to each of the interventions.

Figure 1: AGYW M&E Framework (pathway of change)[4]



IV. Monitoring Programs for Adolescents Girls and Young Women

1. Targeting the most at risk AGYW

In order to control the HIV epidemic among females 15 – 24 years, programs require mechanisms for **identification and enrollment of the most vulnerable AGYW** into the program. This should be coupled with delivery of age appropriate interventions to different sub groups with mechanisms to track

[4] Adapted from UNAIDS 2016 Guidance- HIV prevention among adolescent girls and young women

service delivery and measure results in a timely way. According to PEPFAR AGYW guidance[5], these sub-groups vary across and within countries; for example, they may include;

Those whose parent or parents have HIV or have died of AIDS
Those having sex with older men
Those engaged in transactional sex with high-risk partners
Those engaged in sex work
Those who are food insecure
Those married early
Those whose partners are violent or who have experienced violence
Those who are mobile or whose partners are mobile
Those who gave birth under the age of 18

Analysis of available qualitative and quantitative data at national and sub-national levels could facilitate this exercise by first identifying geographical areas with high-risk populations of AGYW and subsequent identification of the most vulnerable AGYW to be included in the program. One of the commonly used tool is the "girl roster tool" developed by Population council[6], which has been credited as an innovative approach to ending the gender data gap. Box 2 provides a brief summary of the girl roster tool and steps followed in the protective asset building approach.

Box 2 - The girl roster tool

This tool has been used by implementers in communities to reach more girls in more cost effective ways to attain measurable results. The tool helps program managers enumerate the universe of girls in the program community , break them into meaningful segments by age, schooling, by marital, childbearing and living arrangement status and through appropriate community engagement increase girls access to a fair share of community resources. It maps vulnerable AGYW in a geographic area. Information gathered is used to prioritize the most vulnerable girls to enroll in the program especially in cases where there is funding constraint.

The Protective Asset-Building Approach

It involves the following:

Step 1: Identify geographic area based on available data for example, HIV Prevalence/incidence, early marriage, school dropout rates etc.

Step 2: Intentional recruitment of those most in need. Aim to reach those socially excluded and not rely on demand-led recruitment

Step 3: Segment to find the right girls - do not treat girls and young women as a homogenous group. Understand the unique risks and opportunities facing different sub populations or segments and tailor programs accordingly

Step 4: Identify resources and structures on the "walkable community" that provide personal safety to the target group and allow them to take action. Community – not just physical boundary but also people and resources who define their social space.

Step 5: Identify safe spaces to deliver community based interventions. Establish community based platforms that are accessible, private and safe and where AGYW can meet regularly with peers and mentors.

Step 6: Build social and other protective assets. Assets is a store of value tangible or intangible that programs build to empower girls and young women and enable them reduce their vulnerability, risks and expand their opportunities.

[5] Preventing HIV in Adolescent Girls and Young Women (AGYW) Guidance for PEPFAR Country Teams, Dec 2014

[6] Population Council The girl roster, 15th May, 2016 publication

An asset is a store of value that AGYW can use to reduce vulnerabilities and expand opportunities. Examples include social assets (self-esteem, social networks, group membership, relationships of trust, access to wider institutions of society), economic assets (cash, savings) and human assets (skills and knowledge, self-esteem, bargaining power, autonomy and control over decisions).

Source: Population Council (2010), Girl-Centered Program Design Tool Kit

2. Identification and prioritization of the right mix of interventions

The UNAIDS guidance[7] on HIV prevention among adolescent girls and young women provides a detailed strategic mix of HIV interventions, a menu of option for countries and programs planning to implement combination prevention packages for AGYW. It is critical that programs setting out to implement AGYW programs identify the right mix of age appropriate interventions relevant to their country context. This should include decisions on the scale and intensity at which to implement a defined package of interventions in order to maximize impact. Prioritization of interventions should be based on country or geographic context and the epidemiologic setting. Among other things it should take into account the following:

- Epidemiological trends and the key drivers of the epidemic
- National strategic plans on AGYW programming
- Lessons learnt from similar AGYW programs
- Level of programmatic gap based on what other partners are supporting
- Existing evidence on Intervention effectiveness

Overall, these decisions should focus on interventions or a combination of interventions that give the most efficient use of available resources while delivering desired results. Countries should define a package of interventions suitable for their specific context. The United States President's Emergency Plan for AIDS Relief (PEPFAR), World Bank and United Nations Population Fund (UNFPA)[8] have documented reviews of existing evidence for HIV prevention interventions among young women and rated different interventions as either most effective, moderately effective or not effective (Annex 2 and 3). This information can be used to support selection of interventions especially in resource-constrained situations.

3. Tracking service provision for Adolescents Girls and Young Women programs

3.1. Identify data needs and select indicators

In order to support program monitoring, it is important to identify- what data elements are needed to inform progress, what information is needed for program management, planning and decision making and for national and global reporting, how frequently the data or information is needed and in what format.

[7] UNAIDS 2016 Guidance- HIV Prevention among adolescent girls and young women
[8] UNAIDS 2016 Guidance- HIV prevention among adolescent girls and young women

This will help develop a strong data system that is responsive to program and country data needs, enhancing availability and use of high quality data for program management at various levels. Table 1 below provides a list of indicators for reference, to be used to during program planning to identify and select indicators relevant to specific interventions being implemented by the country. Box 3 below provides a summary of key considerations for indicator selection for Global Fund grants. This guidance applies to all new Global Fund grants and any grants undergoing revisions during grant implementation.

Box 3 - Indicator selection in Global Fund grants

As a part of the grant agreement, the Global Fund requires a performance framework. The performance framework is a statement of intended performance and impact, to be reported to the Global Fund over the grant period. It includes a small set of impact, outcome and coverage indicators and targets, linked to the goals and objectives of the program supported by the Global Fund.

The performance framework is used to track progress of the Global Fund grant supported programs and forms the basis for routine disbursements to the Principal Recipient during grant implementation. The performance framework is an essential part of the Grant Agreement between the Principal Recipient and the Global Fund.

The Global Fund has identified a core list of indicators derived from available technical partner guidance. In addition to the indicators for HIV, TB, Malaria and HSS, it includes a set of indicators to track coverage, outcome and impact of AGYW programs. The core list is available on the Global Fund website- Modular Framework Handbook. Complementing this list, some additional indicators have been proposed that can be included as custom indicators in the grant performance frameworks, to capture any interventions not covered by the core list. Table 1 includes all the recommended indicators that can be used in Global Fund grants to report progress in implementing programs for adolescent girls and young women including the13 selected countries. To ensure consistency of data from all countries and comparability over time countries should select indicators from this proposed list.

The use of these indicators in the grant performance frameworks is critical to successful grant monitoring and reporting of progress. Where necessary, countries should include plans for strengthening monitoring and evaluations systems to be able report on these indicators in their funding requests to the Global Fund.

Please note that the grant performance framework may not meet all the data needs in the country. Additional information may be required to meet the program needs and to assess the overall performance of the program.

The indicators selected in the grant performance frameworks should be:

- ✓ Relevant to the epidemic and aligned to the national program priorities and interventions supported by the grants
- ✓ Appropriate to measure the goals and objectives of the programme
- ✓ Monitor progress of impact, outcome and coverage at national level. In some specific cases, these may be reported at sub-national or project level
- ✓ Relevant to the AGYW being reached by the grant

- ✓ As much as possible selected from the proposed list
- ✓ Supported by adequate systems to collect and report high-quality data for all indicators

The results against the selected indicators are reported using the Global Fund progress reporting templates. The performance framework also requires the countries to report on disaggregated data (by age groups 15-19 and 20-24 and by sex) for some of the impact/outcome and coverage indicators when they report on programmatic results.

Box 4 - Global Fund Key Performance Indicators

The Global Fund's 2017-2022 Strategic Key Performance Indicator (KPI) Framework was developed in line with the Global Fund's 2017-2022 Strategy. The Framework consists of twelve Strategic KPIs to measure progress towards the strategy's targets and objectives set out for the next six years. The strategic KPI 8 and the related operational KPI aim to ensure reduction in new HIV infections among AGYW based on evidence informed comprehensive programming.

Strategic KPI-8: HIV incidence in women aged 15-24

Operational KPI: Percentage of AGYW reached with HIV prevention programs (defined package of services)

These KPIs are to be reported from 13 countries implementing programs targeting AGYW. The countries are selected from Sub-Saharan Africa having- 1) highest estimated HIV incidence rates among 15-24 year old females; 2) female-male ratio of new infections in 15-24 >1. HIV incidence estimates are derived from the Goals model (2016), which uses EPP/Spectrum estimates.

The operational KPI is to ensure countries implement comprehensive package of prevention programs for AGYW in order to drive incidence reduction. It is included in the grant performance frameworks and reported through regular progress updates.

In addition, The Global Fund requires reporting on results disaggregated by age and sex for selected indicators and is monitoring countries' performance in this regard through **KPI 6e (number and percentage of countries reporting on disaggregated results)**. It aims to ensure the availability of disaggregated data and its use in making evidence informed program and policy decisions.

Table 1: Recommended impact, outcome and coverage indicators for AGYW programs*

Category	AGYW Interventions in GF technical brief	Interventions in the modular framework	Indicator code	Coverage Indicator	Outcome Indicator	Impact indicator
	All interventions	**All interventions**	**YP-2**	**Percentage of adolescent girls and young women (AGYW) reached with HIV prevention programs- defined package of services**		HIV I-14: **Number of new HIV infections per 1000 uninfected population**
Biomedical	HIV Testing services	HIV testing services for adolescents and youth, in and out of school	YP-3	Number of adolescent girls and young women who were tested for HIV and received their results during the reporting period	HIV O-11: Percentage of (estimated) people living with HIV who have been tested HIV-positive	
Biomedical	HIV treatment adherence and care	Treatment, care and support	TCS-1 (M)	Percentage of people living with HIV currently receiving antiretroviral therapy	HIV O-1: Percentage of adults and children with HIV, known to be on treatment 12 months after initiation of antiretroviral therapy	
Biomedical	PreP	Pre-exposure prophylaxis (PrEP) for adolescents and youth	YP-4	Percentage of adolescent girls and young women using PrEP		
Biomedical	VMMC	Male circumcision (module-Prevention progs for GP)	GP-5	Number of medical male circumcisions performed according to national standards	HIV O-12: Percentage of people living with HIV and on ART who are virologically suppressed	
Behavioural	Social and behavioral change communication programmes Comprehensive Sexuality Education (including life skill education) Condom promotion and distribution (female & male)	Behavioral change as part of programs for adolescent and youth; Male and female condoms for adolescents and youth, in and out of school; Linkages between HIV programs and RMNCH	YP-1	Percentage of young people aged 10–24 years reached by life skills–based HIV education in schools	Percentage of young women age 15 - 24 who had 2+ partners in the past 12 months (Source:DHS) GAM (3.18): Percent of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months (Disagg to provide F 15 - 24yrs) Percentage of females age 15-24 who report unintended pregnancy of current pregnancy or most recent births (teen pregnancy) (Source: UNFPA (FP 2020 indicator no. 5)	
Behavioural			Custom	Percentage of young people aged 10 -24 years reached by comprehensive sexuality education (Comprehensive Sexuality Education)		
Structural	Transforming harmful cultural and gender norms through community mobilization Reducing stigma and discrimination reduction and increasing access to justice	Addressing stigma, discrimination and legal barriers to care for adolescents and youth; Community mobilization and norms change	Custom	Percentage of AGYW who received GBV related services e.g referral for legal or medical care including Post Violence Care (PEP)	HIV O-13: Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months Proportion of people who have an independent source of income by sex and age (Source: UN Women SDG 1 (Ending poverty) Percentage of females aged 15 - 24 who dropped out of school in the last year (Source: Education sector)	
Structural	GBV including intimate partner violence prevention and management	Gender-based violence prevention and treatment programs for adolescents and youth				
Structural	Financial incentives including cash transfers and other economic empowerment approaches; Livelihood Support	Socioeconomic approaches	Custom	Percentage of AGYW who received livelihood support (cash transfer or other economic empowerment approaches)		
Structural	Keeping girls in school	Keeping girls in school	Custom	Percentage of AGYW who received education subsidy or other "keeping girls in school" initiative		

*More than one intervention can contribute to achievement of outcome and impact indicators

3.2. Conduct Adolescents girls and young women M&E systems assessment

Once program data needs and appropriate indicators have been identified, implementers should find out if existing M&E system is responsive to identified data needs. The focus should be to build and strengthen existing systems. Conducting a comprehensive assessment of existing country level AGYW M&E systems will help identify gaps and inform country action plans towards developing a robust M&E systems for AGYW programs. Assessments should look at the existing service delivery modalities and platforms including identification and enrollment mechanisms, availability of measurement and reporting mechanisms (routine reporting, surveys and surveillance), tracking of referrals and linkages, ways of addressing potential duplication with regards to unique identification of beneficiaries, data quality assurance mechanisms, data collection and analytical capacities etc. The WHO/GF M&E system assessment tool[9] can be adapted for such an assessment.

3.3. Invest to strengthen existing Adolescents girls and young women M&E systems

In collaboration with other partners including national governments, information gathered from the assessment of needs and gaps should inform investments in M&E systems to ensure adequate tracking of programmatic results and investments for adolescents and youth, including AGYW, with age disaggregation. As mentioned earlier, majority of AGYW HIV prevention interventions are delivered at the community level, which also have weak data systems in most countries. Consequently, deliberate efforts to strengthen community level data systems ensuring linkage with health facility data systems are needed. This will lead to availability of both community and facility level data at sub national and national levels.

Given below is an illustrative list of areas for investments in M&E systems to improve monitoring and evaluation of AGYW programs:

a) Routine reporting
   - Scaling up systems for health facility and community level reporting
   - Mechanism to aggregate data from various sources at regional and national levels.
   - Development and printing of data collection tools.
   - System for reporting age/sex disaggregated data.
   - Setting up an effective referral and linkage mechanism between different service points including health facility.

b) Program and data quality assurance mechanisms

c) Surveys (population based and among risk groups - AGYW) for reporting on program outcomes and impact
   - Strengthen platforms that measure outcome and impact of AGYW programs, for example; ensuring existing surveys/special studies capture indicators related to AGYW, individual level outcome data, increasing availability of AGYW data for modeling purposes etc.

d) Analytical capacity and reviews - training of staff in data collection, analysis, reviews and use of data to inform programmatic decision making and planning.

[9] WHO/GF HMN Monitoring and Evaluation Systems Strengthening Tool

e) Administrative and financial data sources- to allow for financial analysis such as cost efficiency/effectiveness analysis
f) Civil registration and vital statistics systems- to gather AGYW related information especially on deaths.

3.4. Program monitoring

Accurate, timely and reliable monitoring of AGYW programs is critical to track progress towards the goal of reducing new HIV infections among females 15 – 24 years old. Systematic collection of data will help identify trends and understand differences in processes or outcomes across various sub-groups of AGYW over time across geographic locations.

To facilitate regular and complete reporting, AGYW programs should ensure that:

- Data collection forms/tools are standardized, simple and user-friendly (enrollment forms, service uptake forms, referral and linkage forms, data summary forms and a system to minimize double counting)
- Data collection forms/tools are available at all levels; relevant staff trained on using these forms
- Where possible, data collection methods and tools are harmonized across service delivery points
- Roles and responsibilities for staff for different monitoring tasks is clear
- Only relevant information is collected for program management and decision making

In addition, the monitoring system should strive to minimize double counting of individuals by reporting unique individuals receiving a defined package of service and to monitor how well a program is layering services, an analysis of the proportion of age groups (10-14, 15 – 19 20 -24) receiving one or more services as identified in the package of services is needed. This is an important pointer to service coverage for the different age groups and a dimension of program quality.

Outcome measurement: The pathway of change underpins the importance of monitoring HIV prevention outcomes that lead to reduction in new HIV infections. Monitoring of HIV prevention outcome indicators can be through existing platforms such as demographic health surveys (DHS), violence against children (VAC) surveys or special studies commissioned for this purpose. As a way of tracking individual level outcomes, programs are encouraged to document HIV positivity rates based on HIV testing data to measure progress especially in settings where incidence and outcome data is not readily available. In addition, the programs should link both positive and negative individuals with specific AGYW interventions. Tracking outcome level indicators in GF programs is important in understanding if programs are contributing to reduction in new HIV infections for this population. For list of outcome indicators used in Global Fund grants, refer to Table 1 and Annex 1.

3.5. Monitoring referral-linkages and coordination among service providers

Because of the multi-sectoral and multi-layered approach in AGYW programs, it is critical to strengthen collaboration and coordination among different service providers ensuring a comprehensive approach in addressing the needs of AGYW. This will help avoid double counting of unique individuals who receive different services from different service providers. In addition, a good referral and linkage system with a mechanism of monitoring successful linkages is paramount. Often this is challenging in diverse geographical areas that do not have unique identifiers for all clients

receiving HIV prevention interventions. However, this could be possible within smaller geographical implementation areas with good coordination and collaboration among different service providers.

Box 5 below is an example of how programs can establish a system for counting unique beneficiaries in a multi layered service delivery platform.

Box 5 - Steps to ensuring unique counting of beneficiaries because of service layering.

Wherever possible, the AGYW program should ensure there is one principle recipient, sub-recipient or other community based organization responsible for all clients and keeps all their records i.e. enrollment and service uptake data. They should update client records every time beneficiaries access a service. It may however not be possible to ensure that all services are provided by one entity. In such cases, where a service has been received elsewhere, a completed referral form indicating that the beneficiary received the service must be shared with the referring entity to update beneficiary service uptake forms. A summary tool that aggregates both unique individuals supported with the defined package of interventions in the program and the total number of beneficiaries who received each of the services is needed e.g. number who received cash transfer, number who received life skills education etc. To compute unique individuals who were reached, the responsible entity should develop a unique identity for every girl that is enrolled in the program – one can make use of existing administrative unit codes/numbers combined with serial numbering as girls are enrolled. This can be generated in a simple excel spreadsheet that tracks girls who are in the clients loop. Where possible, investments need to be geared towards Access-Based database that is programmed to generate unique IDs at enrollment and captures all service data. The program should generate two key outputs among other data outputs on a monthly, quarterly and annual basis- unique girls reached in a given time period receiving all interventions in the defined package as per the agreed frequency and intensity and the numbers reached with individual services. In a scenario where different departments/agencies or implementers are supporting different services to the same population, mechanisms should be put in place to for de-duplicating final results before they are reported to the next level. The method and process of setting up a unique identifier system should be discussed and agreed upon by all the implementing agencies.

3.6. Data quality

Data quality assurance mechanisms should be in place to assess the quality of data and provide timely correction where necessary. This includes periodic programmatic spot checks, desk reviews, data quality reviews and field monitoring activities by implementers to ensure that reported data meets the minimum data quality standards. Where possible use of technology should be explored for data capture and reporting as a means of reducing errors that emanate from manual paper based systems. As data flows from implementation sites to the next levels, districts, provincial, national and global levels it should be systematically verified and timely correction made where necessary to ensure quality data is available for decision making at all levels.

3.7 Program quality

Similarly, periodic program quality assessments that look at specific program quality parameters should be in place. Examples of quality parameters include- implementation of evidence based interventions within approved boundaries and dosage, age appropriateness of interventions, in country coordination especially in a multi sectoral implementation platform within the context of layering services etc. Currently, there is no single global guidance on program quality assessments. However, where available countries can adapt existing tools based on quality parameters recommended by partners and agreed in country to assess how programs are ensuring quality programming. If possible, programs should design and implement community monitoring of quality of services for both community and health facility level interventions

V. Evaluations and Program Reviews

a. Program reviews

Structured and systematic in-country program reviews and synthesis of available AGYW data will be critical to identify programmatic gaps and opportunities for program improvement. In addition, reviews will provide opportunity for program managers at national and sub-national levels to identify key implementation issues and make informed decision for effective implementation.[10]

AGYW programs should aim to undertake the following analysis;

- Coverage of different AGYW age groups with various HIV prevention interventions against set targets,
- Layering of HIV prevention services, periodicity and intensity as part of the HIV prevention cascade,
- Individual and population level outcomes such as reduction in risky sexual behaviors, and
- Impact of different interventions on new HIV infection.

The list is not exhaustive and can be expanded depending on need and availability of data.

Outcomes from such analysis and reviews should inform necessary adjustments in program implementation leading to reprogramming of GF grants as needed.

b. Program evaluation

Evaluation of AGYW programs or specific interventions will generate evidence of what is working and what is not working and help improve ongoing programs and future program designs and scale up. In addition, specific country evaluations could also provide information on program effectiveness, sustainability, quality of services and quality of data. Depending on the design, they can define causal pathways and determine any link (or lack of it) between the interventions targeted at AGYW and achieved results. Findings will allow program managers, beneficiaries, partners, donors including the Global Fund and other stakeholders to learn from the experience and to improve intervention prioritization and implementation approaches.

[10] THE GLOBAL FUND STRATEGIC FRAMEWORK FOR DATA USE FOR ACTION AND IMPROVEMENT (2017-2022) Draft 31 January 2018

These evaluations could be country led or led by partners and other donors including the Global Fund. In addition to any other aspects deemed necessary by the program, the evaluations should address the following questions:

- if country programs are reaching and engaging in a meaningful way the most vulnerable AGYW;
- if program design and implementation framework is contributing to increased delivery of quality services to AGYW interventions;
- if interventions are effective and the program is meeting the needs of AGYW;
- how the interventions are symbiotic, or the intervention mix is contributing to the overall aim;
- effectiveness of M&E systems, program and data quality assurance mechanisms in tracking progress towards program objectives;
- national governments commitments towards sustainability

The scope of the evaluations should be based on country context and relevance to the program, program-funding levels and identified risks during implementation. For countries piloting new AGYW interventions or implementation approaches, these evaluations can provide information that can be used to make decisions on whether to scale up the interventions. The Global Fund has developed a scope of work for service providers that will support countries in evaluating AGYW programs (refer to annex 3). It outlines broad areas for consideration when planning for an evaluation of AGYW programs. Where possible, countries are encouraged to undertake joint evaluations together with partners, such as, PEPFAR DREAMS initiative.

In addition, in order to improve the Global Fund model and programs, prospective country evaluations are being undertaken in two AGYW focus countries (Uganda and Mozambique) led by Technical Evaluation Reference Group (TERG)[11]. These program evaluations will establish country platforms that support dynamic, continuous monitoring and evaluation, learning and problem solving including interventions related to AGYW.

c. Impact evaluation and incidence measurement

Global Fund's strategic KPI 8 "Percentage reduction in HIV incidence in women aged 15-24" measures progress towards the goal of reducing new HIV infections among females aged 15 – 24 years. Currently most countries rely on models to estimate national level data on new HIV infection due to limitations in current data platforms and systems to compute actual number of new HIV infections at national level. According to WHO working group on HIV Incidence assays[12], several methods for estimating HIV incidence have been developed and used in developed and developing countries. These include, cohort studies, modelling of repeated cross-sectional measures of prevalence, and cross-sectional use of biomarker assays for recent infections. Where possible, countries implementing AGYW programs should also compute the estimates of new HIV infections at sub-national level, using one of the following methods:

[11] The Technical Evaluation Reference Group (TERG) is an independent evaluation advisory group, accountable to the Global Fund Board through its Strategy Committee for ensuring independent evaluation of the Global Fund business model, investments and impact https://www.theglobalfund.org/en/technical-evaluation-reference-group/

[12] WHO Working Group on HIV Incidence Assays. Estimating HIV incidence using HIV case surveillance. Meeting report, Glion, Switzerland, 10–11 December 2015. Geneva: World Health Organization; 2017 (WHO/HIV/2017.03). Licence: CC BY-NC-SA 3.0 IGO.

a. Cross sectional analysis of HIV testing data: this involves analysis of routine programmatic data on HIV testing among females aged 15 – 24 years, comparing girls within and outside of the intervention areas over a given time period.
b. Cohort analysis of programmatic data: this method uses routinely collected HIV testing data. It takes into account the time when individuals are enrolled in the program, the time when they sero- convert to HIV positive status and the duration they stay in the program. Depending on the nature of the cohort group, whether strict cohort or dynamic/open cohort computation of HIV incidence will vary. For a dynamic/open cohort, computation of HIV incidence uses person-years as the denominator and number of those who sero-converted as numerator. This analysis can be linked to data on exposure and intensity of interventions to estimate effect of interventions on HIV infection. AGYW programs need to have data systems that collect individual level data on variables mentioned above to support computation of new HIV infection using programmatic data. In addition, analysis of programmatic data can also provide the proportion of those who retain HIV negative status from an initial HIV negative test result. The aim of HIV prevention programs is to ensure that those who are HIV negative retain their HIV negative status.
c. Lag Avidity assay: this relies on HIV positive blood sample and measures recency of HIV infection to compute new HIV infection. This method can be used in sentinel surveillance sites or antenatal clinics.
d. Population Based HIV Impact Assessment Surveys (PHIAS): These are multi country household surveys that measure the reach and impact of HIV programs. Specifically, these surveys measure HIV incidence, prevalence and viral suppression among other behavioral parameters. This is a good data source for national HIV incidence in GF AGYW focus countries for establishing baseline and monitoring impact of AGYW programs at national level and at sub national where such surveys are powered to do so. The challenge is in aligning timing of the surveys with program implementation and reporting timelines. In addition, in countries where interventions are not to scale, national surveys will not document sub – national or program specific impact of the intervention. In such cases, site or sub population methods of measuring change in knowledge, behavioral and biological outcomes should be considered.

Table 3: List of completed and ongoing surveys to measure population level outcomes and HIV incidence*

Country	**Population based HIV Impact Assessments (PHIAs)**	**Violence against Children Survey (VACs)**	**Demographic Health Survey (DHS)**
Indicators	Incidence, prevalence, HIV-related risk behaviors	Prevalence of violence by type (GBV, Sexual violence etc.)	Gender/domestic violence, women empowerment etc.
Botswana		2017 ongoing	1988
Cameroon	2017/18 ongoing		2011
Kenya	2017/18 ongoing	**2012 complete** 2017/18 ongoing	2014/15
Lesotho	**2016/17 complete**	2017/18 ongoing	2014
Malawi	**2015/2016 complete**		2015/16
Mozambique	AIS (2015)	2017/18 ongoing	2011
Namibia	2017/18 ongoing	2017/18 ongoing	2013
South Africa			
Swaziland	**2016/2017 complete**	**2007 complete**	2006/07

Tanzania (United Republic)		**2012 complete**	2015/16
Uganda	**2016/17 complete**	2017 ongoing	2016
Zambia	**2015/16 complete**	2017 ongoing	2013/14
Zimbabwe	**2015/16 complete**	**2013 complete** 2017 ongoing	2015

*Note: only the PHIAs and a few DHS have collected incidence data

e. HIV incidence model: UNAIDS supports countries to develop estimates of new HIV infections including among females 15-24 years. Models are developed annually in collaboration with partners using the best available data. Although these modeled estimates of incidence are not very precise for short term changes (less than two years); they can provide important indication of incidence decline over longer periods. The estimates are available for most countries at the national level and for most of the high HIV burden countries at sub-national levels. Full descriptions of the input and techniques used in the models are available at UNAIDS website. The AIDS impact module in Spectrum is used to model the historic and current estimates of HIV. The Goals module in Spectrum can also be used to project the impact of future interventions. A new age-sex Goals module is currently being developed to more accurately estimate the impact of different coverage on AGYW.

VI. Data Use- learning, adjusting, program improvement

At country level, AGYW related data and information is needed for planning (development of national strategic plans, annual operational planning at national and sub-national levels), program management and implementation, reparation of funding applications to donors etc. Countries should undertake regular systematic in-country analysis and reviews to identify bottlenecks and opportunities for increasing program performance, quality of services, efficiency and impact. Existing information sharing platforms should be strengthened to foster ongoing learning and improve evidence informed programmatic decision making.

Where needed, the capacity of community based organizations implementing AGYW programs should be strengthened to enable simple data analysis that could generate evidence for program management and planning. In country and cross country sharing of lessons learnt and best practices on what works and what does not work should be encouraged and supported for program improvement.

Annex 1: Global Fund Core list of AGYW Indicators

The following is a list of core and additional custom indicators that grants supporting Adolescents Girls and Young Women programs should include in their performance frameworks based on specific AGYW interventions supported by the Global Fund grant.[13]

Indicator code	Indicator	Numerator	Denominator	Data source	Reporting frequency to GF	Disaggregation of reported results	Additional information required for analysis
HIV I-14 **Impact**	Number of new HIV infections per 1000 uninfected population	Number of new infections	Total uninfected population (which is the total population minus people living with HIV) x 1000	Internationally consistent modelled estimates, e.g. Spectrum AIM; Derived from analysis of country data on HIV prevalence, particularly among young age groups and where available, direct HIV incidence data.	Annual	Sex (female, male) Age (0-14, 15+) Age|Gender 15-19 (by female, male) Age|Gender 20-24 (by female, male)	
HIV I-13 **Impact**	Number and % of people living with HIV	Number of people living with HIV	Total population	Surveys, surveillance (including case-based surveillance) and national demographic and program data, with globally consistent estimation method.	Annual	Sex (female, male) Age (0-14, 15+) Age|Gender 15-19 (by female, male) Age|Gender 20-24 (by female, male)	When available in survey reports, provide the disaggregated prevalence data.

[13] For HIV O-11, 12 and 13 there is no disaggregation required in the core list. It is recommended that the programs focusing on AGYW collect disaggregated data by age groups 15-19 and 20-24 for indicator HIV O-11, 12 and 13

HIV I-4 **Impact**	Number of AIDS related deaths per 100,000 population	Number of people dying from AIDS-related causes	Total population per 100,000	1. Vital Registration 2. Facility- or population-based survey that may include verbal autopsy 3. Mathematical modelling using such tools as Spectrum	Annual	Sex (female, male) Age (0-14, 15+) Age|Gender 15-19 (by female, male) Age|Gender 20-24 (by female, male)	
HIV O-11 **Outcome**	Percentage of (estimated) people living with HIV who have been tested HIV-positive	Number of people living with HIV who have been diagnosed with HIV and received their results	Estimated number of people living with HIV	Best estimate based on available sources, e.g. 1. HIV case reports or representative case based surveillance data (numerator) and national PLHIV estimate based on modelled estimates (denominator); 2. Population-based surveys	Annual	Age|Gender 15-19 (by female, male)[11] Age|Gender 20-24 (by female, male)[11]	
HIV O-1 **Outcome**	Percentage of adults and children with HIV, known to be on treatment 12 months after initiation of antiretroviral therapy	Number of adults and children who are still alive and receiving antiretroviral therapy 12 months after initiating treatment	Total number of adults and children who initiated ART who were expected to achieve 12-month outcomes within the reporting period	Program monitoring tools; ART registers and cohort and group analysis forms	Annual	Sex (female, male) Age (0-14; 15+) Duration of treatment -24, 36 and 60 months	Report by pregnancy status at start of therapy
HIV O-12 **Outcome**	Percentage of people living with HIV and on ART who are virologically suppressed	Number of people living with HIV and on ART who have suppressed viral load (<1000 copies per mL)	Number of people living with HIV who are currently receiving ART	ART register and cross-sectional report, patient records Population-based survey, such as Health-Impact Assessment surveys, that collect data on ART coverage and viral suppression	Annual	Age|Gender 15-19 (by female, male)[11] Age|Gender 20-24 (by female, male)[11]	
HIV O-13 **Outcome**	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a	Women 15–49 years old who have or have ever had an intimate partner and report experiencing physical	Total number of women 15–49 years old surveyed who currently have or	Population-based surveys, such as WHO multi-country surveys, Demographic and Health Surveys or AIDS Indicator Surveys (domestic	3-5 years	Age 15 – 19; 20 - 24[11]	

	male intimate partner in the past 12 months	or sexual violence from at least one of these partners in the past 12 months.	have had an intimate partner	violence module) and the International Violence against Women Surveys.			
Custom **Outcome**	Percentage of young women age 15 - 24 who had 2+ partners in the past 12 months	Number of young women age 15 - 24 who had 2+ partners in the past 12 months	Total number of women age 15 – 24 who have had sexual intercourse in the past 12 months	DHS, Special studies	3-5 years or adapted to existing need	Age 15 – 19, 20 - 24	
Custom **Outcome (GAM (3.18)**	Among women 15 - 24 who had 2+ partners in the past 12 months, percentage of those who reported using condoms in the last sexual intercourse	Number of women 15 - 24 who had 2+ partners and used a in the last sexual intercourse	Total number of women age 15 – 24 who have had sexual intercourse with 2+ sexual partners	DHS, Special studies	3-5 years or adapted to existing need	Age 15 – 19, 20 - 24	
Custom **Outcome UNFPA (FP 2020 indicator no. 5)**	Percentage of females age 15-24 who report unintended pregnancy of current pregnancy or most recent births (teen pregnancy)	Number of females age 15-24 who report unintended pregnancy of current pregnancy or most recent births (teen pregnancy)	Total number of females 15-24 currently pregnant or who has had a child within the last one year	DHS, Special studies	3-5 years or adapted to existing need	Age 15 – 19, 20 - 24	
Custom **Outcome (UN Women SDG 1 (Ending poverty)**	Proportion of people who have an independent source of income	Number of young people reached with socio-economic empowerment intervention	Total number of 15-24 surveyed or in study group	Special study	As planned	Age|Gender 15-19 (by female, male) Age|Gender 20-24 (by female, male)	

Custom **Outcome**	Percentage of females aged 15 - 24 who dropped out of school in the last year	Number of females aged 15 - 24 who dropped out of school in the last year	Total number of 15-24 surveyed or in study group	DHS, Education survey, Special studies	3-5 years or adapted to existing need	Age 15 – 19, 20 - 24	
YP-1 **Coverage**	Percentage of young people aged 10–24 years reached by life skills–based HIV education in schools	Number of young people reached through any effort to affect change, including peer education, classroom, small group, and/or one-on-one information, education and communication or behavior change communication to promote change in behavior in a school setting	Number of young people attending targeted schools	Program records	Annual and every six months; In Focused countries-Annual		
YP-2 **Coverage**	Percentage of adolescent girls and young women (AGYW) reached with HIV prevention programs-defined package of services	Number of adolescent girls and young women reached with HIV prevention programs-defined package of services	Estimated number of AGYW in the targeted area	Program records	Annual and every six months; In Focused countries-Annual		1. Specify the components of the HIV prevention package. 2. Expected frequency of contacts per month/qrt/six months 3. Describe the system in place to avoid double counting. 4.Survey results when available

YP-3 **Coverage**	Number of adolescent girls and young women (AGYW) who were tested for HIV and received their results during the reporting period	Number of adolescent girls and young women who were tested for HIV and received their results in the reporting period		Program records	Annual and every six months; In Focused countries- Annual	Age 15-19, 20-24, 15-24* Test result (positive, negative) *Age 15-24 is to be reported in cases where data for age groups 15-19 and 20-24 is not available	
YP-4 **Coverage**	Percentage of adolescent girls and young women (AGYW) using PrEP	Number of adolescent girls and young women (AGYW) using PrEP	Number of adolescent girls and young women in priority AGYW populations	Program records			
Custom **Coverage**	Percentage of adolescent girls and young women (AGYW) who received PEP	Number of adolescent girls and young women (AGYW) who received PEP	Total number of adolescent girls and young women in priority AGYW populations	Program records	Annual and every six months; In Focused countries- Annual	Disaggregate by sexual violence, occupational and other reasons	
Custom **Coverage**	Number of AGYW who received GBV related services (e.g. referral for legal or medical care e.g. PEP)	Number of AGYW who received GBV related services (e.g. referral for legal or medical care e.g. PEP)	Total number of adolescent girls and young women in priority AGYW populations	Program records	Annual and every six months; In Focused countries- Annual		
Custom **Coverage**	Percentage of AGYW who received livelihood support (cash transfer or other economic empowerment approaches)	Number of AGYW who received livelihood support (cash transfer or other economic	Total number of adolescent girls and young women in priority AGYW populations	Program records	Annual and every six months;		

		empowerment approaches)			In Focused countries- Annual		
Custom **Coverage**	Percentage of AGYW who received education subsidy or other "keeping girls in school" initiative	Number of AGYW who received education subsidy or other "keeping girls in school" initiative	Total number of adolescent girls and young women in priority AGYW populations	Program records	Annual and every six months; In Focused countries- Annual		
GP-5	Number of medical male circumcisions performed according to national standards	Number of medical male circumcisions performed according to national standards			Annual and every six months; In Focused countries- Annual		
TCS-1 (M)	Percentage of people living with HIV that initiated ART with a CD4 count of <200 cells/mm3	Number of PLHIV who initiated ART 12 months (±3 months) before the start of the reporting period and who have a suppressed viral load (<1000 copies/ml) at 12 months after initiating ART	Number of people living with HIV who initiated ART 12 months (±3 months) before the start of the reporting period	N&D: Program records, e.g. ART register, cohort reporting forms, patient records, combined with estimates for the population with no VL data	Annual and every six months; In Focused countries- Annual	Age | Gender 15-19 (female, male) Age | Gender 20-24 (female, male)	
TCS-3.1	Percentage of people living with HIV and on antiretroviral therapy who have a suppressed viral load at 12 months (<1000 copies/ml)	Number of PLHIV who initiated ART 12 months (±3 months) before the start of the reporting period and who have a suppressed viral load	Number of people living with HIV who initiated ART 12 months (±3 months) before the start of the reporting period	N&D: Program records, e.g. ART register, cohort reporting forms, patient records, combined with estimates for the population with no VL data	Annual and every six months; In Focused	Age | Gender 15-19 (female, male) Age | Gender 20-24 (female, male)	

		(<1000 copies/ml) at 12 months after initiating ART			countries- Annual		

Annex 2: PEPFAR Core Package Evidence[14]

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

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

A Three or more experimental trials, meta-analyses, and/or several high quality quasi-experimental studies coupled with evidence from observational studies
B 1-2 experimental studies or high quality quasi-experimental studies coupled with evidence from observational studies
C Observational data only, or only one quasi-experimental study and few observational studies

[14] PEPFAR Guidance (Draft Dec 9th 2014) Preventing HIV in Adolescent Girls and Young Women (AGYW)

Annex 3. Core package of interventions – Level of Evidence & Outcomes Impacted[15]

Adolescent-Friendly Sexual Reproductive Health for Girls				
Intervention	Biologic Outcomes	Biologic Outcomes - Evidence	Behavioral Outcomes	Behavioral Outcomes - Evidence
Condoms (female and male)	Most data are from male condoms	A1		
PrEP	HIV incidence	A2		
Post-Violence Care (PEP)	HIV acquisition	B2		
Post- Violence Care, beyond PEP (trauma focused counseling)			Reduced trauma symptoms, functional impairment, depression	A2
Post- Violence Care, beyond PEP (advocacy/case management)			Decreased physical abuse by intimate partners; higher quality of life and social support; less difficulty obtaining community resources	B2
Post- Violence Care, beyond PEP (parenting programs)			Decreased physical abuse by caregivers	B3
Post- Violence Care, beyond PEP (short-term emergency housing)				Prudent Practice
HTC		Prudent Practice		Prudent Practice
↑ Contraceptive Mix (in countries with generalized epidemics)		Prudent Practice		
Strengthening the Community				
Intervention	Biologic Outcomes	Biologic Outcomes - Evidence	Behavioral Outcomes	Behavioral Outcomes - Evidence
School-Based HIV Prevention	Pregnancy, STIs	B3	Reduced number of sexual partners; reduced frequency of sex and unprotected sex; increased male and female condom use; delayed sexual debut	A3
Community Mobilization/ Norms Change		Prudent Practice		Prudent Practice

[15] PEPFAR Guidance (Draft Dec 9th 2014) Preventing HIV in Adolescent Girls and Young Women (AGYW)

Strengthening the Family				
Intervention	Biologic Outcomes	Biologic Outcomes - Evidence	Behavioral Outcomes	Behavioral Outcomes - Evidence
Parenting/Caregiver Programs			Increased male and female condom use; delayed sexual debut	A3
Unconditional Cash Transfers	HIV prevalence, HSV incidence	B1	Decreased involvement with age-disparate sex, multiple partners, transactional sex; delayed sexual debut	B1
Conditional Cash Transfers-Education	HIV prevalence, HSV incidence	B2	Decreased childbearing; delayed sexual debut	B2
Education subsidy (uniforms, fees, adult mentors)			Decreased school dropout; delayed sexual debut	B3
Combination Socio-Economic Approaches			Decreased involvement with age-disparate sex, multiple partners, transactional sex; decreased childbearing; increased male and female condom use	B1
Decreasing Risk in Sex Partners				
Intervention	Biologic Outcomes	Biologic Outcomes - Evidence	Behavioral Outcomes	Behavioral Outcomes - Evidence
ART (Male Partners)	HIV incidence	A1		
VMMC (Male Partners)	HIV incidence	A1		

Annex 4: Scope of Work for Evaluating AGYW Programs

Terms of Reference for evaluating adolescent girls and young women programs

When to use this ToR: This ToR should be used 1-2 years after the implementation of AGYW activities to determine what is working well and areas that need improvement.

Background: The Global Fund Strategy 2017–2022, "Investing to End Epidemics", has committed to scaling-up HIV prevention programs to support adolescent girls and young women in 13 focus countries. The goal is to reduce new HIV infections among adolescent girls and young women (AGYW) aged 15-24 by 58% in 13 focused countries in Sub Saharan Africa. The UN Political Declaration on Ending AIDS adopted in June 2016 sets the target to reduce new HIV infections among AGYW to fewer than 100,000 by 2020.

Globally, almost 60% of new HIV infections among 15-24 year olds were contracted by AGYW. In 2015, 380,000 new HIV infections occurred among AGYW. Among adults newly infected in east and southern Africa, 25% were young women (aged 15-24), and the average prevalence in young women was double compared to young men. This is rooted in gender inequality-related, social, cultural, economic, and human rights barriers, which disproportionately affect AGYW, and biological differences that result in elevated risk of HIV acquisition. It is thus critical that country responses continue to improve to address remaining challenges and barriers, which are still significant in many countries (Global Fund Technical Brief on AGYW, 2017[16]).

Global Fund-supported countries are implementing HIV prevention programs to address behavioral, biological and structural factors driving HIV acquisition and transmission by and to AGYW. Some of these factors include: gender inequality; unequal power relations and dynamics; risky practices; social and gender norms; economic vulnerability; limited education preventing them from making decisions about their health and lives; harmful community norms (laws and practices) on gender and violence in relation to early marriage; early pregnancy; and lack of access to confidential sexual and reproductive health services which prevents them from obtaining essential HIV prevention information and services.

Programmatic evaluation is needed to show if programs are on course to achieving set objectives by determining what is working well and what is not working well. It is envisioned that achievement of program objectives and intermediary outcomes will contribute towards reduction in new HIV infections among AGYW.

Objectives: The overall purpose of the evaluation is to assess implementation progress, document lessons from existing practices, identify challenges and successes and provide recommendations for program improvement. Specifically, the evaluation is aimed at:

1. Assessing if country programs are reaching and meaningfully engaging the most vulnerable AGYW;
2. Assessing if program design and implementation framework is contributing to increased delivery of quality services to AGYW interventions;
3. Assessing how the interventions are symbiotic, or the intervention mix is contributing to the overall aim;

[16] Adolescent Girls and Young Women in High-HIV Burden Settings, January 2017 Geneva, Switzerland

4. Assessing if program is meeting the needs of AGYW;
5. Assessing effectiveness of information, program and data quality assurance systems in in tracking progress towards program objectives;
6. Assessing national governments commitments towards sustainability;
7. Documenting challenges, lessons learnt findings, conclusions and recommendations for program improvement.

Scope of work and Methodology: The main operational questions to guide the evaluation will include the following:

I. Program coverage and scale:

a. What is the geographic scale of the program? National or selected subnational sites?
b. Is the program reaching the most vulnerable AGYW by age and vulnerability profiles?

II. Program design:

a. What implementation arrangement is the program using to deliver interventions to AGYW?
b. Is current program design and implementation framework contributing to increased delivery of quality programs to AGYW?
c. Are there interventions that are not included in the package that may affect the ability to reach the intended incidence reduction targets?

III. Program Implementation:

a. Which recruitment strategy or strategies is the program using to reach the most vulnerable AGYW? Are these the groups that the program intended to reach?
b. Is there a structured process the program uses to continually identify needs of AGYW, and whether the program is addressing those needs through timely and effective interventions?
c. In cases where the program is unable to provide needed intervention, are there adequate referral and linkage mechanisms to meet needed intervention? Are these indicative of coordination landscape with other stakeholders?
d. Are the implementation arrangements facilitating effective program delivery?
e. Are there any barriers to effective implementation, and if so what are they?
f. What is working well in delivery services to AGYW?

IV. Effective program monitoring for quality and results

a. Is there an M&E system to chart the success of the program and whether the program is making a difference?
b. Are there tools that keep track of the following: who the participants are in the program; program activities; interventions AGYW are receiving; changes occurring in girls because they participate in the program, etc.?
c. Is the program reaching set targets at implementation and national levels?
d. Are there a program quality assurance mechanisms in place? If so, how effective are they in identifying and improving program quality issues, where necessary? Is the community involved in any of the quality assurance mechanisms?
e. Are there data quality assurance mechanisms in place? If so, how effective are they in identifying and improving data quality issues, where necessary?

V. Program financing and sustainability

a. Is there additional funding to the program apart from GF funding?

b. Is there a sustainability plan in place for this program? How will the national program ensure that the program is sustainable beyond donor funding?

The evaluation will apply mixed method approach using qualitative and quantitative methods. The following technical approaches will be used. These are indicative and should be adapted and expanded based on the country context.

1. Desk review of programmatic data and existing incidence data, project documents related to the project, including, but not limited to: technical proposal, work plan, project reports (technical and financial), national policies and guidelines;
2. Field visit to implementation sites;
3. Key Informant/structured and semi-structured interviews. This will include, defining the type and relevant stakeholders, program staff, representative of target population to be interviewed; type and quantity of data/information to be collected and program sites;
4. Focus group discussions interviews with clients
5. Data/information analysis - develop an analytical plan for data and information collected;
6. Stakeholders results validation meetings; and
7. Report writing and dissemination – this will also include abstracting key messages for different target audience

Geographic Scope

The evaluation will be conducted in any of the 13 AGYW focused countries in sub-Saharan Africa that also have the highest HIV burden. The scope will be modified whenever a multi-country evaluation is envisioned.

Sources of information

- National strategy related documents;
- Program documents maintained at the service delivery points;
- Programs and reporting guidelines and SOPs;
- Supervision reports;
- Monthly, quarterly, annual reports;
- Key informants interviews guidance; and
- Referrals slips.

Means of data collation and analysis

Quantitative data: will be used to generate evidence on utilization, coverage and uptake of AGYW services

Qualitative data: will be thematically summarized to present what works well and what doesn't work well in terms of program design, implementation framework, service delivery model, comprehensiveness of defined package of service, service quality, data reporting systems including management of referrals, partnerships and coordination.

Outputs:

- What are key successful and replicable practices that should be implemented at scale?
- What are the gaps, challenges, and bottlenecks to be addressed?
- What are existing opportunities to be explored further?

- What are the key recommendations that could be carried forward at local, national and system levels?

Expected time and LOE required: (tailor to country specific needs)

- Preparatory work, including document review: approximately 2 weeks
- Implementation: 4-5 weeks
- Report preparation: 1 week

Deliverables: The assessment should provide:

- A full proposal / study protocol
- A preliminary report.
- A final evaluation report with actionable recommendations, incorporating the findings from the assessment

The final submission should also include a:

- User-friendly summary document (3-5 pages) and
- A deck of slides (10-15) summarizing key finding and recommendations for dissemination at the country level

Profile Required

The assessment team will work closely with national stakeholders and should have the requisite expertise and experience to execute all tasks with sensitivity to the environmental, cultural and health issues in the country. The team should comprise a team lead; a public health/social scientist with a focus on community service delivery; a statistician; and a health financing expert.

Study Team Lead

The Study Team Lead (STL) will provide oversight to the overall assessment, including all aspects of implementation. The STL should have a good understanding of mixed methods research methodology and be skilled in project management. It is not expected that the STL have expertise in all specific areas of the study protocol and implementation, but will bring in other team members to assist in the more technical aspects. The focus of the STL will be to ensure the overall process stays on time and deliverables are completed to specified standards. The STL will also serve as the main contact with the in-country counterparts, as well as Global Fund and other key stakeholders.

Qualifications of the Study Team Leader:

- At minimum, a Master's degree in public health/international development;
- 7 or more years of experience in international public health work;
- Experience working in the region;
- Extensive track record of research including mixed methods research or public health studies;
- Experience working with international teams and dealing in a culturally appropriate manner with a range of stakeholders, from high-level government officials to community members;
- Excellent analytical, writing and presentation skills; and

- Excellent written and verbal communications skills required; ability to produce high quality documents/reports in English and a good working knowledge of the language of the country.

Public Health/Social Behavioral Scientist

A public health Social Behavioral expert with a proven experience in gender/AGYW programming and specific experience in mixed methods research methods and design is required for this assignment. This person may be needed to assist in overall study design; interview/focus group questionnaire design, the analysis plan and interpretation of results. There may be additional phases when public health expertise will be required. It would be beneficial for this person to have previous experience in HIV/AIDS and AGYW programming.

Qualifications of the public health experts:

- Master's degree in public health, social science or other related fields;
- 7 or more years of experience in international public health work, including at least 4 in qualitative research/social science;
- Proven track record on mixed method research and/or public health studies;
- Proven experience in community-based health care delivery;
- Experience working with international teams and dealing in a culturally appropriate manner with a range of stakeholders, from high-level government officials to community members;
- Excellent analytical, writing and presentation skills; and
- Fluency in English and working knowledge of the national language.

Statistician

Input from a qualified statistician will be critical in at least two aspects of the assessment – 1) completing the sampling methodology during the protocol development and 2) throughout the data cleaning and analysis process. In both cases, the statistician should work with local counterparts if applicable. In cases where the local partner has strong capacity, the statistician may just validate their work, rather than completing the sampling/analysis.

Qualifications of the statistician:

- Master's degree in epidemiology, statistics, or other related fields;
- 5 or more years of experience in international public health work;
- Extensive track record of research or public health studies. Experience in meta-analysis would be desirable;
- Familiarity with statistical packages and tool to facilitate both data capture and analysis; and
- Experience working with international teams and dealing in a culturally appropriate manner with a range of stakeholders, from high level government officials to community members

Health financing expert

The health financing expert will be required to advise on how to best evaluate the questions around Funding mechanisms and potentially other financing or costing aspects, as well as unit cost and cost effectiveness assessments of programs.

Qualifications for a health financing expert:

- Master's or PhD in health economics, financing, health policy, or related fields;
- 5 or more years of experience in international public health work, including at least 3 specific to health care financing and economics.
- Proven track record on cost-effectiveness and efficiency analysis for health services, preferably for community health.
- Experience working with international teams and dealing in a culturally appropriate manner with a range of stakeholders, from high-level government officials to community members.
- Excellent analytical, writing and presentation skills
- Fluency in English required and national language preferable.

References:

1. Austrian, K. and Ghati, D. 2010. Girl Centered Program Design: A Toolkit to Develop, Strengthen and Expand Adolescent Girls Programs. Population Council.
2. THE GLOBAL FUND STRATEGIC FRAMEWORK FOR DATA USE FOR ACTION AND IMPROVEMENT (2017-2022) Draft 31 January 2018
3. Global Fund, Modular Framework Handbook February 2017 Geneva, Switzerland
4. Global Fund, Technical Brief on Adolescent Girls and Young Women in High-HIV Burden Settings, Jan, 2017
8. http://www.who.int/hiv/pub/guidelines/person-centred-hiv-monitoring-guidelines/en/
5. https://www.pepfar.gov/press/releases/2017/276082.htm
6. Lung Vu, et al., Effectiveness of Behavior Change Communications for Reducing Transmission Risks Among People Living with HIV in 6 Countries in Central America.
7. Napierala Mavedzenge et al. Effective Approaches for Programming to Reduce Adolescent Vulnerability to HIV Infection, HIV Risk, and HIV-Related Morbidity and Mortality: A Systematic Review of Systematic ReviewsJ Acquir Immune Defic Syndr Volume 66, Supplement 2, July 1, 2014
8. PEPFAR Guidance (Draft Dec 9th 2014) Preventing HIV in Adolescent Girls and Young Women (AGYW)
9. Population Council The girl roster, 15th May, 2016 publication
1. UNAIDS guidance; HIV prevention among adolescent girls and young women, 2016. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women.pdf
10. WHO Working Group on HIV Incidence Assays. Estimating HIV incidence using HIV case surveillance. Meeting report, Glion, Switzerland, 10–11 December 2015. Geneva: World Health Organization; 2017 (WHO/HIV/2017.03). Licence: CC BY-NC-SA 3.0 IGO.
11. Yankah E, Aggleton P. Effects and effectiveness of life skills education for HIV prevention in young people. AIDS Education and Prevention 2008; 20(6): 465-485. [PubMed: 19072524]