



Technical Brief

Adolescent Girls and Young Women in High-HIV Burden Settings

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I. Introduction

Background

The **Global Fund Strategy 2017–2022, “Investing to End Epidemics”**, aims to rapidly reduce HIV incidence and mortality by scaling up universal access to HIV prevention and treatment.¹ It also commits to scaling-up programs to support women and girls, including programs to advance sexual and reproductive health and rights, and has adopted a key performance indicator on reducing HIV incidence for **adolescent girls and young women (AGYW)** in focus countries. The **UN Political Declaration on Ending AIDS** adopted in June 2016 sets the target to reduce new HIV infections among AGYW aged 15-24 years 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.² 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.³

Purpose of this technical brief

The purpose of this technical brief **is to provide guidance to Global Fund applicants on investing strategically in AGYW in the development and implementation of HIV-related programming** in the 2017-2019 funding cycle.⁴ It aims to support applicants in identifying opportunities to integrate interventions in their funding requests that address the needs and rights of AGYW, and emphasizes the need to **scale up comprehensive, quality programming** for AGYW. It also highlights opportunities for a **stronger participation and inclusion of AGYW** in Global Fund-supported programs.

The technical brief is intended for programs that aim to reduce HIV infection among AGYW in all **countries and subnational locations where HIV prevalence is above 1% among AGYW**.⁵ Nearly all countries where HIV prevalence among AGYW aged 15-24 years exceeds 1% at the national level are in sub-Saharan Africa. However, AGYW can also be at the epicentre of severe local **micro-epidemics** (subnational epidemics with high HIV prevalence among AGYW of >1%) including amongst adolescent members of key populations. These micro-epidemics need to be addressed as part of the national HIV response and this technical brief also intends to guide the HIV response in such subnational settings.

In their funding requests, Global Fund applicants should also strongly consider the specific needs of **young key populations**, such as young sex workers, young women who inject drugs, young transgender women, and women who have sex with women, whose vulnerability to HIV is further exacerbated by punitive laws, stigma, and social exclusion.

This technical brief **defines AGYW as females aged 10-24**. At the same time, it 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.

All stakeholders at country-level, including representatives from the relevant ministries (health, gender, etc.), members of the Country Coordinating Mechanism (CCM), civil society and community organisations, including those representing adolescent girls and young women, key partners and consultants providing technical assistance are encouraged to make use of this brief. As an effective HIV response requires a broad

¹ Global Fund Strategy 2017-2022 “Investing to End Epidemics.” <http://www.theglobalfund.org/en/strategy/>

² UNAIDS. AIDS info : <http://aidsinfo.unaids.org/>

³ UNICEF (2016): For every child, end AIDS.

⁴ In this context, this briefing emphasizes that reducing HIV infections among AGYW requires a comprehensive combination of approaches and services that also reach out to men and adolescent boys.

⁵ UNAIDS (2016): HIV prevention among adolescent girls and young women.

participation of actors beyond the health sector, it is strongly encouraged that this note is read by all relevant actors (e.g. ministries of justice, education, gender etc.).

This **technical brief should be read in conjunction** with other technical briefs and information notes provided by the Global Fund as well as technical guidance published by its partners. Access to more detailed technical information is provided via links to key documents. General guidance on how to develop a funding request for the Global Fund is provided in the updated Global Fund's Applicant Handbook and the Instructions Guide to the Funding Request.⁶



II. Approach for designing effective HIV responses for AGYW in high-burden settings

a. Developing, implementing and monitoring HIV programs for AGYW

Reducing HIV incidence amongst AGYW requires a gender-responsive and evidence-based approach that is grounded in human rights principles. The HIV strategic investment approach suggests a number of key steps for prioritizing the components of a country's HIV response.⁷ These steps also apply to the design and at scale implementation of an effective HIV response for AGYW:

- i. Understand** the HIV epidemic among AGYW in the context of the overall national epidemic;
- ii. Design and deliver** effective responses for AGYW using evidence-based approaches that build on existing, holistic and multi-sectorial programs and bring them to scale;
- iii. Measure and sustain** program impacts for AGYW.

This section discusses how this **process** can be used to develop and implement effective HIV programs for AGYW.⁸ In this context, Global Fund applicants are strongly encouraged to strengthen engagement with AGYW throughout this process (Box 1). Available data indicates that AGYW currently do not sufficiently participate in CCMs, the key Global Fund mechanism at country-level, and can be of enormous value for strengthening interventions.⁹ AGYW should also be supported to meaningfully participate in country dialogue processes.

⁶ Global Fund (2016): The Applicant's Handbook: A practical guide to preparing a funding request. The Global Fund has revised its approach to funding applications and reviews to align with the new Global Fund Strategy 2017-2022 and have a bigger impact on the three diseases. Changes to the 2017-2019 funding cycle are designed to better serve people in need by enabling tailoring of funding application approaches to different country circumstances.

⁷ Schwartländer B. et al. (2011): Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet*, 277:2031-2041.

⁸ More guidance to Global Fund applicants on employing strategic investment thinking can be found in the [Global Fund HIV Information Note](#). UNAIDS and other technical partners provide guidance on how to understand the epidemic situation, design effective responses, deliver programs and measure and sustain program impact.

⁹ Reed, S. J., Miller, R. L., & Adolescent Medicine Trials Network for HIV/AIDS Interventions. (2014). The benefits of youth engagement in HIV-preventive structural change interventions. *Youth & society*, 46(4), 529-547.

Box 1: Participation of AGYW in the development, implementation and evaluation of programs

In 2014, the PACT and UNAIDS released a “Youth Participation Tool”, which shows how youth can be involved in Global Fund processes “from start to finish”.¹⁰ This tool can also be specifically adapted to AGYW. Meaningful participation requires programs to use a combination of three lenses:

- Working as beneficiaries: Programs, policies and funding streams are designed for AGYW, recognizing and addressing their specific needs;
- Engaging AGYW as partners: AGYW should be invited to collaborate on the design, implementation, M&E of programs, policies and interventions that affect them.
- Supporting AGYW as leaders: AGYW should be enabled to initiate and direct their own interventions.

There are opportunities to support the participation of AGYW in CCM processes, the country dialogue, and the implementation and monitoring of programs. In countries where AGYW are heavily affected, countries should consider adequate representation of these groups, allocating at least one seat for an AGYW representative.

For the implementation of programs targeting AGYW, it is critical to have a wide-range of partners including AGYW-led and serving organizations as sub-recipients or sub-sub-recipients. These organizations will contribute expertise in working with and for youth at all levels. M&E efforts will also benefit from community monitoring approaches. This is particularly important for incorporating lessons learned into efforts to improve and further tailor projects to the needs of AGYW.

Investment in AGYW organizations to strengthen their capacity to participate in advocacy, decision-making and planning, implementing and monitoring programs is an essential intervention to ensure AGYW can effectively take up their crucial role in the HIV response.

Understanding the epidemiological situation of AGYW in high-burden settings

Designing an effective HIV response for AGYW requires **understanding of the inter-related behavioral, structural and biological factors** that drive HIV acquisition and transmission by and to AGYW.¹¹ Reducing HIV infections among AGYW therefore requires an in-depth understanding of the extent and dynamic of the entire HIV national epidemic and response (rather than an isolated understanding of the epidemic for young populations only).

While knowledge of the national HIV epidemic is critical, it is imperative to go beyond the collection and analysis of national level data, which tend to mask local variations. Substantial **heterogeneity** exists in many countries in terms of where and in whom HIV infections occur, with certain **locations and populations** being more vulnerable to infection than others.

As a first step to understanding this heterogeneity, it is important to identify the groups with the highest HIV incidence and the greatest risk to acquire HIV. If the assessment of the epidemiological situation has identified AGYW as of particular concern, the next step is to **understand the risk factors among AGYW and the challenges they face in accessing key prevention and treatment services and remaining in care and adhering to treatment** (only then it will be possible to determine the best programmatic response).¹² For example, **high HIV incidence among AGYW** may be driven by age-disparate and transactional sex, lack of economic empowerment and secondary schooling, child marriage, or gender-based violence (which also is prevalent within child marriage) or through transmission within young key populations, especially young sex workers and sexually exploited adolescents, and AGYW who inject drugs.

¹⁰ UNAIDS (2014): Making the money work for young people: a participation tool for the Global Fund to Fight AIDS, Tuberculosis and Malaria. http://www.unaids.org/sites/default/files/media_asset/JC2661_part2_en.pdf

¹¹ UNAIDS (2016): HIV prevention among adolescent girls and young women.

¹² Among AGYW in countries and settings with high HIV prevalence, most HIV acquisition is through heterosexual sex.

Age-disparate relationships are an important determinant of HIV transmission in AGYW. A study in South Africa showed that the primary source of HIV infection among young women under 25 years of age were older men aged 25-40 years.¹³ The fact that HIV prevalence in countries in eastern and southern Africa reaches a peak at older ages in men than in women, shows that age-disparate sex plays an important role in the transmission cycle.^{14,15} The practice of transactional sex, or exchanging sex for financial or other rewards,¹⁶ is associated with HIV risk factors such as sexual violence, multiple partners and high sexual frequency.

Young key populations, including young sex workers, adolescent transgender women, adolescent women who have sex with women, adolescent women who use drugs and adolescent women in prisons and other closed settings have specific vulnerabilities to HIV that must be addressed with a human-rights based approach when designing programs.^{17,18} Young key populations face additional vulnerabilities compared to older key populations because of their age, power imbalances in relationships and their vulnerability to exploitation or violence.

Disaggregated data are critical to understand HIV epidemics among AGYW and to inform effective HIV programming for AGYW and to drive interventions towards impact (Box 2). When developing funding requests, countries should use available data and analyses to target those groups of AGYW who are at a higher risk of HIV infection (i.e. defining social, geographic, economic, or other criteria related to HIV risk). **HIV incidence, vulnerabilities, barriers to services and needs may also differ across AGYW age groups** (i.e. between the 10-14 age group, the 15-19 age group and young adult women aged 20-24), which in turn requires different programmatic strategies.

National surveys and other large population-based surveys are critical data sources to inform HIV programming for AGYW. For example, **Demographic and Health Surveys** (DHS) provide data on a range of relevant data, including on the age of sexual debut, sex differences in prevalence by age group, and fertility. Data from cohort studies and other specific data on the HIV epidemic among AGYW (and the respective response) may also be very useful as an indication for the epidemiological dynamics at local level if other data is unavailable. For example, **PMTCT data at local level** could be an important source of data – high prevalence in young pregnant women (15-24) is considered as a good proxy for new infections. Data from other sources (e.g. in small studies, qualitative data and unpublished reports) should be used with caution when extrapolating and generalizing findings. In addition, countries have the opportunity to address data gaps through inclusion in the Global Fund application, including catalytic funding (Section 3).

Box 2: Critical types of data for tailoring a strategic HIV response to the needs of AGYW

- Updated **disaggregated HIV epidemiological data** (HIV and TB prevalence, HIV and TB incidence, morbidity, and mortality) by sex, age group, marital status, AGYW in and out of school, geographical area and other demographic factors over time is necessary for linking epidemiological trends to program efforts. This should also include information on how HIV is being transmitted (e.g. not only who is newly acquiring HIV but how, when and where and by whom), including for young key populations, and on latest transmission dynamics.
- **Age disaggregated data** by narrow age groups (e.g. ages 10-14; 15-19, and 20-24) rather than large age groups (10-24 years) are particularly critical for understanding the HIV dynamic among AGYW. Data on key HIV-related knowledge, attitudes and practices, such as age of first sexual experience, are prone to change quickly as AGYW age.¹⁹ Given the importance of young

¹³ de Oliveira T, Kharsany ABM, Gräf T, et al. Transmission networks and risk of HIV infection in KwaZulu-Natal, South Africa: a community-wide phylogenetic study. *Lancet HIV* 2016.

¹⁴ Gouws, Eleanor et al. Age-mixing and the incidence of HIV among young women. *The Lancet HIV*, Volume 4, Issue 1, e6 - e8.

¹⁵ Age-disparate relationships can also have unequal power dynamics that might reduce the use of condoms and access to health care, and thus increase the risk of HIV and other STIs.

¹⁶ Stoebenau K, Heise L, Wamoyi J, Bobrova N. Revisiting the understanding of “transactional sex” in sub-Saharan Africa: a review and synthesis of the literature. *Soc Sci Med* 2016; 168: 186–97.

¹⁷ Applicants should refer to the ‘Global Fund Technical Brief Addressing people who sell sex, men who have sex with men, transgender people, people who use drugs and people in closed settings in the context of the HIV epidemic’ for guidance on how to include key populations in funding requests.

¹⁸ WHO technical briefs (2015): [HIV and young people who sell sex](#), HIV and young transgender people, [HIV and young people who inject drugs](#).

¹⁹ UNAIDS (2015). ALL In to End Adolescent AIDS: Launch Document <http://allintoendadolescentaids.org/wp-content/uploads/2015/02/ALL-IN-Launch-Document.pdf>

key populations in many countries, age-disaggregated data on key populations should be collected – at least for the adolescent age group (ages 10-19).

- Data on **access to and use of HIV prevention, treatment, and care and support services** for AGYW in the context of the HIV situation of other groups. Investments should align with other efforts on AGYW, requiring an understanding of existing programs and their effectiveness as well as existing providers and their capacity, particularly for community based services.²⁰
- Data on **behavioural factors affecting HIV risk** which include both individual and relational factors (age-disparate sex, multiple partnerships, sex work and transactional sex, early sexual debut, alcohol and drug use, and limited risk perception).²¹
- **Structural factors** preventing optimal delivery of services: These factors include social and gender norms on relationships and gaps in knowledge and risk perception, human rights violations, including stigmatization, discrimination, gender inequality, punitive laws and policies as well as other structural factors, including access to secondary and tertiary education, unethical or unscientific health services, and labour migration that can influence health-seeking behaviours and overall HIV trends. Such data is critical for addressing the cross-cutting human rights and gender-related factors influencing services and care. One critical source of data are Violence Against Children Surveys (VACS) that collect data on sexual, physical and emotional violence as well as data on risk factors.²²
- Data on health systems-related capacity and constraints at the national, sub-national and community levels that could be affecting the HIV burden of AGYW.

Tools have been developed to ensure national AIDS planning bodies and monitoring systems address these gender-related dimensions when developing their national strategic document and Global Fund applications: WHO/UNAIDS Tool for strengthening gender-sensitive national HIV and Sexual and Reproductive Health Monitoring and Evaluation systems²³, provides step-by-step guidance to strategic information specialists and monitoring and evaluation officers of HIV and SRH programs on how to strengthen monitoring and evaluation systems to enable appropriate data collection and gender analysis. Based on available data the [UNAIDS' Gender Assessment Tool](#) supports countries with identifying gender-related barriers to services and care and develop programmatic recommendations; and [UNDP's Checklist for Integrating Gender into the Processes and Mechanisms of the Global Fund](#) spells out steps and examples on how to address gender dimensions of HIV are addressed in all phases of programming.²⁴

Design effective responses for AGYW to be delivered at-scale

Based on this evidence, the next step it to **decide on the combination of interventions to prioritize** — considering the interventions' effectiveness in reducing new HIV infections among AGYW and retaining AGYW living with HIV in treatment and care programs. To be effective, HIV interventions should be part of a **comprehensive, integrated package** of accessible and high quality health services delivered where AGYW can access them – health settings, schools and communities.

²⁰ An important initiative on AGYW is PEPFAR's DREAMS program which aims to reduce HIV infections AGYW in 10 sub-Saharan African countries. <http://www.pepfar.gov/partnerships/ppp/dreams/>

²¹ Behavioral factors are often linked to underlying structural factors (which e.g. may force girls to sex work).

²² Participants in VACS are 13-24 years of age.

²³ WHO/UNAIDS (2016) Tool for strengthening gender-sensitive national HIV and Sexual and Reproductive Health Monitoring and Evaluation systems: <http://apps.who.int/iris/bitstream/10665/251903/1/9789241510370-eng.pdf?ua=1>

²⁴ UNAIDS (2014) UNAIDS Gender Assessment Tool:

http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/JC2543_gender-assessment_en.pdf & UNDP (2015) Checklist for Integrating Gender into the Processes and Mechanisms of the Global Fund to Fight AIDS, TB and Malaria http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/JC2543_gender-assessment_en.pdf

HIV interventions should be integrated with other health services, including but not limited to **sexual, reproductive, maternal, newborn, child and adolescent health** (SRMNCAH) services (e.g. antenatal care), TB services, and **resilient and sustainable systems for health** (RSSH) investments. Programs should be linked to programs for AGYW outside the health sector (e.g. in cooperation with ministries of gender and education), such as efforts to keep girls in or return girls to school, address violence and harmful cultural practices and gender norms.

To ensure effectiveness, **program design should be tailored to the specific needs of the different age groups within the population of AGYW** (10-14, 15-19 and 20-24 age groups). Very young adolescent girls (ages 10-14) may face additional barriers to seeking services, such as the inability to travel alone to the clinic, age of consent and fear and stigma related to sexual activity at a young age. Programs should also be responsive to and inclusive of sub-populations of AGYW, including female key populations, AGYW married/unmarried, in- and out-of-school, rural/urban and AGYW living in poverty. UNAIDS provides prevention guidance with a 'priority programs' menu countries can use to tailor their response depending on HIV incidence levels amongst AGYW.²⁵

Integrated SRH, TB, GBV, and HIV Programming

There is a growing base of evidence that shows how **integrating sexual and reproductive (SRH), gender-based violence (GBV), tuberculosis (TB) and HIV services**²⁶ can improve **cost-effectiveness, uptake, access to and quality of care** (see Technical Brief: Strengthening sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) interventions in funding requests to the Global Fund).²⁷ Integrated services assist providers to deliver comprehensive, consistent and multidisciplinary care and support. Health service integration can increase the likelihood of adolescent girls and young women to use these services, as they can access them in one place and ideally at one time.

Joint programming includes regular screening of AGYW living with HIV (PLHIV) for TB and cervical cancer, provision of sexual and reproductive health services to high-risk AGYW and AGYW living with HIV, HIV testing of TB symptomatic AGYW and patients, provision of ARV and TB medicines for co-infected patients and provision of TB preventive therapy for PLHIV without active TB. Building **RSSH is crucial to ensuring that AGYW** have access to effective, efficient, and accessible HIV services through well-functioning and responsive health and community systems. The goal is to provide a package of comprehensive services along the continuum of prevention and care that work in time and place for women, children and adolescents.

As discussed in Section III below, a **mix of interventions and delivery channels** is needed, such as through schools, or through community or health facility-based programs, with effective referral systems as appropriate.

Adolescent-responsive health services

HIV services must be delivered in an **'adolescent-responsive' manner (also referred to as 'adolescent-friendly')**, meaning that they are equitable, accessible, acceptable, appropriate and effective, to encourage engagement and improved outcomes, such as adherence to treatment and remaining in care.²⁸ **Adolescent-responsive approaches** aim to ensure that all adolescents obtain the health services that they need, that policies and interventions are in place to facilitate the provision of these services, and that every

²⁵ UNAIDS (2016): HIV prevention among adolescent girls and young women

http://www.unaids.org/en/resources/documents/2016/20160715_Prevention_girls

²⁶ Examples of SRH and HIV integration include, but are not limited to: family planning into HIV counselling and testing (HCT); cervical cancer screening (women living with HIV should be screened for cervical cancer regardless of age, CD4 count or viral load²⁶); prevention of mother to child transmission (PMTCT) of HIV and syphilis in antenatal care (ANC); gender-based and intimate partner violence prevention and treatment; HIV treatment and care into post-partum care; and the screening, prevention and co-management of STIs (e.g., syphilis, HPV) and HCV in HIV treatment, care and support.

²⁷ Sexual & Reproductive Health & HIV Linkages: Evidence Review & Recommendations, IPPF, UCSF, UNAIDS, UNFPA, WHO, 2009

²⁸ WHO (2016): Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach - Second edition <http://www.who.int/hiv/pub/arv/arv-2016/en/>

adolescent, regardless of behavior, HIV status or other characteristics is being treated with respect and equal care by health care workers.²⁹

This **approach should be incorporated into all HIV services used by adolescents**, including community-based services and antenatal care. Health care workers should be specifically trained in delivering “adolescent-responsive” health services. Youth and adolescent-responsive health services in geographic locations with high levels of key populations should incorporate dedicated health service delivery points and outreach work to reach key populations of AGYW who may avoid service-delivery points that are open to all.³⁰ The Evidence to Action Project (E2A) developed a decision-making tool for designing youth-friendly services targeted to the country context and specific sub-populations of adolescents.³¹

WHO and UNAIDS have developed a set of **global standards to improve the quality of health care for adolescents**.³² Acceptability can be improved by delivering services that reflect the unique and diverse needs of AGYW, including new and innovative approaches to service delivery. WHO provides specific guidance on delivering HIV services to adolescents, which include adolescent participation in health services.³³

Measure and Sustain

It is critical to measure and sustain program impacts for AGYW. A **thorough evaluation of programs and interventions is needed to ensure learning and continued improvements in the response**. In their funding requests, applicants may allocate funding to strengthen quality data systems to monitor and evaluate progress, as well as invest in community-based monitoring and research for program quality. Such investments are important as currently countries face challenges to monitor the delivery of the comprehensive package of interventions for AGYW rather than the individual interventions separately. This requires both investments in **monitoring and evaluation (M&E)** and referral systems. The Global Fund and its partners developed core lists of indicators based on existing guidance, out of which implementers can select their program indicators. This includes indicators specific for AGYW. See the **full list of indicators** for each component here: <http://www.theglobalfund.org/en/me/framework/>.

In addition, investments in program **evaluations and operational research** are required. This is particularly critical in order to understand how to best implement programs for AGYW, and their impact. Countries eligible for catalytic funding can consider using this money for sound evaluation and operational research attached to AGYW interventions.

b. Addressing structural barriers

Structural barriers prevent uptake of services by AGYW, including HIV prevention, testing, treatment and care. To be effective, it is crucial that HIV programs include specific interventions to address and overcome these barriers.

Reducing stigma and discrimination and increasing access to justice

Programs to prevent and treat HIV in AGYW must incorporate efforts to **address human rights barriers, including stigma and discrimination** that may be limiting access to treatment care and support services.³⁴ In many countries, **legal and policy environments** create barriers to AGYW receiving services, such as the age of consent to receive SRH services, or school policies that force pregnant girls to drop out of school. AGYW that engage in selling sex or transactional sex, or use drugs particularly face stigma and discrimination. The

²⁹ WHO (2016): Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach - Second edition <http://www.who.int/hiv/pub/arv/arv-2016/en/>

³⁰ WHO (2012): Making health services adolescent friendly: developing national quality standards for adolescent friendly health services.

³¹ Evidence to Action Project, USAID (2015): [Thinking outside the separate space: A decision-making tool for designing youth-friendly services](#)

³² WHO and UNAIDS. (2015) Global standards for quality health-care services for adolescents.

http://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/

³³ WHO (2016): Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach - Second edition <http://www.who.int/hiv/pub/arv/arv-2016/en/>

³⁴ WHO (2015): HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policy-makers and managers. <http://www.who.int/hiv/pub/guidelines/adolescents/en>

Global Fund Transition, Sustainability and Co-financing policy requires all applicants, regardless of the income level, to include programs to address human rights and gender-related barriers as appropriate. Furthermore, the Global Fund has aligned its human rights module with the UNAIDS 7-key programs to *reduce stigma and discrimination and increase access to justice* which include:

1. Stigma and discrimination reduction;
2. Training for health care workers on human rights and medical ethics related to HIV;
3. Sensitization of law-makers and law enforcement agents;
4. Legal literacy (“know your rights” campaigns);
5. HIV-related legal services;
6. Monitoring and reforming laws, regulations and policies relating to HIV; and
7. Reducing discrimination against women in the context of HIV.³⁵

Gender based violence, including intimate partner violence

HIV programs should be integrated with **gender-based violence prevention and management**. Integrations between HIV and gender-based violence services involve economic empowerment and gender training approaches, working with men and boys to transform cultural and social norms related to gender, addressing violence in HIV risk-reduction counselling and HIV testing services, mental health care, providing PrEP for AGYW at substantial risk³⁶ of HIV infection, and providing comprehensive post-rape care, including **post-exposure prophylaxis and emergency contraception** to prevent pregnancy.³⁷ In high HIV incidence settings, social and behavior change programs for adolescent and young women and men should focus on addressing gender-based violence.³⁸

Transforming harmful cultural and gender norms

Programs should aim to **empower AGYW with social and protective assets** that will enable them to reduce their risk of HIV infection and to thrive. Protective assets, such as confidence, negotiating power, knowledge of sexual health and savings, help girls safely navigate a variety of risks. The Population Council provides tools for designing programs that build girls’ protective assets.³⁹ Community mobilization efforts on HIV should aim to change social and gender norms, regardless of HIV incidence levels.⁴⁰ Community leaders can play a critical role in changing social and gender norms, and the inclusion of men and boys is paramount to transforming harmful gender norms. Young female leaders can build ownership of programs among AGYW, improve community understanding, and increase sustainability. **Adolescent and young male leaders** can serve as role models for communicating behavioral messages, including on HIV prevention and changing gender norms, to men.⁴¹

c. HIV prevention, testing, treatment, and care

HIV prevention, testing, treatment and care services should be delivered in a comprehensive package of health services and integrated with SRH, TB, GBV services to ensure cost-effectiveness, uptake, access to and quality of care.

³⁵ UNAIDS (2012): Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses.

http://files.unaids.org/en/media/unaids/contentassets/documents/document/2012/Key_Human_Rights_Programmes_en_May2012.pdf

³⁶ AGYW at substantial risk of HIV: (1) in high HIV incidence locations (2) with partners who are at high risk and with unknown HIV status. (3) in serodiscordant relationships (in particular for when the male partner is newly initiated on antiretroviral therapy and not yet virally suppressed).

³⁷ WHO (2013):16 Ideas for addressing violence against women in the context of the HIV epidemic. A programming tool.

http://www.who.int/reproductivehealth/publications/violence/vaw_hiv_epidemic/en/

³⁸ Priority programs and program elements listed on page 22 and 23 of UNAIDS (2016): HIV prevention among adolescent girls and young women.

³⁹ Population Council (2016): Building Girls’ Protective Assets: A Collection of Tools for Program Design.

⁴⁰ UNAIDS (2016) HIV prevention among adolescent girls and young women.

http://www.unaids.org/sites/default/files/media_asset/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women.pdf

⁴¹ UNAIDS (2016) HIV prevention among adolescent girls and young women.

i. HIV prevention amongst AGYW

Preventing new HIV infections among AGYW requires a comprehensive combination of approaches and health services that also **reach out to men and adolescent boys. In addition, there are specific core prevention interventions that are especially relevant for preventing HIV among AGYW.**

Increasing HIV knowledge awareness, and risk perception, with materials and messages throughout communication campaigns tailored to the way that AGYW receive information. When relevant, using social media and other technology platforms may be an effective platform to share information on health, including HIV and sexuality issues, and referral information. Social behavior change communication programs, which intend to result in safer behaviors, increased service use, HIV disclosure, risk perception, reduced gender-based violence and positive changes in social and gender norms, should be integrated into other information sharing platforms such as comprehensive sexuality education.

Male and female condoms remain complementary to all other HIV prevention methods, as they are the only devices that both reduce the transmission of HIV and other sexually transmitted infections (STIs) and prevent unintended pregnancy. AGYW, particularly sex workers, should have access to adequate supplies of water-based lubricants to minimize condom usage failure. The female condom has the advantage that is controlled by AGYW themselves, and can be inserted several hours before intercourse. Many young women and girls, including those in long-term relationships and sex workers, might not have the power to negotiate condom use, and men are often resistant to using condoms.

Condom interventions should therefore address barriers that hinder access to condom use and ensure AGYW have the knowledge, skills and empowerment to use them correctly and consistently.^{42,43} Barriers to condom access include legal barriers for adolescents to buy condoms, criminalization of the possession of condoms, policy barriers such as the prohibition to distribute condoms in schools, stigma towards adolescents and young people asking for condoms and lack of privacy and confidentiality. Condom distribution and sales should be tailored to the sub-age groups within AGYW to ensure access. Condoms can be delivered to adolescent girls through youth responsive health facilities, condom dispensers, schools and communities such as by peer providers. Public sector distribution can be complemented by social marketing and commercial sector sales.⁴⁴

Voluntary medical male circumcision (VMMC) is a highly cost-effective HIV-prevention intervention that can reduce the risk of transmission from women to men by about 60%,⁴⁵ and indirectly provides protection against HIV infection in women through reduced HIV prevalence in males. VMMC may be performed surgically or non-surgically. In programs offering non-surgical circumcision, WHO recommends tetanus vaccination to enable adequate protection prior to the use of prequalified non-surgical adult circumcision devices.^{46,47} Specific tetanus toxoid containing vaccination schedule depends on each individual's vaccination history; if no vaccination history exists, a minimum, 2 doses at least 4 weeks apart, with the second dose at least 2 weeks before device placement are required for protection against tetanus.^{48,49} Reaching young men with VMMC will provide the greatest efficiency and HIV-prevention impact and is a unique opportunity to provide information on HIV and SRH, and serves as a gateway to other health services.

⁴² UNFPA, WHO and UNAIDS (2015): [Position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy.](#)

⁴³ WHO, UNFPA, FHI (2010; revised 2013): Male latex condom. Specification, prequalification and guidelines for procurement. http://www.who.int/reproductivehealth/publications/family_planning/9789241599900/en/

⁴⁴ USAID, PEPFAR, SHOPS (2015): Using Total Market Approaches in Condom Programs. http://www.rhsupplies.org/uploads/tx_rhscpublications/Using%20Total%20Market%20Approaches%20in%20Condom%20Programs%20v2-1.pdf

⁴⁵ Mehta SD, Moses S, Agot K, et al. The long-term efficacy of medical male circumcision against HIV acquisition. *AIDS*. 2013;27(18):2899–907.

⁴⁶ WHO (2016) [A framework for voluntary medical male circumcision](#)

⁴⁷ WHO (2016) List of prequalified male circumcision devices. http://www.who.int/diagnostics_laboratory/evaluations/PQMCdevices_list/en/

⁴⁸ WHO (2016) [A framework for voluntary medical male circumcision](#)

⁴⁹ WHO (2016) List of prequalified male circumcision devices. http://www.who.int/diagnostics_laboratory/evaluations/PQMCdevices_list/en/

Pre-exposure prophylaxis (PrEP), the use of ARVs by HIV-negative individuals to avoid HIV infections, should be an additional prevention choice for AGYW at substantial risk of HIV⁵⁰ in a comprehensive package of HIV services. PrEP uptake and adherence among AGYW can be supported by tailoring adherence support to their specific needs in ways that reach them, such as by offering provider counselling, adherence clubs, community-, peer- or school-based support, or SMS reminders. Population Council provides guidance on how to introduce PrEP to specific sub-groups of AGYW.⁵¹

Post-exposure prophylaxis (PEP) should be offered to all AGYW with an exposure that has the potential for HIV transmission, initiated as soon as possible and ideally within 72 hours.⁵² Before PEP is prescribed, a discussion of the risks and benefits, including discussion of possible side effects and the importance of full adherence to PEP should occur. In the case of rape or intimate partner violence, PEP should be included in a comprehensive care package of care (including psychological interventions and emergency contraception to prevent pregnancy).

Key populations are at higher risk of contracting HIV, and have lower access to HIV-related services. HIV prevention interventions should be tailored to the **specific needs of AGYW key populations**,⁵³ and address the legal and structural barriers that limit their access to health services. Harm reduction programs are crucial for preventing HIV among AGYW who use drugs. Specific barriers for AGYW to access harm reduction services include age restrictions, criminalization of drug use and drug possession, parental consent requirements and lack of confidentiality.⁵⁴ Prevention programs for **young sex workers and sexually exploited AGYW** should reach these sub-populations early and effectively, as a significant proportion of new infections may occur soon after they begin to sell sex.⁵⁵ AGYW sex workers may not be able to negotiate condom use due to their economic need or lack of individual empowerment, and are subject to violence, particularly in contexts where sex work is criminalized. Programs should be responsive to their specific needs of transgender AGYW, who are often grouped with men who have sex with men (MSM) in programs, but often do not identify with MSM. Services for key populations should be integrated in a broad range of health services, including SHR, mental health and social support in order to be effective.

Comprehensive Sexuality Education

School-based **comprehensive sexuality education (CSE)** can prevent HIV infections particularly delivered together with a comprehensive package of health services to adolescents, including access to condoms, as that curriculum-based programs alone might not have an effect on the number of young people infected with HIV, STIs or the number of pregnancies.⁵⁶ CSE has demonstrated impact in improving self-esteem, self-efficacy and changing attitudes and gender and social norms.^{57, 58, 59, 60} In settings where girls are not in formal education, community based programs to deliver CSE and HIV prevention education and information are important investments.

⁵⁰ AGYW at substantial risk of HIV: (1) in high HIV incidence locations (2) with partners who are at high risk and with unknown HIV status. (3) in serodiscordant relationships (in particular for when the male partner is newly initiated on antiretroviral therapy and not yet virally suppressed).

⁵¹ Population Council (2016): [Building evidence to guide PrEP introduction for adolescent girls and young women](#).

⁵² WHO (2016): Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach - Second edition <http://www.who.int/hiv/pub/arv/arv-2016/en/>

⁵³ Applicants can refer to the WHO and Interagency Working Group on Key populations technical briefs (2015): [HIV and young people who sell sex](#); [Interagency Working Group on Key Populations. HIV and young people who inject drugs](#); [Interagency Working Group on Key Populations. HIV and young transgender people: technical briefs](#)

⁵⁴ Youth Rise (2014): [Ain't I a woman? Recognizing and protecting the rights of young women affected by HIV & drug use](#).

⁵⁵ Onyango MA, Adu-Sarkodie Y, Agyarko-Poku T et al. "It's all about making a life": poverty, HIV, violence, and other vulnerabilities faced by young female sex workers in Kumasi, Ghana. *J Acquir Immune Defic Syndr*. 2015 Mar 1;68 Suppl 2:S131-7.

⁵⁶ Mason-Jones, Amanda Jayne, Sinclair, David, Matthews, Catherine et al. (2016): School-based interventions for preventing HIV, sexually transmitted infections, and pregnancy in adolescents. *Cochrane Database of Systematic Reviews*. CD006417. ISSN 1469-493X.

⁵⁷ UNESCO and UNFPA (2015): Emerging evidence, lessons and practice in comprehensive sexuality education. A global review. <http://www.unfpa.org/publications/emerging-evidence-lessons-and-practice-comprehensive-sexuality-education-global-review>

⁵⁸ UNESCO(2015): [Comprehensive Sexuality Education: A global review](#).

⁵⁹ UNAIDS (2016) HIV prevention among adolescent girls and young women.

⁶⁰ UNESCO (2009): International Technical Guidance on Sexuality Education. <http://unesdoc.unesco.org/images/0018/001832/183281e.pdf>



Financial incentives including cash transfers

Various studies show the **promising effects of cash transfers and other financial incentives** for preventing HIV and other STIs among AGYW.^{61,62,63} They can prevent AGYW from engaging in transactional and age-disparate relationships, which is often fuelled by poverty, gender inequality and social norms. AGYW who make partner choices based on immediate economic needs commonly engage with older men, who have a higher likelihood of being infected with HIV. These age-disparate relationships can also have unequal power dynamics that might reduce the use of condoms, and thus increase the risk of HIV and other STIs. Cash transfers should always be complemented with other HIV prevention programs.

Keeping Girls in School

Keeping adolescent girls and young women in school, especially at the end of primary and into secondary level, not only reduces their vulnerabilities to HIV infection but has the potential to create a critical mass of healthy, educated and financially independent women who make well-informed choices about their lives, including family planning. For countries with HIV incidence above 1% among AGYW ages 15-24, UNAIDS recommends cash transfers, incentives, parenting programs and parental monitoring to keep AGYW in school.⁶⁴ Cash transfers and other financial incentives can increase school attendance and reduce teenage pregnancy and child marriage.

Livelihood Support

Livelihood support should be considered for girls and young women that are not in school, including female heads of households. Cash transfers can also be used for livelihood support, particularly for women aged 18-24.

ii. HIV testing services:

Access to confidential HIV **testing services for AGYW** and their male partners is essential for reducing the spread of HIV. WHO recommends HIV testing services with linkages to prevention, treatment and care for all adolescents in generalized epidemic settings, and to all adolescents from key populations in all settings.⁶⁵ Yet

⁶¹ Baird S, Chirwa E, McIntosh C, Ozler B. The short-term impacts of a schooling conditional cash transfer programme on the sexual behaviour of young women. *Health Econ.* 2010;19 Suppl: 55–68.

⁶² Björkman Nyqvist M, Corno L, de Walque D, Svensson J. Using lotteries to incentivize safer sexual behavior. Evidence from a randomized controlled trial on HIV prevention. World Bank Policy Research Working Paper 7215. March 2015.

⁶³ De Walque D, Dow W, Nathan R, Abdul R, Abilahi F, Gong E et al. Incentivising safe sex: a randomised trial of conditional cash transfers for HIV and sexually transmitted infection prevention in rural Tanzania. *BMJ Open.* 2012;2:e000747 doi:10.1136/bmjopen-2011-000747.

⁶⁴ UNAIDS (2016) HIV prevention among adolescent girls and young women.

http://www.unaids.org/sites/default/files/media_asset/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women.pdf

⁶⁵ WHO (2015) Consolidated guidelines on HIV testing services

http://apps.who.int/iris/bitstream/10665/179870/1/9789241508926_eng.pdf?ua=1&ua=1

testing coverage is often low among AGYW due to structural and age-related barriers, as well as actual or perceived poor quality services including pervasive discrimination. Fewer than one in every five adolescent girls in the Africa Region are aware of their HIV status.⁶⁶

Countries should examine and potentially revise their current age of consent policies and ensure privacy and confidentiality measures are put in place for AGYW.⁶⁷ HIV self-testing (HIVST) has the potential to increase access to HIV testing, especially for young people. WHO recommends that HIVST and voluntary assisted partner notification services should be integrated into HIV testing and care services.⁶⁸ HIVST is particularly appropriate and acceptable for AGYW and has been shown to increase the uptake of HIV testing among adolescent women and men.⁶⁹ WHO also recommends HIV testing by trained lay providers or peers.⁷⁰ Providing linkage to counselling and treatment services should be considered as part of HIV testing services, as adolescents may find it more difficult to handle an HIV-positive diagnosis, disclose to partners and may need more assistance in accessing and adhering to treatment. Linkage to effective prevention services for AGYW who test HIV negative is important to ensuring that they remain uninfected. This includes linking boys and young men who test negative to VMMC services. HIV testing services should be integrated with SRH services, as those services might be an important way to reach young women and men with HIV testing services.

iii. HIV treatment adherence and care

Supporting access, retention and adherence of HIV health services is of particular importance to AGYW, as they are prone to higher loss to follow-up rates than older adults⁷¹ and suboptimal adherence.⁷² Specific adherence challenges that adolescents face include peer pressure, inconsistent daily routine and limited availability of treatment literacy and adherence counselling tools that is adolescent-specific. Programs should also focus on treatment access and adherence for boys and young men to prevent AGYW from becoming infected with HIV.

In alignment with the treatment initiation recommendation for adults, **ARV therapy (ART) should be initiated to all adolescents living with HIV at any CD4 cell count.** In settings where malaria and/or severe bacterial infections are highly prevalent, cotrimoxazole prophylaxis should be initiated regardless of CD4 cell count and continued until adulthood, irrespective of ART provision.⁷³ By aligning recommended initiation criteria and drug regimens between adolescence and adults, programs can be simplified and ART coverage improved.⁷⁴ ARV regimens for AGYW should also include, as much as possible, once-daily dosing and the use of fixed-dose combinations, as this increased convenience allows for higher retention.⁷⁵

Long-term ART adherence of young people can be improved by ensuring that health services are adolescent-responsive.⁷⁶ The training of health-care workers and community-based approaches can contribute to treatment adherence of adolescents living with HIV. Peer-based interventions are particularly well accepted among adolescents; learning from others facing the same challenges is critical for supporting their treatment

⁶⁶ WHO (2016). Overview of the new guidelines on HIV self-testing and partner notification. <http://www.who.int/hiv/pub/vct/hiv-self-testing-guidelines/en/>

⁶⁷ WHO (2014) Adolescent HIV testing counseling and care http://apps.who.int/adolescent/hiv-testing-treatment/page/Informed_consent_and_HIV_testing

⁶⁸ WHO (2016). Overview of the new guidelines on HIV self-testing and partner notification. <http://www.who.int/hiv/pub/vct/hiv-self-testing-guidelines/en/>

⁶⁹ Choko AT, MacPherson P, Webb EL, Willey BA, Feasy H, Sambakunsi R, et al. Uptake, accuracy, safety, and linkage into care over two years of promoting annual self-testing for HIV in Blantyre, Malawi: a community-based prospective study. *PLoS Med.* 2015;12(9):e1001873.

⁷⁰ A lay provider is any person who performs functions related to health-care delivery and has been trained to deliver specific services but has received no formal professional or paraprofessional certificate or tertiary education degree. WHO: Policy Brief WHO recommends HIV testing by lay providers (2015)

⁷¹ Lamb, Matthew R., et al. "High attrition before and after ART initiation among youth (15–24 years of age) enrolled in HIV care." *AIDS* (London, England) 28.4 (2014): 559. Auld, Andrew F., et al. "Antiretroviral therapy enrollment characteristics and outcomes among HIV-infected adolescents and young adults compared with older adults-seven African countries, 2004-2013." (2014).

⁷² WHO (2015): What's new in adolescent treatment and care. <http://www.who.int/hiv/pub/arv/arv2015-adolescent-factsheet/en/>

⁷³ WHO (2016): Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach - Second edition <http://www.who.int/hiv/pub/arv/arv-2016/en/>

⁷⁴ WHO (2015): What's new in adolescent treatment and care. <http://www.who.int/hiv/pub/arv/arv2015-adolescent-factsheet/en/>

⁷⁵ WHO (2015): What's new in adolescent treatment and care. <http://www.who.int/hiv/pub/arv/arv2015-adolescent-factsheet/en/>

⁷⁶ WHO (2016): Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach - Second edition <http://www.who.int/hiv/pub/arv/arv-2016/en/>

adherence and engagement in care.⁷⁷ Adolescents should be counseled about the potential benefits and risks of disclosure of their HIV status to others and empowered and supported to determine if, when, how and to whom to disclose. Assisted partner notification services by a trained health provider can help adolescents notify their sexual and/or drug injecting partner(s).⁷⁸

AGYW HIV services must also take into consideration the **transition from pediatric to adult HIV** services, establishing linkages and referral pathways to ensure a smooth transition and comprehensive continuum of care,⁷⁹ as they might face challenges related to disclosure to partners and peers, increased responsibility of their own care, lack of links between pediatric and adult services and inadequately skilled health workers.⁸⁰ Peer-based adherence support is particularly important for this group.

AGYW living with HIV should have access to other health care services, including mental health services, and not be stigmatized by the health care system or health care workers because of their HIV status.



⁷⁷ Pangaia Global AIDS Foundation. Preliminary report of the community led consultation for WHO 2015 Consolidated treatment guidelines update. Acceptability of early initiation of antiretroviral therapy (ART) and viral load monitoring: values and preferences of service users and providers 2015 2015.

⁷⁸ WHO (2016). Overview of the new guidelines on HIV self-testing and partner notification. <http://www.who.int/hiv/pub/vct/hiv-self-testing-guidelines/en/>

⁷⁹ WHO (2015) : What's new in adolescent treatment and care. <http://www.who.int/hiv/pub/arv/arv2015-adolescent-factsheet/en/>

⁸⁰ Hussen SA, Chahroudi A, Boylan A, Camacho-Gonzalez AF, Hackett S, Chakraborty R. Transition of youth living with HIV from pediatric to adult-oriented healthcare: a review of the literature. *Future Virol.* 2015;9(10):921–9.

III. Service Delivery

HIV services should be adapted across the prevention, testing, treatment and care cascade, to reflect the needs, preferences and expectations of various groups of AGYW, including AGYW living with HIV, while also reducing unnecessary burdens on the health system. This approach is also referred to as differentiated care for HIV.

Health facilities

New and innovative approaches to service delivery that are responsive to the unique and diverse needs of AGYW can improve access, uptake and acceptability. Of particular relevance for AGYW are the new WHO and PEPFAR recommendations on reducing the frequency of ARV refills (to once every 3-6 months), clinical visits (to once every 6-12 months) and laboratory testing for people stable on ART.⁸¹ Providing more appropriate care with fewer and less intense interactions (e.g. reduced waiting times) with the health system can improve retention in care and viral suppression. Other important acceptability themes include adapting service hours to accommodate school and work hours, dedicated hours and spaces for adolescents, health workers that are trained to deliver adolescent-responsive services, comprehensive care that addresses issues beyond HIV and task shifting (including community-based services).⁸²

Decentralization of services⁸³ can also increase uptake and acceptability. This includes services closer to home, such as peripheral health facilities and service delivery at the community level. Mobile clinics can be an effective model to deliver services close to targeted groups of AGYW, for example at schools, prisons, shelters, or places where key populations live and work.

The Global Fund published a [toolkit](#) for health facilities on differentiated care for HIV and tuberculosis. The website www.differentiatedcare.org includes examples of [differentiated models of care](#), and [the decision framework for ART delivery, which](#) contains a 5-step plan to guide ART program managers, and present the building blocks of service delivery with examples of differentiated ART delivery in sub-Saharan Africa. Further iterations of the document will be developed for specific sub-populations, including adolescents.

Schools

Schools are an important delivery channel to reach AGYW with health services, including HIV prevention interventions, comprehensive sexuality or life skills education, and psycho-social support. Depending on the legal, regulatory and socio-cultural environment, health services may be offered in a school setting, including the provision of HIV prevention and testing services, and SRH services, including contraception, condoms, HPV vaccination, and VMMC referrals. Schools can work with health settings to establish referral networks in environments where school-based health services are not possible. In this case, it is critical to ensure that consideration is given to the accessibility and acceptability of health services, and employing tactics like mobile clinics and community-based services.

⁸¹ WHO (2016): Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach - Second edition <http://www.who.int/hiv/pub/arv/arv-2016/en/>

⁸² Task shifting involves the rational redistribution of tasks among health-care workers. Where appropriate, tasks are reassigned from highly qualified health workers to health workers with shorter training and fewer complementary qualifications, such as community health workers.

⁸³ Decentralization includes initiation of ART in hospitals with maintenance in peripheral health facilities, both initiation and maintenance in peripheral health facilities, or maintenance at the community level between regular clinic visits.

Community Based Responses

Community systems⁸⁴ and responses are essential to designing effective interventions, to implementing, monitoring⁸⁵ and evaluating the robustness and quality of services and creating a demand for services. Community-based service delivery⁸⁶ can increase access to and uptake of services and retention in care, as they can be delivered close to where AGYW live, and for specific communities of and age groups within AGYW. Community-based interventions, such as prevention, testing and treatment services, adherence support, community mobilization and peer education, can increase the acceptability of services for young people,⁸⁷ improve treatment adherence and retention in care of adolescents living with HIV,⁸⁸ ⁸⁹ and provide critical outreach, particularly to young women and young key populations. The communities most affected by HIV have a unique ability and responsibility to identify, understand and respond to the needs of those who are affected by inequitable access to health and other basic services, such as AGYW.

The Global Fund **strongly encourages the inclusion of interventions to strengthen community systems and responses within disease-specific and RSSH funding requests.** Guidance on how to include investments to strengthen community systems and responses in Global Fund grants is provided in the [Strengthening Community Systems and Responses: Technical Brief](#). Applicants are also encouraged to refer to the [Building Resilient and Sustainable Systems for Health through Global Fund Investments](#) Information Note.

IV. Catalytic funding

The Global Fund has recognized AGYW as one priority for **catalytic investments⁹⁰** in HIV and will focus on countries in Southern and Eastern Africa with highest HIV incidence and prevalence in women aged 15-24 years. Eligible countries are notified through their allocation letters. This funding stream aims to incentivize the programming and use of country allocations towards strategic priorities of the Global Fund and its Partners, including for scale up of programs to address HIV amongst adolescent girls and young women. This funding stream should inspire innovation and ambitious programming approaches that are driven by evidence, in order to maximize impact in these strategic priorities.

⁸⁴ "Community systems" is a broad term that describes community structures, mechanisms, processes and actors involved in community responses. Community Systems Strengthening (CSS) is an approach that promotes the development of informed, capable and coordinated communities, community-based organizations, groups, networks and structures.

⁸⁵ Community-based monitoring for accountability is a critical intervention to enable communities to monitor access to services and whether the programs are meeting the need of the community, which is critical to improve the quality and responsiveness of programs.

⁸⁶ Community-based services can be delivered through different models such as community-based organizations, local nongovernmental organizations or community health workers. Outreach, mobile services, drop-in centres and venue-based approaches are useful for reaching those with limited access to, or underserved by, formal health facilities. These approaches allow for critical linkages and referrals between the community and health facilities, and they support decentralization.

⁸⁷ WHO (2016): Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach - Second edition <http://www.who.int/hiv/pub/arv/arv-2016/en/>

⁸⁸ WHO (2016): Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach - Second edition <http://www.who.int/hiv/pub/arv/arv-2016/en/>

⁸⁹ WHO (2013): HIV and adolescence: Guidance for testing and counseling and care for adolescents living with HIV. <http://www.who.int/hiv/pub/guidelines/adolescents/en/>

⁹⁰ The Global Fund has set aside funds for catalytic investments, which serve the critical objective of catalyzing country allocations to ensure delivery against the aims of its 2017-2022 strategy. Catalytic funding is intended to build on country allocations to underpin direct investments in countries and to strengthen countries' responses to fight the three epidemics.

V. Key documents

- Global Fund: Technical brief: [Strengthening Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health in Funding Requests to the Global Fund](#) (2016)
- Global Fund Technical Brief: [Maximizing Impact by Strengthening Community Systems and Responses](#) (2016)
- Global Fund Technical Brief: Addressing people who sell sex, men who have sex with men, transgender people, people who use drugs and people in closed settings in the context of the HIV epidemic.
- Global Fund Information Note: [Building Resilient and Sustainable Systems for Health through Global Fund Investments](#) (2016)
- Global Fund Information Note: [HIV](#) (2016)
- Global Fund Information Note: [Tuberculosis](#) (2016)
- Global Fund Information Note: [Malaria](#) (2016)
- Global Fund: [Community, Rights and Gender and the 2017-2019 Funding Cycle Frequently Asked Questions](#) (2016)
- Global Fund: [Focus on Gender Equality](#) (2016)
- Global Fund: [Focus on women and girls](#) (2016)
- Global Fund: [Key Points: Women and Girls](#) (2016)
- Global Fund: [Strategic Investments for Adolescents in HIV, Tuberculosis and Malaria Programs](#) (2016)
- Global Fund: [Maximizing Impact through Strategic Investments – Improving the Health of Women and Girls](#) (2016)
- Global Fund: [Making the money work for young people: a participation tool for the Global Fund to Fight AIDS, Tuberculosis and Malaria](#) (2014)
- Global Fund: [Addressing Gender Inequalities and Strengthening Responses for Women and Girls](#) (2014)
- Global Fund: [Gender Equality Strategy Action Plan \(2014-2016\)](#)
- Global Fund: [Gender Equality Strategy](#) (2008)

WHO guidelines and key documents

- WHO/UNAIDS: [A tool for strengthening gender-sensitive national HIV and Sexual and Reproductive Health \(SRH\) monitoring and evaluation systems](#) (2016)
- WHO: [Global standards for quality health-care services for adolescents - a guide to implement a standards-driven approach to improve the quality of health-care services for adolescents](#). (Volume 1: Standards and criteria - Volume 2: Implementation guide - Volume 3: Tools to conduct quality and coverage measurement surveys to collect data about compliance with the global standards - Volume 4: Scoring sheets for data analysis) (2016)
- WHO: [Core competencies in adolescent health and development for primary care providers](#) (2015)
- WHO: [Financing health care for adolescents: a necessary part of universal health coverage](#) (2015)
- WHO: [Interagency Working Group on Key Populations. HIV and young people who sell sex](#) (2015)
- WHO: [Interagency Working Group on Key Populations. HIV and young people who inject drugs](#) (2015)
- WHO: [Interagency Working Group on Key Populations. HIV and young transgender people: technical briefs](#) (2015)
- WHO: [Adolescent HIV testing counselling and care online implementation tool](#) (2014)
- WHO: [Health for the world's adolescents: a second chance in the second decade](#) (2014)
- WHO: [HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV. Guidance document](#) (2013)
- WHO/UNAIDS: [16 Ideas for addressing violence against women in the context of the HIV epidemic](#) (2013)
- WHO: [Making health services adolescent friendly. Developing national quality standards for adolescent-friendly health services](#) (2012)
- WHO: [What's new in adolescent treatment and care? Fact Sheet: HIV treatment and care Fact Sheet](#) (2016)
- WHO: [WHO, UNFPA, UNAIDS, NSWP, World Bank, UNDP. Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions](#) (2013)

UNAIDS key planning and guiding documents and tools

UNAIDS: [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](#) (2016)

UNAIDS: [Women and Adolescent Girls on the Fast-Track to Ending the AIDS Epidemic](#) (2016)

UNAIDS: [HIV,HPV and Cervical cancer – Leveraging synergies to save women’s lives](#) (2016)

UNAIDS: [UNAIDS and The African Union. Empower young women and adolescent girls. Fast-Tracking the end of the AIDS epidemic in Africa](#) (2015)

UNAIDS: [Women living with HIV speak out against violence](#) (2014)

UNAIDS: [Adolescent girls and young women GAP report](#) (2014)

UNAIDS: [Gender-responsive HIV programming for women and girls. Guidance note](#) (2014)

Other key documents

Centre for Strategic and International Studies:

International Initiative for Impact Evaluation (3ie): [Adolescent sexual and reproductive health: the state of evidence on the impact of programming in low- and middle-income countries](#) (2016)

Systematic review: [Efficacy of school-based interventions in HIV, STDs and pregnancy](#) (2016)

The London School of Hygiene & Tropical Medicine: [Incorporating Structural Interventions in Country HIV Programme Planning and Resource allocation](#) (2016)

UNICEF: [Current status + progress: Turning the tide against AIDS will require more concentrated focus on adolescents and young people](#) (2016)

Population Council: [Building Girls’ Protective Assets: A Collection of Tools for Program Design](#) (2016)

Population Council: [Investing When It Counts: Reviewing the Evidence and Charting a Course of Research and Action for Very Young Adolescents](#) (2016)

CSIS (2015) [Addressing HIV risk in adolescent girls and young women](#) (2015)

UNICEF: [Strengthening the adolescent component of national HIV programmes through country assessments](#) (2015)

Journal of International AIDS Society: [Adolescent girls and young women: key populations for HIV epidemic control](#) (2015)

PEPFAR: [Preventing HIV in adolescent girls and young women. Guidance for PEPFAR country teams](#) (2015)

The Global Coalition on Women and AIDS: [Community innovation: achieving an end to gender-based violence through the HIV response](#) (2014)

World Bank: [The global HIV epidemics among sex workers](#) (2012)