

In sub-Saharan Africa, adolescent girls and young women (AGYW) account for 74% of new HIV infections among people aged 15-24.¹ This is roughly 360,000 AGYW a year – about 1,000 AGYW per day.²

AGYW experience converging social, cultural, economic, and political factors that undermine their sexual and reproductive health and rights (SRHR),³ which makes them vulnerable to HIV infection. In South Africa alone, about 102,000 new HIV infections occur among AGYW each year.⁴ Innovative and country-specific approaches that holistically address the risk factors of AGYW are critical for effective HIV prevention.⁵

HIV Prevention for AGYW: Strategies and Approaches that Work

WHAT WORKS FOR AGYW

Because AGYW experience numerous factors that put them at risk of HIV,⁶ prevention efforts must be multi-faceted. Effective interventions implement context-sensitive approaches while encouraging dialogue, collaboration, and partnerships that meet the SRHR needs of AGYW. In high-burden geographical areas, which are areas with a high incidence of HIV, PEPFAR's [DREAMS](#)¹ Partnership (Determined, Resilient, Empowered, AIDS-free, and Safe) has successfully worked to prevent new HIV infections while empowering AGYW.⁷ DREAMS uses a core package⁸ of evidence-based approaches to address structural, individual, and community factors that increase HIV risk for AGYW.⁹ Since 2015, 10 African countries (Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe) have implemented DREAMS programming and in 2017, five more (Botswana, Côte d'Ivoire, Haiti, Namibia, and Rwanda) began programming.¹⁰ As of 2017, in all original 10 DREAMS countries, 65 percent of the highest burden districts recorded a 25-40 percent decline in new HIV infections among AGYW.¹¹

Holistic and layered approaches that go beyond medical interventions to implementing evidence-driven initiatives that go beyond medical interventions are most effective. This approach addresses poverty, gender inequality, human rights, access to education, and sexual and physical violence barriers that undermine HIV prevention.

¹ DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) public-private partnership is a three-year global partnership between the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, ViiV Healthcare and Gilead. It committed over \$450 million to reduce new HIV infections in adolescent girls and young women in 10 sub-Saharan African countries. DREAMS programs implement the frameworks and strategies of the DREAMS initiative and have been incorporated into Country Operating Plans (COPs) beyond the original two-year scope of the DREAMS Partnership.

- 1) Keeping Girls in School:** Education serves as a protective factor against HIV amongst AGYW¹² and can improve financial security,¹³ lessen transactional sex encounters,¹⁴ reduce unplanned pregnancies,¹⁵ and improve overall health.¹⁶ Schooling that integrates school-based HIV and violence prevention interventions has demonstrated success in curbing risk behaviors.¹⁷ One DREAMS implementing organization in Lusaka, Zambia uses local libraries to reach a targeted 20,000 in-school and out-of-school AGYW aged 15-24 years with a mentorship program that fosters self-esteem, empowerment, and resilience.¹⁸

- 2) Comprehensive Sexuality Education (CSE):** CSE is a life-skills and evidence-based education, with a **thorough** curriculum that covers all aspects of sexuality.¹⁹ CSE provides information on the full breadth of available sexual and reproductive health care options.²⁰ CSE uptake in HIV prevention strategies may be challenging because of its sensitive nature and heavy politicization.²¹ Topics covered include condom promotion and provision, HIV testing and counseling (HTC), pre-exposure prophylaxis (PrEP) counseling and provision for high risk populations, contraceptive mix, factual information on abortion, post-violence care, and abstinence as one of many methods for prevention of STIs and unintended pregnancy.²² One study reviewed 22 systematic reviews and 77 randomized control trials and showed that comprehensive school-based sexuality education programs increased knowledge on pregnancy, HIV, STIs, risk behaviors and sexuality, and improved attitudes around sexual and reproductive health (SRH).²³ A randomized control study looked at Kenya's national HIV/AIDS curriculum at primary school level, which encouraged abstinence until marriage, and did not discuss interventions like condom use and partner selection as risk reduction strategies.²⁴ This abstinence-only program was compared to a Relative Risk (RR) information program that focused on improving girls' understanding of the risks associated with intergenerational sex. The study found that the abstinence-only program had no effect on risk reduction, whereas the RR program resulted in a 28 percent decrease in the likelihood of pregnancy within a year. This data, along with qualitative survey responses from the girls about their sexual behavior, suggest that the RR program lead to a decrease in unprotected sex amongst this group.²⁵

Comprehensive Sexuality Education is defined as “an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgmental information”.²⁶ The objectives of sexuality education programs may include “to increase knowledge and understanding; to explain and clarify feelings, values and attitudes; to develop or strengthen skills; to promote and sustain risk-reducing behavior.” – UNESCO²⁷

3) Holistic Adolescent and Youth Friendly Approaches:

- **Health services:** Training health providers to engage with adolescents and youth is essential for young people to access and accept health services targeted for their needs.²⁸ Médecins Sans Frontières' (MSF) youth-friendly clinic in Zimbabwe offers an adolescent corner for peer-to-peer mentoring, an area for clients to play pool and chat with trained peer educators about HIV and sexual health issues, and is staffed by providers who do not wear uniforms.²⁹ Health access points that integrate and link services (one-stop shop) are crucial for AGYW to receive and reinforce prevention messaging and activities. In Lesotho, the organization Phelisanang Bophelong (PB) partnered with Avert in 2015 to work with youth aged 15-24 years by providing HIV testing and referrals, youth group meetings, LGBT and prisoner youth groups, intergenerational exchange talks between parents and youth, as well as community and school-based health talks.³⁰ In the first year of this partnership, 5,600 youth participants received information about SRH; 3,600 participants received counseling and testing, 2,500 of which were tested for the first time; and about 2,500 participants attended youth clubs.³¹
- **Social approaches:** Interventions that creatively add on skill-based exercises or specific content in a **safe and supportive** environment provide a time and space for peers to interact and speak about SRH and strategies.³² **Social groups/clubs** encourage peer-led SRH knowledge exchange between young people.³³ In Malawi, one such youth group named Zathu brings young women and men together as brand ambassadors to use music and storytelling to engage with gender-related topics about relationships and confidence. Over one million people have engaged with this group's messaging. Brand ambassadors have connected with more than 7,500 young people, 300 youth clubs, and 200 village heads, while Zathu's digital music platforms have been used more than 1.02 million times.³⁴
- **Economic approaches:** Financial security reduces HIV risk behavior among AGYW.³⁵ When AGYW are economically vulnerable, they may become dependent on men for financial support, which can restrict their ability to negotiate condom use, discuss fidelity, or even refuse sex.³⁶ The South African Child Support Grant (CSG) is an unconditional cash transfer program for economically vulnerable children and adolescents.³⁷ Studies exploring the effects of this cash transfer program on adolescents' engagement in risky behaviors showed that the program played a vital role in reducing the likelihood of early sexual debut among female adolescents;³⁸ and girls in households receiving CSG were less likely to engage in transactional and age-disparate sex, compared to their non-beneficiary peers.³⁹ Cash programs are not effective in all country settings. In Malawi, a cash transfer program to keep girls in school increased school attendance, reduced risk behaviors, and lowered HIV and

herpes prevalence.⁴⁰ The same cash transfer program did not work in South Africa. Although school attendance increased, there was no effect on STI prevalence.⁴¹ Educational subsidies are also costly and can become unsustainable.⁴²

4) Reducing Gender-based violence (GBV): GBV is a driver of HIV risk for AGYW.⁴³ Globally, one in three women experiences GBV in her lifetime.⁴⁴ Girls aged 9-14 are at a high risk of sexual violence and GBV,⁴⁵ which makes them **three times** more likely to get an STI or HIV.⁴⁶ Addressing intimate partner violence (IPV) and sexual violence to curb HIV infection includes school-based programs that address partner violence, and gender-equitable community-based interventions and attitudes.⁴⁷ A six-week self-defense program for adolescent girls in Nairobi, Kenya schools was effective in reducing sexual assault incidences among these girls. Over half of the girls in the survey had used self-defense to prevent sexual assault within one year after the training.⁴⁸ In the U.S., Safe Dates was a multi-component school-based program for both boys and girls offered at the beginning of their dating careers with the aim of reducing sexual and dating violence.⁴⁹ A randomized control study assessing the program found that four years after being in the Safe Dates program, adolescents were perpetrators of significantly less sexual and dating violence, compared to their non-beneficiary counterparts.⁵⁰ A multi-country (Chile, Brazil, Rwanda, India) intervention study to engage men in reducing GBV found that targeted education for young and adult men resulted in increased discussion about gender equality and decreased tolerance for attitudes that support IPV.⁵¹

5) Working with men, families, and communities:

- **Male engagement:** HIV prevention for AGYW includes bringing more men into the health system. Young men have been systematically underserved in HIV services⁵² and if infected, may eventually go on and infect young women.⁵³ Young men are less likely to access HIV services compared to young women.⁵⁴ Male-friendly clinics that are a one-stop shop, have male staff, and offer a short waiting time could shift this dynamic.⁵⁵ MSF in Cape Town, South Africa employs various strategies to encourage men to seek care. They staff a clinic with only male providers as well as convert one primary health care facility into a males-only clinic from 4pm to 8pm once per week⁵⁶ to encourage more men to get Voluntary Counseling and Testing.
- **Voluntary Medical Male Circumcision (VMMC):** As of 2017, PEPFAR has provided VMMC to 15.2 million young men in Eastern and Southern Africa.⁵⁷ VMMC protects men and boys against HIV infection by removing the foreskin of the penis, which is highly susceptible to HIV infection.⁵⁸ Expanding socially acceptable VMMC for boys and young men will further decrease HIV risk for all, including AGYW.⁵⁹ In South Africa, Aurum Institute hosts a program that provides VMMC for adolescent boys

aged 15-19 and addresses the barriers of masculinity and manhood that circumcision may propagate.⁶⁰

- **Community engagement:** Working with communities, faith-based leaders, and families to shift harmful gender norms that perpetuate violence against young girls and women increases the social acceptability of prevention interventions. In 2017, Voices for Change in Nigeria provided training to religious and traditional leaders on gender and religion topics as a strategy for improving the lives and choices for adolescent girls and young women. About two thirds of the 403 trained leaders reached over 400,000 people with their message and actions against discriminatory practices.⁶¹

WHAT DOES NOT WORK FOR AGYW

- **Single-session, one-off, or isolated** interventions have shown slight improvements in behavioral outcomes with little to no significant impact on biological outcomes such as HIV incidence.⁶² Modifying the interventions in a program during adaptation is likely to reduce the program's effectiveness⁶³ compared to programs that are implemented as intended in their design, approach, and delivery.⁶⁴ The latter is more likely to have the desired positive impacts on young people's health.
- **Sexual-Risk Avoidance Education (SRA)** education refers to what has been known as "abstinence-only" education.⁶⁵ SRA teaches abstinence as the **only form** of sexual expression for adolescents⁶⁶ and usually censors information about condoms and contraception as methods of preventing sexually transmitted diseases and unintended pregnancies.⁶⁷ A systematic review of evidence from 13 trials that encompassed 15,940 youths found that SRA had no impact on reducing unprotected vaginal sex or number of partners, nor increasing condom use or delaying sexual initiation.⁶⁸
- **Peer education programs** alone have minimal impact. Meta-analysis evidence showed that the intervention alone moderately improved behavioral outcomes but showed no significant effect on sexually transmitted infections including HIV outcomes.⁶⁹ More rigorous studies are needed to investigate the long-term effects of peer-based interventions on biological outcomes.

Siloed interventions are less likely to have sustainable HIV prevention compared to comprehensive and layered programs. Efforts should be made to improve reporting and data on which interventions are working in various contexts, including how they have been implemented and evaluated. Comprehensive and layered approaches to support HIV prevention in AGYW have been adopted by partners such as the Global Fund,⁷⁰ Family Planning 2020,⁷¹ PEPFAR⁷² and the United States Agency for International Development (USAID).⁷³

- ¹ UNAIDS 2013 HIV Estimates, in UNAIDS & THE AFRICAN UNION, EMPOWER YOUNG WOMEN AND ADOLESCENT GIRLS: FAST-TRACKING THE END OF THE AIDS EPIDEMIC IN AFRICA 8 (2015), available at http://www.unaids.org/sites/default/files/media_asset/JC2746_en.pdf.
- ² See The United States President's Emergency Plan for AIDS Relief (PEPFAR), Adolescent Girls & Women, <https://www.pepfar.gov/priorities/girlswomen/index.htm> (last visited July 13, 2018); PEPFAR, PEPFAR 2018 ANNUAL REPORT TO CONGRESS 18 (2018), available at <https://www.pepfar.gov/documents/organization/279889.pdf> [hereinafter PEPFAR 2018 ANNUAL REPORT TO CONGRESS].
- ³ See Abigail Harrison et al., *Sustained High HIV Incidence in Young Women in Southern Africa: Social, Behavioral and Structural Factors and Emerging Intervention Approaches*, 12 CURR. HIV/AIDS REP. 207 (2015) [hereinafter Abigail Harrison et al., *Sustained High HIV Incidence in Young Women in Southern Africa*]. See also 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 12-16 (2016), available at http://www.unaids.org/sites/default/files/media_asset/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women.pdf [hereinafter UNAIDS, HIV PREVENTION AMONG ADOLESCENT GIRLS AND YOUNG WOMEN].
- ⁴ Musawenkosi Mabaso et al., *Determinants of HIV infection among adolescent girls and young women aged 15–24 years in South Africa: a 2012 population-based national household survey*, 18 BMC PUBLIC HEALTH 2 (2018).
- ⁵ UNAIDS, HIV PREVENTION AMONG ADOLESCENT GIRLS AND YOUNG WOMEN, *supra* note 3, at 20-21.
- ⁶ Rachael C. Dellar, Sarah Dlamini & Quarraisha Abdool Karim, *Adolescent girls and young women: key populations for HIV epidemic control*, 18 J. INT. AIDS SOC. 64, 66-67 (2015).
- ⁷ See CENTER FOR HEALTH AND GENDER EQUITY (CHANGE), THE U.S. DREAMS PARTNERSHIP: BREAKING BARRIERS TO HIV PREVENTION FOR ADOLESCENT GIRLS AND YOUNG WOMEN (2017), available at http://www.genderhealth.org/files/uploads/change/publications/2017_DREAMS_web_final.pdf; CHANGE, THE U.S. DREAMS PARTNERSHIP: BREAKING BARRIERS TO HIV PREVENTION FOR ADOLESCENT GIRLS AND YOUNG WOMEN (2016), available at http://www.genderhealth.org/files/uploads/change/publications/CHANGE_Dreams_Report_Updated.pdf.
- ⁸ PEPFAR ET AL., DREAMS INNOVATION CHALLENGE 2, available at <https://www.pepfar.gov/documents/organization/247602.pdf> (last visited July 13, 2018).
- ⁹ See Quarraisha Abdool Karim, Cheryl Baxter & Deborah Bix, *Prevention of HIV in Adolescent Girls and Young Women: Key to an AIDS-Free Generation*, 75 J. ACQUIR. IMMUNE DEFIC. SYNDR. S17 (2017).
- ¹⁰ PEPFAR 2018 ANNUAL REPORT TO CONGRESS, *supra* note 2, at 18, 68.
- ¹¹ PEPFAR, FACT SHEET: PEPFAR LATEST GLOBAL RESULTS 1 (2018), available at <https://www.pepfar.gov/documents/organization/276321.pdf> [hereinafter PEPFAR LATEST GLOBAL RESULTS].
- ¹² Jan-Walter De Neve et al., *Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment*, 3 THE LANCET GLOBAL HEALTH e470, e474-e477 (2015).
- ¹³ MONAZZA ASLAM, EMPOWERING WOMEN: EDUCATION AND THE PATHWAYS OF CHANGE, BACKGROUND PAPER PREPARED FOR THE EDUCATION FOR ALL GLOBAL MONITORING REPORT 2013/4 TEACHING AND LEARNING: ACHIEVING QUALITY FOR ALL 22-24 (2013), available at <http://unesdoc.unesco.org/images/0022/002259/225925e.pdf>.
- ¹⁴ See Sarah J Baird et al., *Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial*, 379 THE LANCET 1320, 1328-1329 (2012) [hereinafter Baird et al., *Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi*].
- ¹⁵ Cynthia B. Lloyd, *The role of schools in promoting sexual and reproductive health among adolescents in developing countries*, in WORLD HEALTH ORGANIZATION (WHO), SOCIAL DETERMINANTS OF SEXUAL AND REPRODUCTIVE HEALTH. INFORMING FUTURE RESEARCH AND PROGRAMME IMPLICATIONS 113-132 (Shawn Malarcher ed., 2010). See also UNITED NATIONS POPULATION FUND (UNFPA), MOTHERHOOD IN CHILDHOOD: FACING THE CHALLENGES OF ADOLESCENT PREGNANCY 25 (2014), available at <https://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013.pdf> [hereinafter UNFPA, MOTHERHOOD IN CHILDHOOD].
- ¹⁶ WHO & HUMAN REPRODUCTION PROGRAMME (HRP), GLOBAL CONSULTATION ON LESSONS FROM SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMING TO CATALYSE HIV PREVENTION FOR ADOLESCENT GIRLS AND YOUNG WOMEN 3-4, 13, 15, 32 (2016), available at http://www.who.int/reproductivehealth/topics/linkages/WHO_Meeting_Rpt_HIV_Prevention_AGYW.pdf [hereinafter WHO & HRP, GLOBAL CONSULTATION ON LESSONS FROM SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMING].
- ¹⁷ UNFPA, MOTHERHOOD IN CHILDHOOD, *supra* note 15, at 59-60, 74-75.
- ¹⁸ Lubuto Library Partners, Lubuto receives DREAMS Innovation Challenge grant to keep girls in school, prevent AIDS (Nov. 2016), <https://www.lubuto.org/november-2016/>. See also Lubuto Library Partners, Keeping Girls in Secondary School and AIDS-free, <https://www.lubuto.org/dreams/#dreamsprogramms> (last visited July 16, 2018).
- ¹⁹ United Nations Educational, Scientific and Cultural Organization (UNESCO), INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION: AN EVIDENCE-INFORMED APPROACH 15-20 (2018), available at <http://unesdoc.unesco.org/images/0026/002607/260770e.pdf> [hereinafter UNESCO, INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION].
- ²⁰ Advocates for Youth, Sex Education Programs: Definitions & Point-by-Point Comparison, <http://www.advocatesforyouth.org/publications/publications-a-z/655-sex-education-programs-definitions-and-point-by-point-comparison> (last visited July 16, 2018) [hereinafter Advocates for Youth, Sex Education Programs].
- ²¹ *Id.* at 18-19.

- ²² UNESCO, INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION, *supra* note 19, at 22-24.
- ²³ See UNESCO, REVIEW OF THE EVIDENCE ON SEXUALITY EDUCATION: REPORT TO INFORM THE UPDATE OF THE UNESCO INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION (2016), available at <http://unesdoc.unesco.org/images/0026/002646/264649e.pdf> [hereinafter UNESCO, REVIEW OF THE EVIDENCE ON SEXUALITY EDUCATION].
- ²⁴ Pascaline Dupas, *Do Teenagers Respond to HIV Risk Information? Evidence from a Field Experiment in Kenya*, 3 AMERICAN ECONOMIC JOURNAL: APPLIED ECONOMICS 1, 3 (2011).
- ²⁵ *Id.* at 20.
- ²⁶ UNESCO, REVIEW OF THE EVIDENCE ON SEXUALITY EDUCATION, *supra* note 23, at 6.
- ²⁷ UNESCO, INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION: AN EVIDENCE-INFORMED APPROACH FOR SCHOOLS, TEACHERS AND HEALTH EDUCATORS 3 (2009), available at <http://unesdoc.unesco.org/images/0018/001832/183281e.pdf>.
- ²⁸ Doctors Without Borders SA, Zimbabwe: Providing adolescent sexual and reproductive health services (Mar. 13, 2018), <https://doctorswithoutborderssa.exposure.co/zimbabwe?slow=1>.
- ²⁹ *Id.*
- ³⁰ Avert, Phelisanang Bophelong (PB) in Lesotho, <https://www.avert.org/what-we-do/where-we-work/pb> (last visited July 16, 2018).
- ³¹ Avert, Young People, HIV and AIDS, <https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/young-people> (last visited July 16, 2018); Avert, Effective Civil Society, <https://www.avert.org/effective-civil-society> (last visited July 16, 2018).
- ³² WHO & HRP, GLOBAL CONSULTATION ON LESSONS FROM SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMING, *supra* note 16, at 22; see also MEASURE EVALUATION, BEST PRACTICES FOR ADOLESCENT- AND YOUTH-FRIENDLY HIV SERVICES: A COMPENDIUM OF SELECTED PROJECTS IN PEPFAR-SUPPORTED COUNTRIES 19 (Anastasia J. Gage, Mai Do & Donald Grant eds., 2017), available at https://www.measureevaluation.org/resources/publications/tr-16-134/at_download/document [hereinafter MEASURE EVALUATION, BEST PRACTICES FOR ADOLESCENT- AND YOUTH-FRIENDLY HIV SERVICES].
- ³³ MEASURE EVALUATION, BEST PRACTICES FOR ADOLESCENT- AND YOUTH-FRIENDLY HIV SERVICES, *supra* note 32, at 19.
- ³⁴ PEPFAR 2018 ANNUAL REPORT TO CONGRESS, *supra* note 2, at 69.
- ³⁵ Stefani A. Butts et al., *Let us fight and support one another: adolescent girls and young women on contributors and solutions to HIV risk in Zambia*, 9 INTERNATIONAL JOURNAL OF WOMEN'S HEALTH 727, 731-732, 735 (2017).
- ³⁶ Geeta Rao Gupta, *How men's power over women fuels the HIV epidemic*, 324 BMJ 183, 183 (2002).
- ³⁷ Center for Global Development, A Step Up for the Children Apartheid Left Behind: South Africa's Child Support Grant, <http://millionssaved.cgdev.org/case-studies/south-africas-child-support-grant> (last visited July 16, 2018).
- ³⁸ See Carolyn J. Heinrich, John Hoddinott & Michael Samson, *Reducing Adolescent Risky Behaviors in a High-Risk Context: The Effects of Unconditional Cash Transfers in South Africa*, 65 ECONOMIC DEVELOPMENT AND CULTURAL CHANGE 619 (2017).
- ³⁹ Lucie Cluver et al., *Child-focused state cash transfers and adolescent risk of HIV infection in South Africa: A propensity-score-matched case-control study*, 1 THE LANCET GLOBAL HEALTH e362, e366 (2013).
- ⁴⁰ See Baird et al., *Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi*, *supra* note 14.
- ⁴¹ HIV Prevention Trials Network, HPTN 068: Effects of cash transfer for the prevention of HIV in young South African women, Study Summary, <https://www.hptn.org/research/studies/88> (last visited July 16, 2018).
- ⁴² PEPFAR, PEPFAR 2018 COUNTRY OPERATIONAL PLAN GUIDANCE FOR STANDARD PROCESS COUNTRIES 245 (2018), available at <https://www.pepfar.gov/documents/organization/276459.pdf> [hereinafter PEPFAR 2018 COP GUIDANCE FOR STANDARD PROCESS COUNTRIES].
- ⁴³ See Kristin L. Dunkle et al., *Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa*, 363 THE LANCET 1415 (2004); Rachel K. Jewkes et al., *Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study*, 376 THE LANCET 41, 45-47 (2010).
- ⁴⁴ WHO, LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE & SOUTH AFRICAN MEDICAL RESEARCH COUNCIL, GLOBAL AND REGIONAL ESTIMATES OF VIOLENCE AGAINST WOMEN: PREVALENCE AND HEALTH EFFECTS OF INTIMATE PARTNER VIOLENCE AND NON-PARTNER SEXUAL VIOLENCE. GENEVA: WORLD HEALTH ORGANIZATION 35 (2013), available at http://www.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf.
- ⁴⁵ PEPFAR 2018 ANNUAL REPORT TO CONGRESS, *supra* note 2, at 18, 71.
- ⁴⁶ *Id.* at 18.
- ⁴⁷ Rebecka Lundgren & Avni Amin, *Addressing intimate partner violence and sexual violence among adolescents: emerging evidence of effectiveness*, 56 JOURNAL OF ADOLESCENT HEALTH S42, S46-S47 (2015).
- ⁴⁸ See Jake Sinclair et al., *A Self-Defense Program Reduces the Incidence of Sexual Assault in Kenyan Adolescent Girls*, 53 JOURNAL OF ADOLESCENT HEALTH 374 (2013).
- ⁴⁹ CHRISTINE RICARDO, MARCI EADS & GARY BARKER, ENGAGING BOYS AND MEN IN THE PREVENTION OF SEXUAL VIOLENCE: A SYSTEMATIC AND GLOBAL REVIEW OF EVALUATED INTERVENTIONS 31 (2011), available at <http://www.svri.org/sites/default/files/attachments/2016-03-21/menandboys.pdf>.
- ⁵⁰ Vangie A. Foshee et al., *Assessing the Long-Term Effects of the Safe Dates Program and a Booster in Preventing and Reducing Adolescent Dating Violence Victimization and Perpetration*, 94 AMERICAN JOURNAL OF PUBLIC HEALTH 619, 621 (2004).
- ⁵¹ See INSTITUTO PROMUNDO, ENGAGING MEN TO PREVENT GENDER-BASED VIOLENCE: A MULTI-COUNTRY INTERVENTION AND IMPACT EVALUATION STUDY 10, 13-15 (2012), available at <http://menengage.org/wp-content/uploads/2014/01/Engaging-men-in-GBV-multicountry-impact-study-Promundo-.pdf>.

- ⁵² Kathryn Dovel et al., *Men's heightened risk of AIDS-related death: the legacy of gendered HIV testing and treatment strategies*, 29 AIDS 1123, 1123-1125 (2015).
- ⁵³ See, e.g., Abigail Harrison et al., *Sustained High HIV Incidence in Young Women in Southern Africa*, *supra* note 3.
- ⁵⁴ Morna Cornell, James McIntyre & Landon Myer, *Men and antiretroviral therapy in Africa: our blind spot*, 16 TROP. MED. INT. HEALTH 828, 828-829 (2011); see also UNAIDS, BLIND SPOT: REACHING OUT TO MEN AND BOYS: ADDRESSING A BLIND SPOT IN THE RESPONSE TO HIV 5, 8-9 (2017), available at http://www.unaids.org/sites/default/files/media_asset/blind_spot_en.pdf [hereinafter UNAIDS, BLIND SPOT: REACHING OUT TO MEN AND BOYS].
- ⁵⁵ UNAIDS, BLIND SPOT: REACHING OUT TO MEN AND BOYS, *supra* note 52, at 38, 46; see also BLIA YANG ET AL., WORKING EVENING AND WEEKEND SCHEDULES IS EFFECTIVE IN REACHING MORE MEN FOR HOME-BASED HIV TESTING: FINDINGS FROM HPTN 071 (POPART) IN SOUTH AFRICA 1 (2016), available at http://programme.aids2016.org/PAGMaterial/eposters/0_3266.pdf.
- ⁵⁶ See Amy Green, *Man to man, sexual health needs are better met at male-only clinics*, BHEKISISA, July 10, 2015, <http://bhekisisa.org/article/2015-07-09-man-to-man-sexual-health-needs-are-better-met-at-male-only-clinics>.
- ⁵⁷ PEPFAR LATEST GLOBAL RESULTS, *supra* note 11, at 1.
- ⁵⁸ WHO, Voluntary medical male circumcision for HIV prevention (July 2012), http://www.who.int/hiv/topics/malecircumcision/fact_sheet/en/.
- ⁵⁹ WHO & UNAIDS, A FRAMEWORK FOR VOLUNTARY MEDICAL MALE CIRCUMCISION: EFFECTIVE HIV PREVENTION AND A GATEWAY TO IMPROVED ADOLESCENT BOYS' & MEN'S HEALTH IN EASTERN AND SOUTHERN AFRICA BY 2021 3, 9-10 (2016). See also UNAIDS, BLIND SPOT: REACHING OUT TO MEN AND BOYS, *supra* note 52, at 27.
- ⁶⁰ WHO & HRP, GLOBAL CONSULTATION ON LESSONS FROM SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMING, *supra* note 16, at 19-20.
- ⁶¹ VOICES FOR CHANGE, ENGAGING RELIGIOUS AND TRADITIONAL LEADERS FOR GENDER EQUALITY: VOICES FOR CHANGE STORIES OF LEARNING 7 (2017), available at http://www.v4c-nigeria.com/wp-content/uploads/2014/09/SOL_EngagingLeaders_Web.pdf.
- ⁶² See Sandra I. McCoy, Rugare A. Kangwende & Nancy S. Padian, *Behavior Change Interventions to Prevent HIV Infection Among Women Living in Low and Middle Income Countries: A Systematic Review*, 14 AIDS AND BEHAVIOR 469, 469-482 (2010); see also Melanie Gallant & Eleanor Maticka-Tyndale, *School-Based HIV Prevention Programmes for African Youth*, 58 SOCIAL SCIENCE & MEDICINE 1337, 1346-1347, 1349-1350 (2004).
- ⁶³ Cailin O'Connor, Stephen A. Small & Siobhan M. Cooney, *Program fidelity and adaptation: Meeting local needs without compromising program effectiveness 2-3* (What Works, Wisconsin – Research to Practice Series, Issue #4, 2007), available at https://fyi.uwex.edu/whatworkswisconsin/files/2014/04/whatworks_04.pdf; see also UNESCO, INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION, *supra* note 19, at 29.
- ⁶⁴ Kristien Michiels et al., *Effectiveness of HIV prevention for youth in sub-Saharan Africa: systematic review and meta-analysis of randomized and nonrandomized trials*, 24 AIDS 1193, 1200-1201 (2010); see also UNESCO, INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION, *supra* note 19, at 29.
- ⁶⁵ Advocates for Youth, Sex Education Programs, *supra* note 20.
- ⁶⁶ *Id.*; FAMILY & YOUTH SERVICES BUREAU, ADOLESCENT PREGNANCY PREVENTION PROGRAM, SEXUAL RISK AVOIDANCE EDUCATION PROGRAM FACT SHEET 1 (2017), available at https://www.acf.hhs.gov/sites/default/files/fysb/srae_facts_20170217.pdf.
- ⁶⁷ Advocates for Youth, Sex Education Programs, *supra* note 20.
- ⁶⁸ Kristen Underhill, Paul Montgomery & Don Operario, *Sexual abstinence only programmes to prevent HIV infection in high income countries: systematic review*, 335 BMJ 1, 5-8 (2007).
- ⁶⁹ See Amy Medley et al., *Effectiveness of peer education interventions for HIV prevention in developing countries: a systematic review and meta-analysis*, 21 AIDS EDUC. PREV. 181 (2009).
- ⁷⁰ THE GLOBAL FUND, THE GLOBAL FUND STRATEGY 2017-2022: INVESTING TO END EPIDEMICS 15-18, 21-25 (2016), available at https://www.theglobalfund.org/media/1176/bm35_02-theglobalfundstrategy2017-2022investingtoendepidemics_report_en.pdf.
- ⁷¹ Family Planning 2020, Family Planning 2020: Accelerating Progress: Strategy for 2016-2020, available at <http://www.familyplanning2020.org/microsite/strategy> (last visited July 16, 2018).
- ⁷² PEPFAR 2018 COP GUIDANCE FOR STANDARD PROCESS COUNTRIES, *supra* note 69, at 22.
- ⁷³ PrEPWatch, USAID Microbicide Product Introduction Initiative (MPii), <https://www.prepwatch.org/usaids-supported-initiatives/> (last visited July 16, 2018).