THE U.S. DREAMS PARTNERSHIP:
BREAKING BARRIERS TO HIV PREVENTION
FOR ADOLESCENT GIRLS AND YOUNG WOMEN

A field report on sexual and reproductive health and rights
in the U.S. DREAMS Partnership in South Africa and Kenya

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The views expressed and conclusions drawn in this report are those of CHANGE.
# TABLE OF CONTENTS

LETTER FROM THE PRESIDENT ...................................................................................................................... 4

ACRONYMS ...................................................................................................................................................... 5

EXECUTIVE SUMMARY .................................................................................................................................. 6

ABOUT CHANGE .............................................................................................................................................. 8

METHODOLOGY .............................................................................................................................................. 8

PART I. INTRODUCTION .................................................................................................................................. 9
   A. U.S. Global AIDS Policy ........................................................................................................................ 9
   B. The DREAMS Partnership .................................................................................................................... 10
   C. DREAMS Interventions ......................................................................................................................... 11
   D. DREAMS Monitoring and Evaluation ................................................................................................. 13

PART II. BACKGROUND .................................................................................................................................. 14
   A. HIV Prevention, Adolescent Girls, and U.S. Funding in South Africa ................................................. 14
   B. HIV Prevention, Adolescent Girls, and U.S. Funding in Kenya ............................................................ 14

PART III. FINDINGS ....................................................................................................................................... 16
   A. Launching DREAMS ............................................................................................................................ 16
   B. Evidence-based Interventions ............................................................................................................... 18
   C. Civil Society Engagement .................................................................................................................... 23
   D. Adolescent Girls and Young Women with Specific Concerns ........................................................................ 25
   E. The Road to Success for DREAMS ....................................................................................................... 27

PART IV. CONCLUSION AND RECOMMENDATIONS .................................................................................. 28

ENDNOTES .................................................................................................................................................... 29
LETTER FROM THE PRESIDENT

In 2004, President George W. Bush signed into law the President’s Emergency Plan for AIDS Relief (PEPFAR) to combat the global AIDS crisis. One of the most widely recognized accomplishments of his administration, the measure has greatly expanded access to treatment globally for people living with HIV.

Yet from the start, PEPFAR was constrained by funding restrictions that undermined efforts to slow the spread of HIV. Notable was the budget allocation for abstinence-only until marriage and faithfulness in marriage programs—a prevention intervention based in ideology, not public health. The Anti-Prostitution Loyalty Oath (APLO), which requires recipients of global AIDS funding to adopt a policy opposing prostitution, was also written into the law. Like PEPFAR’s abstinence programs, the APLO has been proven ineffective and has undermined access to HIV prevention and treatment services for sex workers.

While PEPFAR has been instrumental in treatment provision and saving lives, these types of restrictions have compromised the health and human rights of the law’s intended beneficiaries, particularly women and girls.

A new pioneering initiative now intends to reach this often forgotten population in the U.S. global HIV/AIDS response. Introduced by U.S. Global AIDS Ambassador Dr. Deborah Birx in 2014, the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) partnership infuses funding into HIV prevention programs for adolescent girls and young women aged 15-24. Importantly, DREAMS addresses HIV from a holistic perspective by considering the economic, social, cultural, behavioral, and biomedical factors that put girls and young women at risk of HIV infection. The initial two-year effort is being implemented in 10 countries in sub-Saharan Africa.

The Center for Health and Gender Equity (CHANGE) recognizes the significance of PEPFAR’s investment of nearly 400 million dollars in HIV prevention for adolescent girls and young women. And as a U.S. based women’s rights organization, it is our role and responsibility to ensure that these funds translate into tangible results for the sexual and reproductive health and rights of girls and young women who are impacted by DREAMS programs.

With that, CHANGE staff traveled to sub-Saharan Africa earlier this year to examine how DREAMS is being implemented, its attention to sexual and reproductive health and rights, and to assess its strengths and challenges. We focused our fact-finding journey in South Africa and Kenya, two countries that, according to PEPFAR, were the farthest along in implementation. Our objective was to identify promising practices along with areas where improvements should be made during the second year of DREAMS.

This report provides an overview of the DREAMS partnership and documents key findings from CHANGE’s fact-finding visits to South Africa and Kenya. The purpose of the report is to inform U.S. policy makers, donors, and advocates about what DREAMS is and how the partnership is being implemented in the two countries in order to better understand some of the challenges and opportunities for successful HIV prevention for adolescent girls and young women. We hope the information will propagate successful practices and spark new ideas and strategies to increase support for the sexual and reproductive health and rights of adolescent girls and young women.

In addition to highlighting findings from the field, the report identifies U.S. policy restrictions that pose significant barriers to the DREAMS targets for HIV reduction among adolescent girls and young women. Our hope is that the findings and analysis will lead to necessary changes in how the
U.S. approaches the health and rights of girls and women globally to truly promote their sexual and reproductive health and rights.

CHANGE is committed to ensuring that this groundbreaking initiative is successful, as it has the potential to significantly improve the lives of adolescent girls and young women across sub-Saharan Africa. With continued funding by the U.S. for HIV programming for girls and women that promotes sexual and reproductive health and rights, and continued involvement of civil society and advocates from around the world, we may just have a fighting chance to turn the tide on HIV and AIDS.

Serra Sippel
President

ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ABC</td>
<td>Abstinence, Be Faithful, and correct and consistent Condom use</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APLO</td>
<td>Anti-Prostitution Loyalty Oath</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>CBO</td>
<td>Community-based Organization</td>
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<tr>
<td>COPs</td>
<td>Country Operational Plans</td>
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<tr>
<td>DREAMS</td>
<td>Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe</td>
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<tr>
<td>GBV</td>
<td>Gender-based Violence</td>
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<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HTC</td>
<td>HIV Testing and Counseling</td>
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<tr>
<td>IS</td>
<td>Implementation Science</td>
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<tr>
<td>MER</td>
<td>Monitoring, Evaluation, and Reporting</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental Organization</td>
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<tr>
<td>OGAC</td>
<td>U.S. Office of the Global AIDS Coordinator</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PLWH</td>
<td>People Living with HIV</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<tr>
<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
</tr>
<tr>
<td>SANAC</td>
<td>South African National AIDS Council</td>
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<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<tr>
<td>STI</td>
<td>Sexually-Transmitted Infection</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VMCC</td>
<td>Voluntary Medical Male Circumcision</td>
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EXECUTIVE SUMMARY

For 30 years, HIV has been considered a serious public health crisis requiring increased funding and programmatic efforts by the U.S. government. In 1991, estimates predicted that in sub-Saharan Africa approximately 9 million people would be living with HIV by the end of the decade—a gross underestimation. In 2000, 5.3 million people were diagnosed with HIV, while the number of people living with HIV totaled 36.1 million.

Since then, significant progress has been made in curbing HIV rates globally. South Africa and Kenya, the two countries this report focuses on, have seen tremendous progress. In 2015, for example, South Africa had approximately 3.5 million people on treatment, more than any other country in the world. Kenya had nearly 900,000 people on treatment at the end of that same year. While these are clear steps in the right direction, not every population has fared equally well.

The world’s adolescent girls and young women have been largely forgotten in the decades-long fight to curb HIV/AIDS. Estimates as recent as 2015 show that there are approximately 36.7 million people living with HIV globally, 2.1 million of whom acquired HIV that year. When these numbers are disaggregated by gender, age, and geographical region, adolescent girls and young women aged 15-24, in sub-Saharan Africa in particular, are disproportionately affected by HIV and face disparate access to treatment and care. The Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Partnership (DREAMS) aims to change that.

DREAMS is a comprehensive, multisectoral strategy introduced by the President’s Emergency Plan for AIDS Relief (PEPFAR) on World AIDS Day 2014. DREAMS is a first-of-its-kind effort intended for the most vulnerable populations of adolescent girls and young women aged 15-24 in 10 countries in sub-Saharan Africa: Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. DREAMS seeks to reduce HIV incidence by 25% in the program’s first year, and by 40% in the second year. It plans to accomplish this by going beyond biomedical interventions alone, to also saturate the target population with an evidence-based mix of programming such as post-violence care, the creation of safe spaces, comprehensive sexuality education, community mobilization, and norms change.

Each DREAMS country determines relevant interventions to include as part of its evidence-based approach to HIV prevention, and to which age groups it will offer services. “Prime partners,” or the U.S. government-funded organizations that coordinate DREAMS programming, collaborate with in-country teams to ensure that DREAMS interventions are properly carried out.

In July 2016, CHANGE traveled to South Africa and Kenya to learn more about the implementation of DREAMS. CHANGE staff conducted interviews with adolescent girls and young women, prime partners, civil society, and U.S. government officials to understand the experiences of program participants, implementers, and funders with DREAMS. These interviews revealed some promising practices and outcomes of DREAMS. For instance, we noted robust civil society engagement, new lines of communication unfolding between civil society and PEPFAR, a highly-praised tool to identify vulnerable girls, and enthusiasm for female condoms.

CHANGE also noted areas for improvement, such as better coordination and communication between PEPFAR and civil society. Many prime partners indicated that a delayed, then swift rollout of DREAMS was marked by a lack of coordination and consultation with civil society and prime partners. This, they said, could have unintended consequences: participants may not be able to achieve their stated targets and the saturation necessary to reduce HIV incidence to the desired extent among adolescent girls and young women within the two-year time frame.
Based on interviews, literature review, and policy analyses, CHANGE provides recommendations for how the U.S. government, and PEPFAR in particular, can support and improve upon an integrated sexual and reproductive health and rights approach to DREAMS. Some recommendations noted in this report include replacing PEPFAR’s “top-down” approach with better engagement of grassroots and community-based organizations; intentionally including sex workers in DREAMS programming, as well as lesbian, bisexual, transgender, queer, and intersex girls, and adolescent girls and young women living with HIV; issuing clearer guidance on the Anti-Prostitution Loyalty Oath; and providing U.S. support for clear and accurate abortion guidelines in Kenya.

Adolescent girls and young women overwhelmingly indicated that DREAMS makes them feel more empowered and better informed to make decisions about their sexual and reproductive health. CHANGE commends the unprecedented commitment that PEPFAR has demonstrated to this often-overlooked population in the fight against AIDS. We also applaud the holistic approach that DREAMS advances, for it rightly recognizes and addresses the multifaceted drivers of HIV infection among girls and young women. We hope the findings in this report offer valuable insight into the successes of DREAMS thus far as well as the areas where improvements will foster the conditions for adolescent girls and young women to grow into empowered, healthy, and productive adults.

ABOUT CHANGE

The Center for Health and Gender Equity (CHANGE) is a U.S.-based nongovernmental organization that promotes sexual and reproductive health and rights as a means to achieve gender equality and empowerment of all women and girls, by shaping public discourse, elevating women’s voices, and influencing U.S. and global policies. We are guided by our vision of a world that respects, protects, and honors sexual and reproductive rights for all. Our four-pronged impact model—advocacy, research, partnerships, and communications—is grounded in and driven by a human rights framework at the intersection of multiple sectors including women’s rights, human rights, family planning, maternal health, HIV/AIDS, and gender-based violence.

METHODOLOGY

CHANGE completed an independent mission in July 2016 to South Africa and Kenya to assess DREAMS. Bergen Cooper, Director of Policy Research, and Preston Mitchum, Policy Research Analyst, traveled to Johannesburg and Durban in South Africa, and to Kisumu and Nairobi in Kenya.* CHANGE interviewed the following in Kenya, South Africa, and the United States: civil society organizations (CSOs) that receive DREAMS funding, CSOs that do not receive DREAMS funding, U.S. Missions, PEPFAR gender advisors, the DREAMS interagency team, and adolescent girls and young women in districts where DREAMS is being implemented. Each individual and organization signed a consent form prior to speaking to the assessment team.

Prior to our travels, CHANGE also issued a request for proposals in June 2016 to support two short-term projects that advocate for sexual and reproductive health and rights (SRHR) in South Africa and Kenya. An important objective of the grants was to encourage civil society engagement in DREAMS, as well as to ensure that local women-and girl-led SRHR organizations are able to engage meaningfully throughout the DREAMS implementation process; and that the implementation of DREAMS interventions embrace SRHR integration, particularly contraceptive choice, including access to female condoms and other reproductive health commodities. The grants were made by CHANGE; they were not administered on behalf of DREAMS.

CHANGE awarded the grants to the National Empowerment Network of People living with HIV/AIDS in Kenya (NEPHAK) and the Children in Distress Network (CINDI) in South Africa. Some of NEPHAK’s preliminary findings are included in the fact-finding section of this report.

* Preston Mitchum only conducted interviews in Kisumu and Nairobi, Kenya from July 24-30, 2016, and in Washington, D.C. in August 2016.
PART I: INTRODUCTION

A. U.S. GLOBAL AIDS POLICY

The U.S. government is the largest funder of global health programs worldwide, accounting for more than half of the total global health funding in 2015. The President’s Emergency Plan for AIDS Relief (PEPFAR) is a commitment by the U.S. government to address HIV globally, including prevention and treatment programs, and is the largest-ever funding initiative dedicated to a single disease. First announced in 2003 during President George W. Bush’s State of the Union address and authorized by Congress in 2004, PEPFAR was designed to strengthen the capacity of the U.S. to lead the global response against HIV.

Despite considerable progress in the global response to the epidemic, AIDS-related illness remains the leading cause of death among women of reproductive age worldwide. Sub-Saharan Africa is the epicenter of the global HIV burden, amounting to nearly 40% of people living with HIV (PLWH) despite comprising 2% of the world’s population. Adolescent girls and young women account for 71% of new transmissions among adolescents in sub-Saharan Africa, with more than 1,000 new infections occurring each day. In South Africa, that number translates to nearly 113,000 new infections in young women aged 15-24 per year, which is more than four times the rate of new infections of adolescent boys and young men in the same age group. And in Kenya, the number of new infections for adolescent girls and young women between 15-24 is 24,336, which is nearly twice the number for boys and young men in the same age group.

As the largest bilateral donor to global health, and to HIV in particular, the policies, strategies, and positions of the U.S. government have significant implications throughout the world. For too long however, U.S.-funded research and programming to prevent and treat HIV among adolescent girls and young women was misdirected. Between 2004 and 2013, for example, the U.S. government invested more than $1.4 billion in PEPFAR programming that promoted sexual abstinence in sub-Saharan Africa. In a 2016 study conducted by Stanford University School of Medicine, researchers could not find any evidence indicating that these programs had any impact on sexual behavior, sexual delay, or HIV reduction.

Under the leadership of U.S. Ambassador-at-Large Dr. Deborah Birx, of the U.S. Office of the Global AIDS Coordinator (OGAC) and Special Representative for Global Health Diplomacy, PEPFAR recognized that one area where progress had not been achieved was among adolescent girls and young women aged 15-24. Subsequently, PEPFAR has deepened its focus on women and girls since it released its Updated Gender Strategy in December 2013, which calls for increasing gender equity in HIV/AIDS programs and services. In FY 2014, over 32 million women and girls were tested for HIV and more than 5 million women and girls were in treatment due to PEPFAR support. Comparative data from earlier years is unavailable since data prior to 2013 was not disaggregated.
B. THE DREAMS PARTNERSHIP

Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) is an ambitious $385 million partnership that aims to curtail HIV infection among adolescent girls and young women in 10 sub-Saharan African countries: Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. In 2014, almost half of all new HIV infections among adolescent girls and young women worldwide were concentrated in these nations.

The initial DREAMS investment is for two years, 2015-2017, and focuses on adolescent girls and young women aged 10-24, as well as the communities in which they live.

Announced on World AIDS Day 2014 by Ambassador Birx, DREAMS is directed by guidance drafted and distributed by OGAC in Washington, D.C. It also incorporates a country-specific program model and implementation plan to reduce HIV incidence in each DREAMS country. OGAC chose specific regions within the countries that have high HIV rates. By saturating these high-burden areas with programming, DREAMS intends to impact incidence rates throughout each target area.

The effort is supported through a public-private partnership between PEPFAR, the Bill & Melinda Gates Foundation, Girl Effect (formerly the Nike Foundation), Johnson & Johnson, Gilead Sciences, and Viiv Healthcare. DREAMS goes beyond traditional biomedical interventions as the sole solution to addressing HIV among adolescent girls and young women. The initiative incorporates evidence-based interventions, outlined in its Core Package, to address the structural and behavioral drivers that increase girls’ risk of acquiring HIV, such as poverty, gender inequality, gender-based violence (GBV), absence of parental and community support, and lack of education and vocational training. DREAMS represents the first time PEPFAR has employed a multisector approach to addressing HIV prevention in adolescent girls and young women.

Overall, DREAMS focuses on creating the conditions for adolescent girls to be informed and empowered to make decisions about their sexual health and wellbeing. Using this holistic lens, DREAMS by the end of 2016 aims to reduce HIV incidence by 25% among adolescent girls and young women in high prevalence areas selected by PEPFAR. And by the close of 2017, the initiative strives to reduce occurrence of the virus by 40% in the same demographic.

These ambitious targets required a quick and efficient rollout. Because of the target goals, OGAC chose existing PEPFAR partners to receive the supplementary DREAMS programs and funds, describing them as “prime partners.” To create the opportunity to collaborate with new and existing partners on innovative programming, PEPFAR worked with Johnson & Johnson and Viiv Healthcare to establish the DREAMS Innovation Challenge Fund (Challenge Fund). The fund commits an additional $85 million to support solutions to address unmet needs of adolescent girls and young women and their male partners not covered by DREAMS interventions. It achieves this by investing in grassroots- and community-led proposals that infuse new thinking and high-impact approaches.

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1 These partners are not fixed. Gilead Sciences and Viiv Healthcare, for example, were added later and other institutions may join DREAMS.

2 Throughout this report, three terms will repeatedly be used: prime partners, implementing partners, and civil society; each word carries a different meaning. Prime partners refer to institutions that receive U.S. government funds to coordinate DREAMS programming and services. In DREAMS regions, prime partners are implementing programming for DREAMS, sub-granting to organizations and institutions who implement programs to adolescent girls and young women directly, or a combination of both. To that end, implementing partners are organizations that receive funds from prime partners to execute programming to girls and young women on the ground in DREAMS countries. Lastly, civil society comprises the broader umbrella of nongovernmental organizations and institutions, with some receiving DREAMS funding and others not.

3 The six focus areas of the Challenge Fund include: strengthening capacity of communities for service delivery; keeping girls in secondary school; linking men to services; supporting pre-exposure prophylaxis (PrEP); providing a bridge to employment; and applying data to increase impact (Data4Dreams).
Each private partner provides a different contribution to DREAMS and the Challenge Fund. For example, Johnson & Johnson is identifying ways to market the program and engage with adolescent girls and young women, while ViiV Healthcare is focusing on building the capacity of smaller organizations. ViiV Healthcare engages in a “bottom-up” approach that entails distributing grants of approximately $20,000 each to smaller community-based organizations (CBOs) to implement DREAMS programming.††

The Challenge Fund process resulted in 56 funding winners33 out of 143 semifinalists, of which 27 are new to PEPFAR funding.‡‡ Further, 64% of the winners are small, local CBOs.³⁴§§ Among the winners, 18 are implementing in Kenya and nine are implementing in South Africa.³⁵

C. DREAMS INTERVENTIONS

An empowering environment

DREAMS interventions are concentrated, comprehensive efforts that aim to tackle the multifaceted barriers to prevention often faced by adolescent girls and young women. They address girls’ and young women’s HIV risk in high-burden communities by layering evidence-based structural, behavioral, and biomedical interventions. The interventions are summarized in the initiative’s Core Package, which is supplemented by Preventing HIV in Adolescent Girls and Young Women: Guidance for Country Teams on the DREAMS Partnership (The Guidance).³⁶ Released by PEPFAR in 2015, the document provides guidance to its country-based teams responsible for implementing DREAMS interventions. In it, PEPFAR underscores the significance of civil society and community engagement and the full inclusion of adolescent girls and young women on country advisory committees for DREAMS.³⁷ The Guidance also states that interventions without a strong evidence base, such as abstinence-only education, should not be implemented³⁸ in DREAMS.

The DREAMS Core Package aims to cultivate an empowering environment for adolescent girls and young women that significantly reduces their risk of acquiring HIV. As such, the interventions recognize and incorporate the economic, political, and social disparities that affect adolescent girls’ and young women’s vulnerability to HIV. For example, it is difficult for girls, especially as they transition to womanhood, to protect themselves from acquiring HIV when they experience GBV and sexual violence, coupled with restrictive systems and policies that deny them access to post-violence care.³⁹ The Guidance therefore identifies interventions such as post-violence care that attempt to address the root of GBV risk for adolescent girls and young women.⁴⁰

In addition to recognizing the structural drivers of risk for HIV infection, DREAMS also incorporates civil society engagement and adolescent-friendly services as well as encourages policies and laws that discourage harmful traditional practices.

In addition to recognizing the structural drivers of risk for HIV infection, DREAMS also incorporates civil society engagement and adolescent-friendly services as well as encourages policies and laws that discourage harmful traditional practices.⁴¹

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†† Interviews conducted also highlighted that ViiV Healthcare has disseminated one $1 million grant outside of the usual $20,000 grants.

‡‡ Out of the remaining organizations, seven are unsure if they have ever received PEPFAR funding; 22 have received funding.

§§ The Challenge Fund winners included 47 NGOs, four for-profit, one multilateral, and six faith-based organizations. Four academic institutions also received funding.
*** Target groups

DREAMS focuses on four interconnected groups: adolescent girls and young women, their male sexual partners, their families, and their broader communities. Recognizing community, family, behavioral, and biomedical layers of risk, DREAMS not only targets adolescent girls and young women, but also identifies and tests their male partners for HIV or refers them for measures such as voluntary medical male circumcision (VMMC) and HIV treatment. DREAMS also works to strengthen families through parent/caregiver programs, cash transfers, educational subsidies, and financial literacy and savings education programs. Community mobilization interventions include school-based HIV prevention measures and efforts to change community and social norms in order to decrease violence against and increase empowerment among adolescent girls and young women.

The Guidance does not discriminate against the inclusion of key populations of adolescent girls and young women. However, it also does not specifically address the needs of these demographics that are also at risk of HIV infection, which includes girls who exchange sex for money, are female sex workers, or identify as lesbian, bisexual, transgender, queer, or intersex (LBTQI).

*** SRHR as prevention

DREAMS aspires to train providers across a spectrum of adolescent-friendly services, from HIV testing to sexual violence screening. Interventions in the Core Package include increasing consistent use and availability of condoms, providing pre-exposure prophylaxis (PrEP), violence prevention and post-violence care, HIV testing and counseling (HTC), social asset building, and increasing contraceptive mix.

In addition to addressing HIV risk among adolescent girls and young women, DREAMS also responds to the need for contraception to prevent unplanned pregnancies. PEPFAR’s guidance stresses the importance of informing girls and young women of their contraceptive choices. DREAMS therefore incorporates discussions of contraception in its programming. The initiative also represents the first instance of PEPFAR implementing PrEP for adolescent girls and young women through its HIV-prevention programming; PrEP is highly effective in HIV prevention when used correctly and consistently.

Within DREAMS, an adolescent girl should have access to all HIV prevention interventions, although she may not use or need all the services. According to The Guidance, partners may substitute some DREAMS Core Package offerings with alternative, evidence-based interventions already proven successful in their communities. The 10 sub-Saharan African countries may also opt in or out of certain programming and introduce some interventions in the first year and some in the second. For example, through the DREAMS Core Package, PrEP is available in Kenya only during the second year, while in South Africa, it is currently available to sex workers, but not to any other community, including other key populations.

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*** Key populations are men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people. See World Health Org., Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014), available at http://www.who.int/hiv/pub/guidelines/keypopulations/en/.

††† PrEP is a way for people who do not have HIV to prevent acquiring HIV by taking daily antiretroviral (ARV) drugs. When taken consistently, data show that PrEP has reduced HIV acquisition by up to 92% in people who are at high risk. See Pre-Exposure Prophylaxis (PrEP), Centers for Disease Control and Prevention (July 21, 2016), http://www.cdc.gov/hiv/risk/prep/.
D. DREAMS MONITORING AND EVALUATION

DREAMS uses a range of data sources to measure program impact, including HIV impact assessment surveys, Demographic and Health Surveys, and site-level data from prevention of mother-to-child transmission (PMTCT) programs. PEPFAR country teams monitor a core set of Monitoring, Evaluation and Reporting (MER) indicators as well as Site Improvement Monitoring Systems data that are associated with PEPFAR’s standard planning and reporting activities. The specific program outputs and outcomes that will be measured as part of DREAMS include:

- Increased number of adolescent girls and young women receiving condoms and HTC
- Increased number of girls and young women initiated on PrEP
- Increased number of girls and young women receiving post-violence care
- Increased number of girls and women or families receiving cash transfers or education subsidies
- Reduced number of 15-24 year old pregnant girls and young women with HIV positive status
- Increased number of young adult men on anti-retroviral treatment (ART) men who are most likely to have sex with adolescent girls and young women
- Increased number of young adult men provided VMCC
- Increased number receiving parenting intervention, school-based HIV/violence prevention and gender sensitization
- Increased number receiving community-based HIV and violence intervention
- Increased number of girls, young women, and families receiving cash transfers
- Increased access to money for girls and young women in an emergency
- Increased educational attainment for girls and young women

There are also several new or significantly modified MER indicators specific to DREAMS, such as PrEP_NEW, which measures the percentage of adolescent girls and young women newly enrolled on PrEP to prevent HIV infection. Implementing partners report on the program outputs and several core outcomes to PEPFAR country teams to assess program delivery and coverage. Rates of HIV among adolescent girls and young women presenting for antenatal care will serve as a key source of data to monitor success. In-country PEPFAR teams make real-time adjustments to ensure that DREAMS achieves its stated goals.

The implementation science (IS) component is spearheaded by Population Council, an international nongovernmental organization (NGO) that conducts research to address health and development issues as they arise. During the development of a country’s work plan, IS research questions that emerge are shared with Population Council, which then funds an investigation of a subset of IS questions. An impact evaluation model, funded by Gates Foundation and coordinated by the London School of Hygiene & Tropical Medicine, will use existing demographic surveillance survey platforms in South Africa and Kenya to assess the impact of the combined DREAMS Core Package on key outcomes, such as HIV incidence, increased ART update, and improved sexual health indicators (e.g. contraceptive use) as well as measures of agency and empowerment.

The University of California in San Francisco (UCSF) works in Kenya and limited additional DREAMS countries to develop monitoring and evaluation tools, and, while not centrally coordinated, is supported by country budgets. MEASURE Evaluation works in South Africa to collect and coordinate monitoring data. UCSF then conducts a quality assessment to evaluate how prime partners are using the tools.

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PART II: BACKGROUND

A. HIV PREVENTION, ADOLESCENT GIRLS, AND U.S. FUNDING IN SOUTH AFRICA

In 2015, PEPFAR committed $410 million towards ending the HIV epidemic in South Africa for the 2016 Country Operational Plan (COP16). In addition to COP16 funding, PEPFAR’s investment in ending HIV in South Africa includes $33 million for the first year of DREAMS.

The investment is critical because South Africa is at the epicenter of the global HIV epidemic and has the world’s largest number of PLWH. There are an estimated 7 million PLWH in South Africa, which represents nearly one in five adults aged 15-49. An estimated 113,000 adolescent girls are newly infected each year, out of a national population of approximately 55 million. Relative to their male counterparts, adolescent girls are at a higher risk of HIV infection, and comprise a high percentage of young people living with HIV, with prevalence exceeding 10%.

The drivers of these disparities are multifaceted. One factor is sexual relationships between adolescent girls and young women and older adolescent boys, young men, and men. A study released by the Centre for The AIDS Programme of Research in South Africa showed that high rates of HIV infection among young women in South Africa are due to their involvement with men who are on average eight years older, which challenges a previous study concluding that age disparity in partners may not predict HIV acquisition. In some intergenerational relationships, men provide money, gifts, and other resources, which complicates adolescent girls’ and young women’s control over the conditions of sex in the relationships, including the ability to negotiate with their partner or demand that he wears a condom. Pervasive GBV, including rape, also heighten risk of HIV exposure and diminishes adolescent girls’ and young women’s control over sex. National survey data indicate that only about half of South African youth aged 15-24 have ever been tested for HIV, a clear shortfall in such a high-burden setting.

Despite these challenges, South Africa has made significant progress in its HIV response, especially in the areas of treatment expansion and PMTCT. The South African constitution guarantees a right to access health services and the government is committed to ensuring universal health coverage. Nevertheless, lingering effects of apartheid mean that significant racial, geographic, and socioeconomic inequalities in life expectancy and health outcomes persist.

B. HIV PREVENTION, ADOLESCENT GIRLS, AND U.S. FUNDING IN KENYA

In 2015, PEPFAR committed nearly $490 million to Kenya, associated with standard COP activities for 2016. In addition, PEPFAR’s investment in Kenya includes a supplement of approximately $18 million for the first year of DREAMS.

The HIV prevalence rate among adults 15-49 years of age in Kenya is 5.9%, which is considerably lower than that of South Africa. There is also significant geographical variation in the prevalence of HIV in Kenya, with 90% of PLWH located in 27 of the country’s 47 counties. Clear disparities emerge with adolescent girls and young women aged 15-24, who accounted for nearly a third of all new HIV diagnoses in the country in 2015.
Early sexual debut, low rates of reported condom use, and low uptake of HTC fuel HIV acquisition for this demographic in Kenya. Less than half of young women aged 15-19 reported comprehensive knowledge of HIV in the National AIDS/STI Control Programme’s 2012 AIDS Indicator Survey.

Kenya developed its first Adolescent Reproductive Health and Development Policy in 2003, which underwent revision in 2015. According to the policy, the goal is “to bring adolescent sexual and reproductive health and rights issues into the mainstream of health and development.” The policy is guided by principles of inclusion of adolescent girls and young women in the implementation, monitoring, and evaluation of programs, as well as the respect for fundamental rights.
PART III: FINDINGS

CHANGE conducted interviews with hundreds of DREAMS stakeholders in South Africa and Kenya, including prime partners, U.S. Missions, DREAMS interagency teams, CSOs, and adolescent girls and young women participating in the initiative. Our primary goals were to assess civil society engagement and identify strengths and challenges faced in the implementation of DREAMS, with special attention to SRHR. What follows is a summary of the central topics, concerns, and promising practices that emerged from the interviews.

A. LAUNCHING DREAMS

DREAMS is being implemented in five districts of South Africa—City of Johannesburg, Ekurhuleni, eThekwini, uMgungundlovu and uMkhanyakude—and includes programming and interventions such as condom promotion and provision, HTC, community mobilization, and norms change. The age range of participating girls varies across these different activities. For example, 10-14 year olds are not included in condom promotion and provision, while PrEP for sex workers is for young women aged 20-24 enrolled in DREAMS. DREAMS participants are identified through existing structures and systems, including local health and welfare services, community and faith-based organizations, and schools.

Since DREAMS implementation began, South Africa has committed to similar programming throughout the rest of the country. In June 2016, South African Deputy President Cyril Ramaphosa launched a three-year campaign to prevent HIV transmission among adolescent girls and young women nationwide. Indeed, South Africa has been making tremendous strides in scaling up interventions to curb HIV incidence rates: In 2016, PEPFAR headquarters recognized the progress of DREAMS programs in South Africa, and at the PEPFAR Annual Meeting, the country received the DREAMS Award for the team best exemplifying excellence in achieving program goals.

In Kenya, DREAMS is taking place in the four high HIV burden counties of Homa Bay, Nairobi, Kisumu, and Siaya, and includes an agreed-upon set of interventions drawn from the DREAMS Core Package. PrEP and Test and START will be fast-tracked in these counties as part of DREAMS. PEPFAR already implements in these counties tuberculosis and HIV services, adult and pediatric HIV care and treatment, HTC, VMMC, PMTCT, and orphans and vulnerable children (OVC) programming. Partners that do not offer these specific services will work with other implementing partners to ensure linkages are offered.

CHANGE found a few noteworthy differences between the rollout of DREAMS in South Africa and Kenya. Key findings follow.

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§§§ In South Africa, PrEP is being targeted strictly at sex workers 20-24 years old, as opposed to any sex workers above the age of 18, because of the desire to maintain integrity between the different populations targeted by DREAMS: 10 to 14-year-old adolescent girls, 15 to 19-year-old adolescent girls, and 20 to 24-year-old young women. Limiting PrEP to a single age classification is meant to allow the PEPFAR county team to work effectively within these targeted age ranges.

**** Test and START has been referred to as the “treat-all approach,” where antiretroviral therapy (ART) is recommended for everyone living with HIV at any CD4 cell count. With Test and START, patients begin ART immediately after receiving an HIV-positive diagnosis. See USAID, TEST AND START: OPTIMIZING ANTIRETROVIRAL THERAPY SERVICES TO SAVE LIVES, https://www.usaid.gov/what-we-do/global-health/hiv-and-aids/technical-areas/test-and-start. See also WORLD HEALTH ORGN, GUIDELINE ON WHEN TO START ANTIRETROVIRAL THERAPY AND ON PRE-EXPOSURE PROPHYLAXIS FOR HIV (2015), http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565_eng.pdf?ua=1
The rollout of DREAMS

For many partners, the rollout of DREAMS—that is, the time from when prime partners learned they would be implementing DREAMS, to the beginning of implementation—has had a direct impact on partners’ ability to meet their stated targets. Noticeable challenges emerged due to the speed of the rollout and limited consultation and coordination on the part of PEPFAR, according to many prime partners. Many also indicated that the monitoring and evaluation process was not in place when they began implementation; they were unaware of which indicators would be measured, or what systems and tools would be used for evaluation. As a result, some prime partners utilized tools they traditionally employ, but had to adapt, and in some cases repeat past work once standardized tools became available.

Funding timelines

The majority of prime partners in Kenya received DREAMS funding between December 2015 and February 2016, whereas in South Africa, funding arrived in April 2016. When discussing this inconsistency, PEPFAR headquarters clarified that the distribution of funding was based on mechanisms that in-country teams had in place for DREAMS programs and activities. Although OGAC distributed funds to DREAMS countries at the same time, the in-country teams determined disbursement based on those mechanisms. This significant difference in funding arrival time allowed Kenya’s prime partners to begin programming sooner than in South Africa.

Prime partners said the discrepancy in funding timelines was the result of a rushed rollout by the U.S. government, which in turn caused partners to struggle in meeting their stated targets. Prime partners in South Africa reported that they were told they could commence programming with current funds, and then use DREAMS funds once received. However, many waited for DREAMS programming funds to be disbursed because utilizing current funds could have caused disarray and financial confusion for their organizations.

Delivery of the core package

South Africa and Kenya differed in how each delivered interventions to adolescent girls and young women in DREAMS. South Africa, for example, followed what is largely referred to as “layering,” whereby each prime partner was assigned one or two interventions drawn from the DREAMS Core Package. The result is that an individual girl is able to access different services from different prime partners. This contrasts with the comprehensive approach practiced in Kenya, where each prime partner carries out the same set of interventions agreed to in the country plans.

There are strengths and weaknesses to both approaches. The South Africa model, while perhaps a more streamlined process due to maintaining fewer interventions per partner, has the potential of assigning services to partners with minimal experience in certain programmatic areas. Although PEPFAR in-country teams attempted to match partners with their expertise, some prime partners were assigned interventions they did not know how to do, most notably, social asset building. In fact, a few prime partners were surprised by some of the organizations that PEPFAR assigned to certain interventions. On the other hand, the Kenya model, albeit more coordinated because partners provide the same interventions, could require more training and be more time consuming.

Enrollment

The enrollment process in Kenya was based on Population Council’s Girl Roster, an individual census tool used to reach all adolescent girls in a walkable area and identify those that are “off-track,” including the most at-risk and hardest to find. PEPFAR mandated prime partners in Kenya to use the new instrument, which is being slowly introduced in other DREAMS countries. Prime partners felt the Girl Roster was an important tool to help identify vulnerable girls and increase their access to resources, facilities, and services.

Although many deemed the Girl Roster a very useful method, some difficulties arose, primarily due to miscommunication. One prime partner in particular, who received funding in December 2015, was not told that
the Girl Roster was being created. Accordingly, this prime partner created its own tool and had already identified vulnerable adolescent girls for DREAMS programming. Once PEPFAR headquarters informed partners in Kenya of the Girl Roster, that prime partner had already singled out girls to participate in DREAMS. The partner then had to begin again using Population Council’s tool for the first time, which created inefficiencies in time and resources and resulted in the same vulnerable girls being identified, the partner said.

The majority of prime partners in Kenya that conducted their own census and then had to redo their work using the Girl Roster did not feel that their survey was as useful as the Girl Roster. While some partners indicated that some of the same adolescent girls were identified as vulnerable, others indicated that their models identified completely different adolescent girls. Most prime partners thought the Girl Roster was a user-friendly and effective tool for identifying vulnerable girls.

Only one prime partner conducted specific outreach to find vulnerable girls instead of using the Girl Roster. Once girls were identified, the partner held a “mixer” that brought together adolescent girls and young women, those delivering services, and those in charge of interventions. The prime partner noted how successful that mixer was in establishing relationships between the adolescent girls and those leading DREAMS services.

In South Africa, prime partners used existing networks to engage and enroll adolescent girls and young women in DREAMS.

**B. EVIDENCE-BASED INTERVENTIONS**

Part of what makes DREAMS a groundbreaking effort is the evidence-based comprehensive, multisectoral approach it applies to address drivers that increase adolescent girls’ and young women’s risk of HIV infection. Despite *The Guidance* noting the clear importance of carrying out interventions rooted in evidence, discrepancies exist between what PEPFAR and what prime partners and civil society consider to be evidence. For example, a PEPFAR partner in South Africa indicated that the evidence base for one DREAMS intervention was gathered by the Centers for Disease Control and Prevention in the U.S., re-tested in Kenya, and thereby approved for South Africa, the assumption being that what worked in Kenya will work in other African countries. However, a similar program that operated in South Africa for years was not considered to have enough of an evidence base for implementation in its own country, even though *The Guidance* for DREAMS clearly states that alternative interventions can be considered and used.

According to numerous prime partners in South Africa and Kenya, PEPFAR asked them to implement for DREAMS new or different programs that are considered evidence-based, when they in fact had been implementing similar (and what they considered better) programming. On one occasion, a prime partner acquiesced to an intervention used for DREAMS but highlighted they were never informed by PEPFAR why their original model was not rooted in evidence.

What follows are insights related to the implementation of specific DREAMS interventions that garnered significant response and discussion during the interviews CHANGE conducted.

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This specific implementing partner also has fewer adolescent girls and young women in its program, thus possibly contributing to an increased success.
Access to pre-exposure prophylaxis (PrEP)

DREAMS is the first instance in which PEPFAR is implementing PrEP for adolescent girls and young women through its HIV prevention programming. This is significant because PrEP—the daily use of oral anti-retroviral medications by HIV-negative people—is a new biomedical intervention that when used correctly significantly reduces the chance of acquiring HIV.90

Access to PrEP in South Africa and Kenya differ, depending on individual PEPFAR country plans and country policy;91 South Africa has a less expansive distribution of PrEP compared to Kenya. In DREAMS South Africa, PrEP is currently only available to sex workers between 20-24 years old. PrEP will not be available in Kenya until the second year of the partnership due to a lack of national guidelines. The Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya, which includes guidance on PrEP, were just completed in 2016.

However, while not fully attributable to DREAMS, many prime partners indicated that the U.S. government helped to spur the conversation with civil society and local government that eventually led to the passage of PrEP guidelines by the Kenyan government. The 2016 guidance on PrEP in Kenya includes summaries on HIV testing and recommendations; standard care for people living with HIV; ART for adolescents living with HIV; the use of antiretrovirals such as PrEP among people with an increased risk of acquiring HIV; and PMTCT.92 The implementation of PrEP in Kenya through DREAMS will expand beyond sex workers to include all adolescent girls and young women aged 18-24. Prime partners specifically noted that the existence of DREAMS pushed the national government to adopt PrEP guidelines and make it expansive.

Contraceptive services

Girls and young women in Kenya were enthusiastic when asked about family planning options they discussed as part of the educational program in DREAMS. Many immediately named methods learned about in educational settings, such as female and male condoms, intrauterine devices (IUDs), birth control pills, injectables, and implants. They also shared their knowledge about post-exposure prophylaxis and violence screening if a rape occurs.

Contraceptive supplies were available while CHANGE was in South Africa and Kenya, though not directly through DREAMS programs. Supplies, however, were at consistent risk of running out. Due to a longstanding policy of PEPFAR headquarters, PEPFAR funds cannot be used for contraceptives other than condoms. It is therefore necessary to establish linkages to other programs and donors for any sort of integrated services.

Provision and promotion of male and female condoms

OGAC recognizes that male and female condoms are tools that should be included in HIV prevention programs. DREAMS is no different.

In South Africa, the United States Agency for International Development (USAID) centrally finances male and female condoms for PEPFAR projects. Interviews underscored that the United Nations Population Fund (UNFPA), also provides male and female condoms to the South African government. Prime partners are responsible for ensuring that both types of condoms are available to CBOs, but UNFPA has not contributed condoms for DREAMS specifically. Prime partners expressed concern about this, due to past experiences with South Africa running out of its
stock of condoms. Partners suggested that for DREAMS to successfully promote and distribute condoms as part of its intervention efforts, the local government must ensure that stockouts do not occur again.

In Kenya, only male condoms are procured and made available exclusively by Kenya Medical Supplies Authority. Female condoms traditionally only have been made available by the U.S. government for sex workers and other key populations. However, for the first time, female condoms will be provided for adolescent girls and young women through DREAMS, thanks to a donation from the Female Health Company (FHC). While a limited amount of FC2 female condoms are made available every year by Kenya’s National AIDS & STI Control Programme, they are only targeted at populations most at risk of HIV infection. As a population, adolescent girls and young women do not have access to the available FC2s within Kenya. FHC will therefore donate 50,000 female condoms to Kenya in addition to three other DREAMS countries—Mozambique, Swaziland, and Zambia—for a total of 200,000 FC2 female condoms. In Kenya, the female condom distribution will be layered with PrEP to emphasize the use of condoms to prevent unintended pregnancies and other sexually-transmitted infections (STIs).

During interviews, Kenyan adolescent girls expressed frustration with the lack of antibiotics for STI treatment. Many indicated that although hospitals are adolescent-friendly and culturally competent enough to meet their healthcare needs, access to STI treatment is often missing. In a focus group in Nairobi, an adolescent girl shared how excited she was to participate in a DREAMS program, but she was frustrated after she learned there were no antibiotics available at the local hospital she visited to treat an STI.

Abortion

The U.S. Supreme Court’s decision in Roe v. Wade legalized abortion in the United States. Following Roe, three amendments—the Helms Amendment (Helms),93 Leahy Amendment (Leahy),94 and Siljander Amendment (Siljander)95—were passed to curtail, then clarify, abortion policies as applied to U.S. foreign assistance. In 1973, Helms was enacted as part of this wave of measures introduced to cut off access to safe and legal abortions both domestically and globally.96 Helms states that, “no foreign assistance funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions.”97 The existing policy standard on abortion restrictions is to allow abortion funding in three situations: rape, incest, and life endangerment of the pregnant person.98 Nevertheless, the U.S. government treats Helms as a complete ban on using federal funding for abortion overseas.

In that respect, the U.S. government has misinterpreted the Helms language of “[a] method of family planning” to exclude funding for abortion services, even in instances where it is not used as family planning, such as rape.99 In addition, in 1994, policymakers passed Leahy to address concerns that providing information on counseling about legal pregnancy options violated Helms; Leahy clarifies that it does not.100 The legal conditions for abortion in South Africa and Kenya are considerably different. Over 20 years ago, South Africa passed the Choice on Termination of Pregnancy Act of 1996 (Act 92 of 1996), which allows abortions upon request of a woman during the first 12 weeks of pregnancy in all circumstances.101 On the other hand, in Kenya “abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.”102 DREAMS stakeholders in South Africa—including adolescent girls and young women—had a clear understanding of their country’s abortion laws, but it is in Kenya where confusion occurred regarding when an abortion, if ever, could be performed.

In Kenya, nearly every interviewee gave a different answer on the state of abortion law and access in the country. All interviewees responded differently when asked what the “life of the mother” provision within Kenya’s abortion laws means, with the extreme interpretation being that a woman would nearly have to experience hemorrhaging to receive medical services. This highlighted the wide-ranging confusion about abortion policies
in Kenya. The U.S. Mission informed CHANGE that abortion referrals were not part of DREAMS policies. In addition, some advocates believe that Kenya’s Ministry of Health (MOH) is undermining women’s constitutional rights and contributing to cases of maternal death by denying access to safe, legal abortions—even in allowable instances, as articulated by Kenya’s 2010 constitution.¹⁰³

In 2013, before the announcement of DREAMS, this confusion could have been removed by the U.S. government at a MOH working group to discuss a strategy to reduce maternal mortality in Kenya. Instead, a message from USAID headquarters communicated to U.S. government partners specifically that no partners attend this meeting because of statutory policies that guide the use of funds, namely Helms and Siljander, and set parameters for restricted activities.¹⁰⁴

Interviewees in Kenya also shared differences of opinion when asked about abortion services and referrals. Prime partners generally believed that if an adolescent girl or young woman in DREAMS were pregnant, although they would not be able to provide abortion services directly, it was possible to refer her to safe abortion services under the Leahy Amendment. However, U.S. interagency representatives’ responses ultimately countered prime partners’ interpretation. For example, in-country teams revealed that girls and young women who are referred for counseling can receive family planning services and post-abortion care but indicated that doctors will not usually perform abortions.

In South Africa, where abortion is legal, the procedure was not an articulated concern throughout most of the interviews. However, one prime partner expressed concern about transporting a student to secure a safe and legal abortion and was unsure if that violated any funding restrictions. Adolescent girls had questions about the ethics of abortion (e.g., “why get an abortion if adoption is an option?”), but nothing substantively related to law or policy.

Adolescent-friendly services

According to OGAC, DREAMS aims to train providers to offer adolescent-friendly care across a spectrum of services. Although The Guidance does not indicate what specifically comprises “adolescent-friendly,” it stresses that such services include condoms, PrEP, violence prevention and post-violence care, HTC, increasing contraceptive mix, and social asset building.

Prime partners in both South Africa and Kenya indicated that the services directed toward DREAMS youth are indeed “friendly,” meaning they are accessible, acceptable, and appropriate for adolescents.¹⁰⁵ A focus group of more than 40 adolescent girls enrolled in DREAMS in Kisumu, Kenya, also agreed.

For example, there are dedicated centers for adolescent girls who have been sexually harassed and assaulted, or who have experienced GBV. According to a prime partner, future efforts to replicate these models would require a concentrated investment in training health professionals for these centers and clinics. Such an approach promotes behavioral and social changes, and recognizes that biomedical interventions are just one of the many components of addressing HIV risk in adolescent girls and young women.
Abstinence/Be Faithful funding and programming

When the U.S. Congress reauthorized PEPFAR in 2008, it removed the 33% “abstinence-until-marriage earmark.” But it was replaced with a requirement that OGAC issue congressional justification if PEPFAR programs in countries with generalized epidemics spend less than 50% of PEPFAR HIV prevention funds on programs that promote abstinence, delay of sexual debut, and fidelity. This continues the promotion of Abstinence, Be Faithful, and Correct and consistent Condom use (ABC) programming as a priority, even without a public health benefit to those it served.

PEPFAR’s current commitments to ABC are much smaller than prior U.S. government’s historical support. A clear example of this is that The Guidance explicitly discourages country teams from using school-based abstinence programming, based on a systematic review showing that comprehensive school-based sexuality education is more effective.

Prime partners reported that abstinence-only was never solely taught but was included as part of comprehensive sexuality-based education in Kenyan schools for adolescent girls between 10 and 14 years old. Thus, prime partners are adhering to the DREAMS Guidance that explicitly discourages abstinence-only education because it is not evidence-based.

Vocational training and education curricula

DREAMS offers educational programs and vocational training to adolescent girls and young women in an effort to equip them with a variety of skills to help them lead healthy, productive lives. During focus group discussions, girls and young women in both countries were noticeably enthusiastic about DREAMS, its impact, and especially about its vocational training and educational opportunities. These skills-building efforts—which address financial literacy and independence, livelihoods, and reproductive and sexual health, among other topics —were deemed by girls to be strong components of DREAMS.

In South Africa, CHANGE observed a school-based HIV and violence prevention program called Vhutshilo 2.2, which is part of a comprehensive package of OVC interventions. Vhutshilo consists of 15 to 19 sessions that incorporate curricula and training programs for structured and comprehensive peer-led sexuality education for adolescent girls. In one such program that CHANGE observed, adolescent girls were excited to learn about family planning options and the female condom, even making hand gestures to demonstrate how to insert one correctly. They were proud to be a part of DREAMS, which was evident when they spelled out its acronym, and enthusiastically explained what each letter meant.

In Nairobi, DREAMS provides adolescent girls and young women vocational training in a variety of areas, including fashion, technology/computers, and cosmetology. Many girls expressed a desire to engage in more interactive interventions in the future, such as games and sports, but several also noted how thrilled they were to be part of DREAMS, and that they would use their newfound skills to build a better life for themselves and their families.

‡‡‡‡ Nathan C. Lo et al., Abstinence Funding Was Not Associated With Reductions in HIV Risk Behavior in Sub-Saharan Africa, 35 HEALTH AFFAIRS 861. (Noting that although PEPFAR is moving away from Abstinence/Be faithful funding and programming, recent funding remains substantial); See also AMFAR, PEPFAR COUNTY/REGIONAL OPERATIONAL PLANS (COPS/ROPS) DATABASE, http://copsdata.amfar.org/s/South%20Africa/Prevention (indicating that in the past five years, the U.S. government has allocated South Africa and Kenya an estimated $111 million in Abstinence/Be faithful funding).
C. CIVIL SOCIETY ENGAGEMENT

“Working with other civil society organizations in the community has been a source of support in the implementation of the PEPFAR DREAMS initiative.”

— Eunice Owino, Director of Jiu Pachi, a CBO in Kisumu, Kenya

The engagement of civil society is a fundamental component of DREAMS. The Guidance and OGAC state that civil society organizations are critical to building relationships between prime partners and local and national governments, and that they must be involved in the advocacy, planning, implementation, and monitoring of programs and services intended for adolescent girls and young women. All prime partners in South Africa and Kenya interviewed by CHANGE are CSOs, with the exception of one.

The interviews revealed positive aspects of DREAMS civil society engagement, notably the increased number of relationships between PEPFAR and CSOs. Prime partners also said that involving civil society has also allowed smaller organizations to provide feedback on how to improve DREAMS in 2017. Despite these strengths, many civil society groups and other prime partners indicated areas for improvement. Based on the responses CHANGE gathered, there is a need for better organization and technical support by the U.S. government to facilitate the CSOs work in DREAMS. Many CSOs did not feel empowered to make decisions about programming in their communities and felt that their opinions or suggestions went unheard by U.S. government officials. Finally, prime partners expressed frustration with how officials initially rolled out DREAMS, which led to concerns about meeting first year targets. Examples of concerns that emerged during CHANGE’s assessment are detailed below.

Information sharing

PEPFAR and other groups organized a variety of meetings to facilitate the implementation of DREAMS in South Africa and Kenya. The gatherings, however, did not always yield the results or create the collaborative environment necessary for carrying out the ambitious comprehensive, multisectoral initiative, according to many prime partners. For instance, teams from PEPFAR created spaces where prime partners, the U.S. government, and local and national governments could meet and strategize. This approach, when it worked, facilitated information sharing and collaboration in DREAMS implementation. One prime partner in South Africa’s eThekwini District noted that such opportunities allowed partners to meet the person they needed to call to address issues, such as condom stockouts. However, other prime partners in the City of Johannesburg reported that these spaces were managed inefficiently and that they had yet to collaborate with other prime partners working in the same district.

In both countries, PEPFAR also organizes meetings with civil society to gather information about progress on DREAMS programming, which government officials and interagency teams are required to report. However, many CSOs said that PEPFAR does not send presentation information in advance of meetings. This put civil society in a position where they needed to respond to feedback immediately, rather than have time to discuss it with their organizations and coalition partners. PEPFAR’s information is also data-heavy, and not all of civil society is well versed on data. PEPFAR does not work with civil society to translate the data, even though it has capacity to do this. Both groups acknowledged the gap in support. They noted that this is not only an issue with DREAMS; it is an ongoing challenge PEPFAR has with civil society engagement.
Some CSOs also were discouraged by how PEPFAR introduced DREAMS to their communities and suggested that PEPFAR was not fully committed to engaging civil society in the implementation of interventions.

Communication and consultation

National and local governments in South Africa, in collaboration with the U.S. government, are coordinating components of DREAMS with the South African National AIDS Council (SANAC). Comprised of government and civil society representatives, SANAC was formed to ensure the inclusion of civil society and strengthen the political leadership in the overall response to HIV and AIDS. It holds technical working groups where DREAMS prime partners discuss interventions and programming. It was at one such meeting—attended by civil society, prime partners, local PEPFAR teams, and South African government representatives—where many CSOs that did not receive DREAMS funding first heard about DREAMS.

CHANGE learned that many SANAC meeting participants were disappointed with DREAMS because it appeared to be based on what the U.S. government assumed people needed, rather than on consultations with in-country partners already working on HIV prevention in districts. “This is not an African Dream, it’s an American Dream,” said Thuli Khoza with Sisonke, a movement formed by sex workers in South Africa. This created resentment among some attendees, who considered walking out of the meeting, or boycotting DREAMS altogether.

The most common frustration expressed by civil society in South Africa and Kenya was that PEPFAR did not include civil society in the consultation that determined DREAMS interventions. While PEPFAR recommended that DREAMS countries include adolescent girls and young women as well as in-country PEPFAR teams, national and local governments, and civil society, many interviews revealed that the voices of girls and civil society had not been heard. In interviews, U.S. government officials in country explained that they provided opportunities for civil society to share concerns about implementation and programming. However, civil society largely disagreed, noting that consultation did not happen before DREAMS was conceived and only occurred after its launch.

PEPFAR also indicated that it provided opportunities for effective civil society communications with regard to implementation. Civil society did not agree, stating that PEPFAR team meetings frequently have more than 100 participants, making it extremely difficult to ask questions. Many prime partners were also hesitant to criticize DREAMS because they did not want to jeopardize future funding from PEPFAR.

Civil society also voiced frustration that PEPFAR encourages local involvement but does not provide funding for transportation or housing. CSOs highlighted that because of limited budgets many of them cannot afford the cost of traveling to meetings, so they rely on funding from U.S. and local governments. One CSO relayed a situation when they brought an adolescent girl, invited by PEPFAR, to a PEPFAR gathering. She did not have funding for travel and accommodations, which left the CSO struggling to locate lodging for her. When the organization mentioned the miscommunication to a PEPFAR in-country team, the CSO was told that in the future, it should send someone who can afford to travel.

Including travel costs as part of budgets will help boost participation at meetings, particularly from smaller organizations. PEPFAR, after all, funds prime partners to build capacity. One prime partner in South Africa noted that funding organizations to attend meetings is a part of their portfolio as an organization that builds capacity and is something they could contribute. CHANGE found that prime partners already play that role and could be helpful to PEPFAR in this phase of implementing DREAMS.
D. ADOLESCENT GIRLS AND YOUNG WOMEN WITH SPECIFIC CONCERNS

According to OGAC, all adolescent girls and young women who are vulnerable to acquiring HIV should be included in DREAMS interventions in South Africa and Kenya, including those who identify as female sex workers (FSWs), those who exchange sex for money, and those who identify as lesbian, bisexual, transgender, queer and/or intersex (LBTQI) and those who are living with HIV. However, CHANGE found that those populations were not included in programming.

LBTQI

“DREAMS has the potential to be inclusive of key populations, but by relying on existing data it is not intentionally meeting the needs of LBTQI adolescents. DREAMS monitoring and evaluation should be taken as an opportunity to increase the evidence base for LBTQI HIV prevention programming.”

— Seanny Odero, Publicist and Sexual Minority Health Consultant, Kenya

CHANGE found that intentional, coordinated programming does not exist for LBTQI adolescent girls and young women in Kenya and South Africa. In one discussion with prime partners, implementing partners, adolescent girls and young women, and civil society in Kenya, tension grew when assessing whether DREAMS was inclusive of LBTQI adolescent girls. Some prime partners admitted that part of the reason was because there is not a strong enough evidence base for effective HIV intervention programming for LBTQI adolescent girls and young women. Many were emphatic that it was due to a lack of dedicated funding for data collection on LBTQI individuals’ sexual and reproductive health. One prime partner noted that if the focus is on behaviors, not identities, then DREAMS should be inclusive of key populations—but so far it is not.

Adolescent girls and young women living with HIV

Interviews in Kenya revealed that girls and young women participating in DREAMS were not tested for HIV prior to their enrollment in the program. Rather, they were asked if they were aware of their HIV status, and if they did know, they were asked to disclose. In an interview organized by CHANGE’s grantee, NEPHAK, we found that PEPFAR had not disseminated clear information regarding the protocol of an adolescent girl who tests positive for HIV while enrolled in programs.

This confusion led many prime and implementing partners to question what to do if such a situation arose. They knew the adolescent girl or young woman should be connected to HIV care, but were unclear if she should remain in DREAMS. Importantly, this sparked a dialogue among prime partners about how success could be measured without a proper baseline of the number of adolescent girls and young women who are living with HIV. PEPFAR headquarters later clarified that DREAMS success is being measured at the community level, and not based on individual girls’ experiences. Some girls will already be HIV-positive prior to enrolling. Others will seroconvert, meaning that they will acquire HIV infection, and HIV antibodies will develop and be detected while girls are in the program. If this does happen, the girl or young woman will be referred to HIV treatment services and remain a part of DREAMS, according to PEPFAR headquarters officials.
Female sex workers

CHANGE found that some confusion exists about how FSWs would be treated if enrolled in DREAMS, and how the U.S. Anti-Prostitution Loyalty Oath (APLO) could negatively affect organizations that receive PEPFAR funding. The APLO requires all recipients of PEPFAR funding to have a policy “explicitly opposing prostitution and sex trafficking.”111 The 2013 Supreme Court ruling that found the APLO unconstitutional112 does not apply to foreign NGOs.113 Therefore, to receive DREAMS funding, U.S. organizations are not required to sign the APLO. However, non-U.S. NGOs are expected to sign the APLO, which excludes some organizations that would be best suited to work with sex workers. The APLO can encourage organizations engaged in best practice HIV prevention and advocacy efforts to decline U.S. funding. In a clinical context, the APLO can force healthcare providers to violate the basic canons of non-judgmental, non-discriminatory care, and providing informed consent.114

The requirement that recipients of PEPFAR funding have a policy opposing sex work has had varied effects with regard to DREAMS programming. Some prime partners in South Africa and Kenya believed that the APLO did not negatively impact their efforts because they did not advocate for sex worker rights or decriminalization but rather offered HIV prevention programming for all adolescent girls and young women, including sex workers. Alternatively, one particular CSO in South Africa, a grantee of a PEPFAR prime partner, relayed how damaging the APLO was for its organization. Originally, the grantee was not asked to sign the APLO by the grantor but was later asked to do so. The grantee did not comply and lost its funding. This would have resulted in terminating significant number of staff, including sex workers, but a foundation stepped in to fill the funding gap. Furthermore, CHANGE learned that CSOs that work with sex workers are being asked by prime partners to help them locate sex workers for DREAMS programming. Because of the APLO, these CSOs are not provided funding for this.

In Kenya, it was unclear whether DREAMS had reached sex workers, and the same was true in South Africa, though largely because DREAMS had just launched when CHANGE visited. According to OGAC, programs and services should engage FSWs, however prime partners indicated it was highly unlikely for a sex worker to be enrolled in DREAMS programming. They suggested that sex workers would be better served by other existing funding, namely through PEPFAR’s Key Populations Investment Fund.115 The fund is a 2016 initiative that provides $100 million to expand access to proven HIV prevention and treatment services.116 Among other objectives, the Key Populations Investment Fund addresses critical gaps needed for key populations in the global HIV response.117

The conversation on key populations and DREAMS, in turn, led to an exchange among prime partners about what constitutes sex work. For example, according to many prime partners, adolescent girls and young women who are being reached through DREAMS and who engage in transactional sex such as exchanging sex for money, gifts, or other resources, do not necessarily identify as sex workers. Prime partners noted that PEPFAR should be aware of this reality and tailor programming accordingly, even with a separate fund such as the Key Populations Investment Fund.
E. THE ROAD TO SUCCESS FOR DREAMS

“The inclusion of the boy child in the PEPFAR DREAMS initiative will give a boost to the girl child empowerment since it will place them at an equal level. Therefore, when the girl, for instance, negotiates for condom use, the boy understands and respects her choices.”

— Jane Mukami, Programmes Officer, NEPHAK, Kenya

In interviews, prime partners described and evaluated success beyond the goal to reduce HIV incidence by 25% in the first year of DREAMS and by 40% in the second year, which they considered aspirational and challenging. Overall, prime partners outlined the following as potential successful DREAMS outcomes: adolescent girls who stay in school longer, changes in gender norms and community attitudes about adolescent girls and young women, and an increase in employment opportunities for girls.

Prime partners indicated they would consider success to be assistance from the president of their respective countries. In Kenya, they noted that the president’s wife, Margaret Wanjiru Gakuo, is involved, but that President Uhuru Muigai Kenyatta could increase his involvement by speaking more publicly about DREAMS, advocating for HIV prevention among adolescent girls and young women, and providing funding.

DREAMS would be successful, too, if PEPFAR improved its coordination and consultation with partners and included vulnerable boys in interventions, prime partners in both South Africa and Kenya said. In fact, the topic of engaging boys and young men emerged frequently during CHANGE’s interviews with partners. Community members also often suggested to implementing partners that some boys needed DREAMS programs and services as much as some adolescent girls. NEPHAK conducted outreach and meetings with adolescent girls in Nairobi, Kisumu, Homa Bay, and Siaya counties and, in its DREAMS preliminary advocacy report to CHANGE, noted that young women in the program want men and boys to be engaged in SRHR interventions in ways that allowed them to be directly connected beyond roles as sexual partners.

Finally, prime partners wanted to ensure DREAMS programming would continue beyond its two years, particularly because of the delays in rollout, and indicated that they have already noticed differences in HIV prevention. They have also observed changes in the overall attitude of community members and adolescent girls. Prime partners repeatedly noted how encouraging DREAMS is and that they did not want it to end after 2017—whether it remains as a standalone program or its interventions and approaches are integrated into the COPs.
IV. CONCLUSION AND RECOMMENDATIONS

Partnerships such as DREAMS are critical to the fast-track strategy of ending AIDS by 2030 and to the education and empowerment of adolescent girls and young women at risk of acquiring HIV. CHANGE applauds PEPFAR’s tailored implementation and programmatic efforts in South Africa and Kenya. For the first time, PEPFAR is addressing HIV prevention by targeting the economic, social, cultural, behavioral, and biomedical factors that put an adolescent girl and young woman at risk for HIV. This is groundbreaking. Through interviews with civil society, prime partners, and U.S. government officials, CHANGE found that through DREAMS adolescent girls and young women are accessing programming that includes a holistic approach to HIV prevention. DREAMS is on track to improve the lives of many adolescent girls across sub-Saharan Africa. We look forward to seeing PEPFAR continue to monitor quality and outcomes and impact, as well as scaling up adolescent-friendly services across all countries to meet the needs and demands of adolescent girls and young women. However, a consistent concern among prime and implementing partners and U.S. government officials was with the speed at which DREAMS was launched in South Africa and Kenya. All prime partners agreed that although DREAMS is a valuable initiative, it was rolled out too quickly. This left them with minimal time to adjust and struggling to meet their stated targets. CHANGE also documented frequent critiques about PEPFAR’s failure to engage non-PEPFAR CSOs, as well some lack of efficient coordination and communication.

While the U.S. has made important strides in the foreign assistance that it directs toward adolescent girls and young women and HIV prevention and treatment programs, there is room for improvement. The U.S. will need to adjust current policy and fine-tune the implementation of DREAMS and coordination among program partners to successfully reduce HIV infection among adolescent girls and young women in DREAMS countries.

CHANGE is committed to ensuring that this pioneering endeavor is a success. Based on the findings, we offer the following recommendations:

- PEPFAR headquarters should prioritize a civil society engagement strategy that builds on the lessons learned in the COP2016, Key Populations Fund, and DREAMS rollout to address concerns about top-down coordination and consultation. PEPFAR should also work with civil society to create innovative and inclusive mechanisms for more effective communication among CSOs, PEPFAR country teams, and PEPFAR headquarters.

- The U.S., South African, and Kenyan governments, along with other donors, should prioritize forecasting formulas and distribution and monitoring plans based on sexual acts to avoid stockout of male and female condoms and STI medicines.

- After consulting with prime and implementing partners, PEPFAR headquarters should direct country teams about the importance of intentionally including LBTQI, sex workers, and adolescent girls and young women living with HIV into DREAMS programming, and this should be reflected in the COP2018 guidance.

- PEPFAR should work with other offices of the U.S. government to develop a plan that will increase safe, secure, and culturally sensitive data collection among LBTQI and sex worker populations, with the PEPFAR goal to specifically include them in the COP2018 process and reporting.

- When the Global AIDS Act is reauthorized in 2018, Congress should remove the APLO and other provisions that undermine evidence-based public health.

- PEPFAR headquarters should produce a clear statement for country teams and the COPs Guidance, reflecting the Leahy Amendment and the importance of providing information and referrals for all pregnancy outcomes, including abortion.
THE U.S. DREAMS PARTNERSHIP: BREAKING BARRIERS TO HIV PREVENTION FOR ADOLESCENT GIRLS AND YOUNG WOMEN

ENDNOTES

4 Id.
9 Id.
14 O Shisana et al., SOUTH AFRICAN NATIONWIDE PREVALENCE, INCIDENCE AND BEHAVIORAL SURVEY 2012 58 (2014).
17 See generally, Rachael D. Dellar et al., Adolescent girls and young women: key populations for HIV control, 18 JAIDS 564, 564 (2015).
18 Nathan C. Lo et al., Abstinence Funding Was Not Associated With Reductions in HIV Risk Behavior in Sub-Saharan Africa, 35 HEALTH AFFAIRS 856, 856 (2016).
19 Id.
21 Id.
24 PEPFAR, PREVENTING HIV IN ADOLESCENT GIRLS AND YOUNG WOMEN: GUIDANCE FOR COUNTRY TEAMS ON THE DREAMS PARTNERSHIP 1, 5-6 (2015) [hereinafter PEPFAR GUIDANCE].
26 PEPFAR GUIDANCE, supra note 24.
28 See generally PEPFAR, Press Release on the DREAMS Partnership, supra note 27.
31 Id.
32 Id.
34 Id.
35 See PEPFAR, CHALLENGE RESULTS (July 18, 2016) (in possession of author).
36 PEPFAR GUIDANCE, supra note 24, at 35-43.
37 Id. at 10.
38 Id. at 50.
39 UNAIDS, THE GAP REPORT 2014, supra note 6, at 3.
40 PEPFAR GUIDANCE, supra note 27, at 37.
42 PEPFAR GUIDANCE, supra note 24, at 7.
43 Id. at 22-3, 41.
44 Id. at 20, 35-8.
45 Id. at 20-2.
46 Id. at 22.
47 PEPFAR GUIDANCE, supra note 24, at 22, 38.


Id.

79 Id.


79 PEPFAR Guidance, supra note 24, at 11.

80 Id. at 33.


82 PEPFAR Guidance, supra note 24, at 12.

83 Id.

84 Id.


86 Id.


89 UNAIDS, AIDSinfo, http://aidsinfo.unaids.org/ (last accessed on Oct. 18, 2016) [hereinafter UNAIDS, Data Tables].

90 Id.


96 See Harrison, supra note 63 (discussing the gendered context of HIV risk, including age-disparate partnerships, gender-based violence and forms of sexual risk behaviors, among others).

97 Shisana et al., supra note 14, at 148.


101 UNAIDS, Data Tables, supra note 61 (The prevalence among adults 15-49 in South Africa is 19.2%).

102 Kenya Country Operational Plan, supra note 72.

103 Id. (If an estimated 78,000 incident infections occurred in 2015, 23,000 occurred in AGYW 15-24).
103 See Press Release, Ctr. For Reproductive Rights, Kenyan Women Denied Safe, Legal Abortion Services (June 29, 2015), http://www.reproductiveverighths.org/press-room/kenyan-women-denied-safe-legal-abortion-services (noting that the Center for Reproductive Rights filed a lawsuit against Ministry of Health in High Court in Kenya for denying women access to safe, legal abortion services, which violates the Kenya constitution of 2010).


107 Id. at 33.

108 PEPFAR GUIDANCE, supra note 24, at 50.

109 Id. at 13.

110 Id. at 44.


116 Id.

117 Id.