

*World Health Organization Department of Reproductive Health and Research*

# Global consultation on lessons from sexual and reproductive health programming to catalyse HIV prevention for adolescent girls and young women

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*Brocher Foundation, Hermance, Geneva, Switzerland, 27–29 April 2016*



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## Acronyms and abbreviations

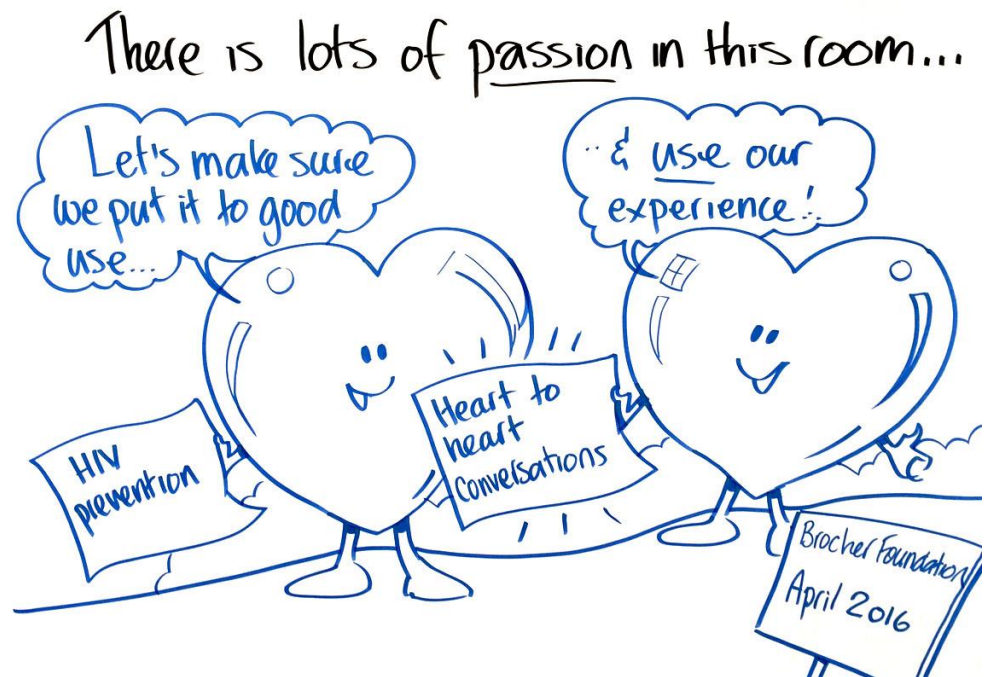
AGYW	Adolescent girls and young women
ART	antiretroviral therapy
ASRH	adolescent sexual and reproductive health
AYSRH	adolescent and youth sexual and reproductive health
CSE	comprehensive sexuality education
DREAMS	A partnership to help girls develop into determined, resilient, empowered, AIDS-free, mentored and safe women
ESA	Eastern and Southern Africa
FP2020	Family Planning 2020
GBV	gender-based violence
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GSWCAH	Global Strategy for Women's, Children's and Adolescents' Health
HPV	human papillomavirus
HRP	UNDP/UNFPA/UNICEF/WHO/World Bank Special programme of research, development and research training in human reproduction
HSV	herpes simplex virus
ICPD	International Conference on Population and Development
IPV	intimate partner violence
MDG	Millennium Development Goal
MPii	Microbicide Product Introduction Initiative
MSM	men who have sex with men
NGO	nongovernmental organization
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PrEP	pre-exposure prophylaxis
RHR	Department of Reproductive Health and Research (WHO)
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
VAW	violence against women
VMMC	voluntary medical male circumcision
WHO	World Health Organization
YFS	youth-friendly services

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## Executive summary

### Importance of linking sexual and reproductive health and rights (SRHR) and HIV for adolescent girls and young women (AGYW)

The commitments made by governments at the 1994 International Conference on Population and Development (ICPD) included support of adolescent sexual and reproductive health (ASRH). Since the ICPD, achievements in improving the health of adolescents, and in particular AGYW, have linked or integrated essential components of SRHR, such as comprehensive sexuality education (CSE) and provision of quality sexual and reproductive health (SRH) services, with efforts to create safe and supportive youth-friendly environments at schools, health-care facilities and other venues in the community. Packages of interventions have been used to show some element of success to address SRH problems such as early and/or unintended pregnancy, unsafe abortion, sexually transmitted infections (STIs), including HIV, violence against women and girls, and to combat harmful practices such as child marriage and female genital mutilation (FGM).

However, the prevention of HIV infection in AGYW remains a particularly concerning and critical challenge. While new HIV infections have fallen globally by 35% since 2000 – and by as much as 41% in sub-Saharan Africa – the situation of HIV infections in AGYW remains bleak. In eastern and southern Africa, for example, three quarters of all new HIV infections among adolescents aged 15–24 years are among adolescent girls, and globally AIDS-related illnesses are the second leading cause of death among adolescent girls and women of reproductive age.

Despite considerable progress in HIV prevention and care, including the development of oral pre-exposure prophylaxis (PrEP) to reduce the risk of HIV infection, the inability to reach AGYW with HIV prevention tools indicates an urgent need to rethink current prevention approaches and strategies.

### Windows of opportunity

As part of its response to achieving the United Nations (UN) Sustainable Development Goals (SDGs), the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (GSWCAH; 2016–2030) aims to bring about transformative change needed to shape a more prosperous and sustainable future for all. The GSWCAH places a focus for the first time on adolescent health.<sup>1</sup>

Some other UN-led initiatives have been launched in 2016 that have the potential to substantially improve ASRH and HIV prevention in AGYW. These include:

- The World Health Organization (WHO) Global Health Sector Strategies for HIV, viral hepatitis and STIs (2016–2021)<sup>2</sup>;
- The WHO Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls and against children<sup>3</sup>; and

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<sup>1</sup> For further information, see: <http://www.everywomaneverychild.org/global-strategy-2>

<sup>2</sup> For further information, see: <http://www.who.int/hiv/strategy2016-2021/en/>



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- The Joint United Nations Programme on HIV/AIDS (UNAIDS) 2016–2021 Strategy and subsequent *Political Declaration on HIV and AIDS: On the fast-track to accelerate the fight against HIV and end the AIDS epidemic by 2030* issued at the 2016 High-Level Meeting on Ending AIDS (UN General Assembly, June 2016).<sup>4</sup>

Furthermore, several other important current global initiatives for ASRH and HIV prevention include:

- The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) partnership to help girls develop into determined, resilient, empowered, AIDS-free, mentored and safe women (DREAMS) (launched in 2014)<sup>5</sup>
- The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) Strategy 2017–2022: Investing to end epidemics<sup>6</sup>
- Family Planning 2020 (FP2020) which supports the rights of women and girls to decide – freely and for themselves – whether, when, and how many children they want to have<sup>7</sup>
- United States Agency for International Development (USAID) Microbicide Product Introduction Initiative (MPii), 2015–2020, which supports HIV prevention for AGYW.<sup>8</sup>

### **Global consultation on lessons from sexual and reproductive health programming to catalyse HIV prevention for adolescent girls and young women**

Over the past 15 years, there have been some major successes towards reaching several of the MDGs related to maternal and child health, but much less progress has been made in improving the health of adolescents. These problems are particularly intractable and there is seldom sufficient political will or resources to make an impact.

A global consultation was convened by the WHO Department of Reproductive Health and Research (RHR) in April 2016 with specific objectives to:

1. review factors contributing to achievements and challenges in improving the SRHR of AGYW, especially those living in high HIV incidence settings; and
2. identify elements of SRH interventions that make HIV prevention programmes more effective in reaching AGYW in order to inform global policy, including the operational plan of the GSWCAH.

Examples of successful interventions were presented and speakers and meeting participants explored the reasons for their success through questions and discussion, focusing in particular on the “nuts and bolts” of the benefits of linking SRHR and HIV. A dynamic mix of participants included a balanced combination of four groups: experts in ASRH and SRHR policies and programming; experts in HIV prevention research; AGYW youth advocates, aged 19–24 years, from a range of backgrounds and diverse settings in Africa, the Americas, Asia and Europe; and representatives and experts from key global health institutions, donor organizations and UN agencies.

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<sup>3</sup> For further information, see: <http://who.int/reproductivehealth/topics/violence/action-plan-endorsement/en/>

<sup>4</sup> For further information, see:

<http://www.unaids.org/en/aboutunaids/unitednationsdeclarationsandgoals/2016highlevelmeetingonaids>

<sup>5</sup> For further information, see: <http://www.pepfar.gov/partnerships/ppp/dreams/>

<sup>6</sup> For further information, see: <http://www.theglobalfund.org/en/strategy/>

<sup>7</sup> For further information, see: <http://www.familyplanning2020.org/microsite/strategy>

<sup>8</sup> For further information, see: <http://www.prepwatch.org/policies-and-programs/usaids-supported-initiatives/>

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On the first day of the meeting, an overview was presented of the epidemiological context, the complexity of the structural drivers, and the range of factors that have helped and hindered efforts to improve SRH, including HIV prevention and care, among AGYW.

The second day covered four priority topics:

- eliminating gender-based and intimate partner violence (GBV and IPV)
- delivering accurate and appropriate comprehensive sexuality education (CSE)
- ensuring comprehensive sexual and reproductive health and rights (SRHR) and
- building safe and supportive environments.

Sessions on the third and final day were focused on brainstorming about next steps, in relation to strengthening programmes, policies and investments to better address HIV prevention in AGYW in the context of SRHR.

A unique aspect of this global consultation was the active involvement of AGYW as participants and presenters, including contributions that were critical to shaping the discussion. They provided personal perspectives on their aspirations, the challenges of navigating relationships and perceptions of risk and the importance of designing, implementing and sustaining appropriate, effective and equitable programmes for AGYW.

## **Key messages**

### **1. Implement evidence-based, rights-based and equitable interventions that can reduce risk and augment protection for AGYW**

Interventions that enable young women to have control and choice over their SRHR can break the cycle of disadvantaged gendered relationships, reduce pervasive GBV and IPV and thus also reduce HIV acquisition among AGYW. Promising, successful and potentially sustainable interventions of this type include those that:

- enable girls to stay in school, delay early marriage and eschew unwanted pregnancy;
- nurture economic independence through academic and vocational training;
- provide well designed and correctly implemented CSE programmes in schools and venues that reach out-of-school youth;
- improve access to HIV testing and comprehensive SRH services, including condom distribution and screening and treatment for STIs and other reproductive tract infections (RTIs);
- meaningfully engage young women throughout the development, implementation and evaluation of policies and programmes, to improve programme quality and policy relevance;
- effectively engage boys and young men around risk reduction issues, including healthy sexuality and respectful relationships with girls and women, to change gender norms and behaviour;
- eliminate unequal legal, economic and social barriers to access information, services and commodities; and
- enforce zero tolerance for coercion, violence and discrimination in any form.

## 2. Strengthening the evidence base

Evidence-based policies and programmes are required in order to confirm and lengthen the above list of promising and effective interventions.

For example, AGYW may be at increased risk of HIV infection, especially when the vaginal microbiome is disturbed through infection and harmful practices like douching. Yet, surprisingly little is known about the impact of reproductive tract infections and inflammation on the risk of HIV infection. Further research on the biological vulnerability of AGYW in addition to research on behavioural, social and gender-related factors affecting this population will lead to other potentially effective interventions to introduce and improve the uptake of HIV prevention.

In addition to implementing the successful interventions, it is also vital to discontinue interventions that do not work so that resources can be shifted to support evidence-based practices.

## 3. Meaningful change through intersectoral collaboration

Linking promising approaches in SRHR and HIV requires long-range vision and long-term investments that facilitate cross-sectoral programmes. While not every programme or policy can cover all aspects of SRHR, including HIV, the responsibility for achieving comprehensive and positive SRHR outcomes falls upon all stakeholders. Although there are no “magic bullets”, meaningful reductions in HIV acquisition among AGYW can be achieved through greater integration of SRHR and HIV interventions in a way that empowers young women to exercise their rights to access optimized and holistic SRH services. The most promising interventions are those that are innovative and multisectoral, integrating health/prevention, education and social protection/gender empowerment.

For example, the implementation of new biomedical interventions for HIV prevention, such as pre-exposure prophylaxis (PrEP) for AGYW, will only be successful and sustainable within a context that combines the provision of prevention products with education and gender-empowerment.





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## Introduction

The commitments made by governments at the 1994 International Conference on Population and Development (ICPD) included support of adolescent sexual and reproductive health (ASRH), as documented in the Programme of Action (1). Since the ICPD, achievements in improving the health of adolescents, in particular adolescent girls and young women (AGYW), have linked or integrated essential components of sexual and reproductive health and rights (SRHR), such as comprehensive sexuality education (CSE) and provision of quality sexual and reproductive health (SRH) services, with efforts to create safe and supportive youth-friendly environments at schools, health-care facilities and other venues in the community. Packages of interventions have been used to address SRH problems such as early and/or unintended pregnancy, unsafe abortion, sexually transmitted infections (STIs), including HIV, violence against women and girls and to combat harmful practices such as child marriage and female genital mutilation (FGM). However, many challenges remain if we are to provide AGYW with services that meet their SRHR needs.

However, prevention of HIV infection in AGYW remains a particularly concerning and critical challenge. While new HIV infections have fallen globally by 35% since 2000 – and by as much as 41% in sub-Saharan Africa (2) – the situation of HIV infections in AGYW remains bleak. In eastern and southern Africa, for example, three quarters of all new HIV infections among adolescents aged 15–24 years are among adolescent girls, and globally AIDS-related illnesses are the second leading cause of death among adolescent girls and women of reproductive age, and the first in sub-Saharan Africa (3).

Despite considerable progress in HIV prevention and care – including the availability of counselling on HIV risk reduction, promotion of consistent condom use, and, more recently, the development of oral pre-exposure prophylaxis (PrEP) to reduce the risk of HIV infection – the inability to reach AGYW with HIV prevention tools indicates an urgent need to rethink current prevention approaches and strategies.

### **Global consultation on lessons from SRH programming to catalyse HIV prevention for AGYW**

Over the past 15 years, there have been some major successes towards reaching several of the MDGs related to maternal and child health, but much less progress has been made in improving the health of adolescents (4–6). These problems are particularly intractable and there is seldom sufficient political will or resources to make an impact. With the overall goal of identifying lessons from health programming that could inform improvements in ASRH, particularly for those AGYW living in high HIV incidence settings, a global consultation was convened by the World Health Organization (WHO) Department of Reproductive Health and Research (RHR) at the Brocher Foundation in Geneva, Switzerland, 27–29 April 2016. Examples of successful interventions were presented and speakers and meeting participants explored the reasons for their success through questions and discussion, focusing in particular on the “nuts and bolts” of the benefits of linking SRH and HIV.

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The specific objectives of the consultation were:

1. To review factors contributing to achievements and challenges in improving the SRHR of AGYW, especially those living in high HIV incidence settings.
2. To identify elements of SRH and/or HIV interventions that make HIV prevention programmes more effective in reaching AGYW, in order to inform global policy, including the operational plan for the United Nations Global Strategy for Women's, Children's and Adolescents' Health (GSWCAH).

This global consultation considered the achievements and challenges of policies and programmes to improve SRHR and specifically HIV prevention for AGYW. Addressing gender inequalities and improving the SRHR and general well-being of AGYW should be priorities in all regions of the world. However, given the severity of the situation facing AGYW in sub-Saharan Africa, the consultation paid special attention to actions that would have greatest impact in this region. The meeting agenda is provided in Annex A.

Part of the second objective of the consultation, as listed above, was to identify specific action items that can inform the operation plan to implement the GSWCAH (7). This Global Strategy is one of the cornerstones to achieving the United Nations (UN) Sustainable Development Goals (SDGs), and now includes a strong focus on adolescents. This strategy is one of several emerging global plans and strategies that could make an impact on SRHR and HIV prevention in AGYW (see Section 1.2: Windows of opportunity).

## Participants

The organizers invited a dynamic mix of participants, including a balanced combination of four groups: experts in ASRH and SRHR policies and programming; experts in HIV prevention research; representatives and experts from key global health institutions, donor organizations and UN agencies; and AGYW youth advocates, aged 19–24 years, from a range of backgrounds and diverse settings in Africa, the Americas, Asia and Europe (see Annex B: Participants).

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# 1. Background

## 1.1 Public health context

### SRH needs of adolescent girls and young women and the intersection with HIV infection

Dramatic improvements in access to antiretroviral drugs for treatment of HIV have led to large reductions in HIV/AIDS mortality and vertical transmission of HIV, but more than a third of people living with HIV do not know their serostatus and more than half of people living with HIV are not virally suppressed (2). Primary prevention of HIV therefore remains a critical global public health challenge. As also mentioned in the Introduction, AGYW bear a disproportionate burden of new HIV infections; according to a Joint United Nations Programme on HIV/AIDS (UNAIDS) report published in July 2016 (presented at the meeting), AGYW aged 15–24 years account for 20% of new HIV infections among adults globally in 2015, despite accounting for just 11% of the adult population (2). In some settings, remarkably high HIV incidence rates in young women persist despite the availability of services, including intensive counselling for HIV prevention. AGYW also continue to have a large unmet need for reliable and safe contraception, and they are at higher risk of pregnancy-related complications than older women. Among the many reasons for these disparities are gender inequities and inequalities, which result in lower levels of education, increased threat of violence, and of child, early and forced marriage (CEFM), and lack of access to services. Progress to reverse these inequities must be made on multiple fronts and new approaches are needed in order to make durable improvements in the SRHR of AGYW and accelerate HIV prevention.

### Structural drivers of the HIV epidemic

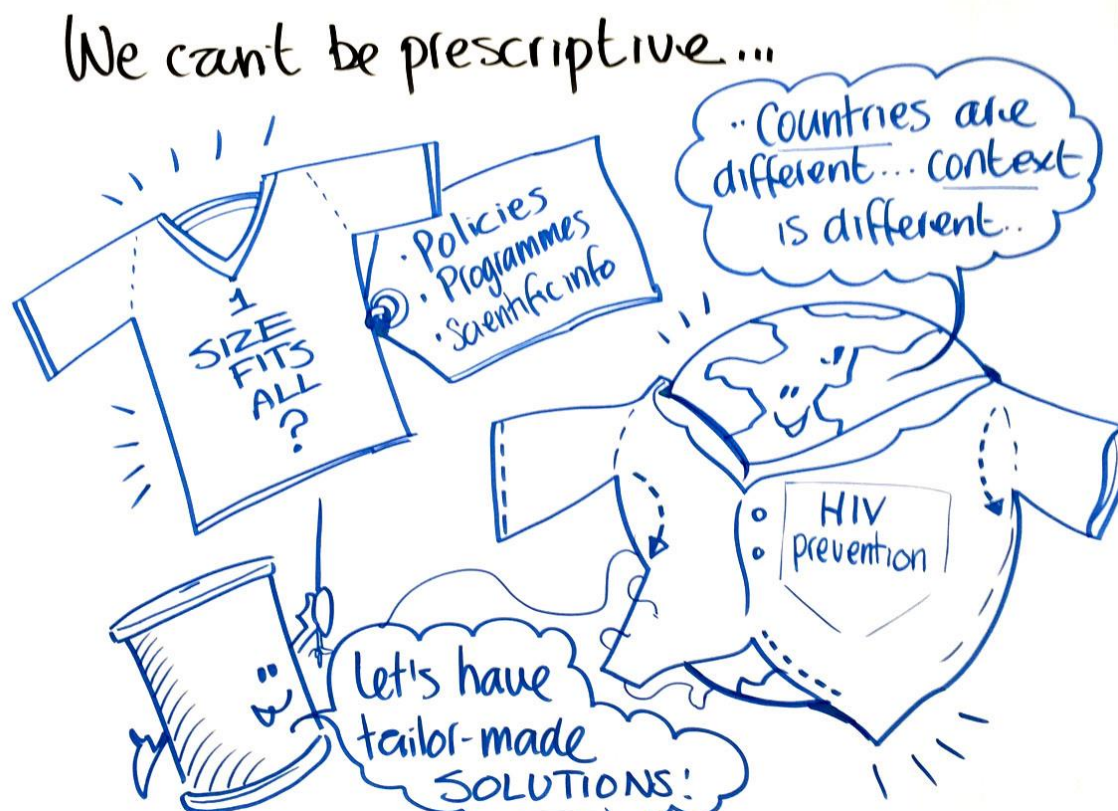
Some structural drivers of HIV include gender, violence, education, poverty, alcohol and stigma. The power and economic differentials between young women and men combine to exacerbate AGYW's higher vulnerability to HIV infection. Wide-ranging presentations and discussion at the meeting covered lessons learnt from SRH programmes that address structural drivers of the HIV epidemic in a way that can accelerate HIV prevention in AGYW.

**Violence against women**, perpetrated by their intimate partners and other men, is a crucial driver of HIV. Being the target of violence is a factor that directly and indirectly increases women's risk of HIV. Sexual violence can increase HIV risk directly through instances of forced and unprotected sex, exposure to multiple sexual partners, and genital trauma. Indirect pathways include, for example, reduced access to SRH services including HIV prevention, and the higher likelihood that men who are violent also engage in other risk behaviours such that they are more likely to be HIV positive. Intimate partner violence (IPV) is also associated with lower uptake of care and poor treatment outcomes among women living with HIV (8); however, at this time it is not clear whether this effect is causal nor whether IPV interventions will have a direct impact on adverse treatment outcomes (see further discussion in section 2.1).

**Girls' reduced access to education** beyond primary school is another driver. A cluster randomized trial in Malawi evaluated the effects of conditional and unconditional cash transfers to young women and their families to encourage retention in secondary school and reduce young women's vulnerability to HIV. The intervention resulted in higher retention of girls in secondary school, lower levels of sexual risk behaviours and lower prevalence of HIV and herpes simplex virus type 2 (HSV-2)

infection after 18 months (9). However, a recent study in South Africa did not replicate these results; while the cash transfers did increase school attendance, there was no impact seen on HIV incidence, possibly due to falling overall incidence rates or the relatively short follow-up period (10). This suggests that the impact of social interventions may not be directly transferable from one socioeconomic and cultural setting to another. The complexities of SRH and HIV interventions, the time scale over which impacts may be measurable, and the wide range of potential health impacts were highlighted.

**Young people's different perceptions of risk and vulnerability, and lack of SRH knowledge,** can also be drivers of the HIV epidemic and must be taken into account. Young people may perceive their HIV risk very differently from older people, in particular in the ways that short-term and long-term risks are weighed, and thus they tend to act differently, sometimes failing to or not being able to protect their own health and well-being. Several of the AGYW participants stressed the importance of information and education for sexual health. In their view, it is difficult for young people to become engaged in improving their own sexual health without knowledge about safe and healthy sex, risks and consequences, and how to avoid risks. Decades of experience in development and delivery of family planning and contraceptive programmes demonstrates that the social, health, economic and educational capacities and needs of young women rapidly evolve during adolescence, so information and services must be tailored to the age, maturity and needs of the clients. The notion of "family planning", for example, can seem remote and disconnected from the immediate needs and desires of young people. The AGYW at the meeting called for the use of more positive and relevant messages, emphasizing the value of avoiding unintended pregnancy as a means of investing in one's own future through improving chances of grasping opportunities to succeed in life, and of developing healthy bodies and healthy minds.



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When given support and education, many **young people are willing and excited to be involved in helping shape policies and programmes** and to participate in the decisions that will shape their lives. A number of discussants strongly advocated for involving young people in identifying, developing and implementing interventions and programmes on SRHR and HIV prevention that resonate with them and their peers. They argued that this could result in better uptake of services and could make programmes more effective, acceptable and sustainable.

**Social norms** are also strong influencers of risk perception and behaviours, and understanding the social and national context remains critical when considering developing or strengthening particular HIV prevention programmes and interventions. This includes gaining a better understanding of complex social factors behind the drivers of intergenerational sex, such as power, status, intimacy and money. Direct interventions engaging with men on their SRHR needs, including reoriented socialization of young men, in addition to working with AGYW on gender empowerment may also be needed (11), but social norms can change, of course – sometimes very rapidly – which can be both an opportunity and a threat to programmes, although young people are generally more likely to be receptive to change and innovation than older people.

As a way of tackling the structural drivers of HIV, there was strong support during the meeting for identifying comprehensive and integrated solutions within and outside the health sector that can have impact on the multiple, complex aspects of ASRH. There is evidence to show that vertical programmes have limited impact on HIV or SRH outcomes. Developing integrated programmes over multiple sectors creates a new array of challenges for programme managers, implementers and funders, but offers the potential for greater benefits over multiple health outcomes.

## 1.2 Windows of opportunity at global policy level

Representatives of international agencies described key developments at the global level which have important implications for improving ASRH and accelerating HIV prevention for AGYW.

The GSWCAH serves as the basis for a common approach by multiple UN agencies, including UNAIDS, United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF), UN Women and WHO as well as the World Bank. The first Global Strategy for Women’s and Children’s Health originated in 2010 and was put into action by the Every Woman Every Child movement, which was launched in the same year to accelerate action towards Millennium Development Goals (MDGs) 4 and 5.<sup>9</sup> The updated Global Strategy is now aligned with the new Sustainable Development Goals (SDGs). While noting that uptake and use of commodities and services are essential, the new strategy also takes a much broader approach to addressing underlying drivers of inequity and ill health by working in parallel across several sectors, and puts special emphasis on adolescents (7). An important structure that supports implementation of the GSWCAH is the Global Financing Facility (GFF), led by the World Bank and supported by bilateral aid organizations through international development assistance funding and foundations.

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<sup>9</sup> For further information, see: <http://www.everywomaneverychild.org/>



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Some other UN-led initiatives include:

- the WHO Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls and against children (12)<sup>10</sup>;
- the UNAIDS 2016–2021 Strategy (13, 14) and subsequent *Political Declaration on HIV and AIDS: On the fast-track to accelerate the fight against HIV and end the AIDS epidemic by 2030* issued at the 2016 High-Level Meeting on Ending AIDS (UN General Assembly, June 2016) (15)<sup>11</sup>; and
- the WHO Global Health Sector Strategies for HIV/AIDS, viral hepatitis and STIs (2016–2021) (16–18).<sup>12</sup>

Other relevant and important global initiatives include:

- the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) DREAMS partnership (with the Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, ViiV Healthcare and Gilead Science) to help girls develop into determined, resilient, empowered, AIDS-free, mentored, and safe women, in 10 sub-Saharan African countries (launched in 2014) (19)<sup>13</sup>;
- the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) Strategy 2017–2022: Investing to end epidemics (20);<sup>14</sup>
- Family Planning 2020 (FP2020) – “a global movement that supports the rights of women and girls to decide – freely and for themselves – whether, when, and how many children they want to have”<sup>15</sup> – FP2020’s new Strategy for 2016–2020 “prioritizes efforts on four crosscutting initiatives: country support; data and performance management; global advocacy, rights, and youth; and knowledge and evidence” (21); and
- United States Agency for International Development (USAID) Microbicide Product Introduction Initiative (MPii), 2015–2020 – supporting HIV prevention for AGYW.<sup>16</sup> For further information on MPii, see section 1.3.iv.

These multiple plans need to strengthen linkages between SRHR and HIV policies and programmes if they are to achieve their stated goals of meeting the health needs of AGYW.

### 1.3 Biomedical interventions for HIV prevention

The presentations and discussion on this topic focused on four technologies. Interventions related to STIs are not covered in this report since a separate meeting was held on this topic by WHO/HRP in collaboration with PEPFAR, USAID, the Initiative for Multipurpose Prevention Technologies (IMPT), and the British Columbia (BC) Centre for Disease Control (CDC) in Vancouver, 31 May – 1 June 2016 (22).

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<sup>10</sup> For further information, see: <http://who.int/reproductivehealth/topics/violence/action-plan-endorsement/en/>

<sup>11</sup> For further information, see: <http://www.unaids.org/en/aboutunaids/unitednationsdeclarationsandgoals/2016highlevelmeetingonaids>

<sup>12</sup> For further information, see: <http://www.who.int/hiv/strategy2016-2021/en/>

<sup>13</sup> For further information, see: <http://www.dreamspartnerhip.org/>

<sup>14</sup> For further information, see: <http://www.theglobalfund.org/en/strategy/>

<sup>15</sup> For further information, see: <http://www.familyplanning2020.org/microsite/strategy>

<sup>16</sup> For further information, see: <http://www.prepwatch.org/policies-and-programs/usaid-supported-initiatives/>

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i. **Condoms** have been used successfully for well over 100 years to prevent unplanned pregnancy and STIs. This dual-purpose method has been the mainstay of HIV prevention since the beginning of the HIV/AIDS epidemic and has made a major contribution to preventing even further spread of the epidemic. Condoms are inexpensive and highly effective when used correctly and consistently; in the range 90–95% for prevention of unintended pregnancy and STIs, including HIV. In practice, however, their effectiveness is much lower, due to incorrect use or non-use (60–70% under typical conditions). One important drawback is that they are difficult to use discreetly and confidentially, unlike, for example, long-acting injectable contraceptive methods. Worldwide, condom use has increased substantially over the past 30 years and plays a major role in HIV prevention in high-risk situations. The 100% condom use programme in Thailand, targeting the sex work industry, is an excellent example of how condoms and condom programming can be successful. However, condoms may be difficult to use during sex between regular partners, particularly if there is no strong motivation to avoid an unplanned pregnancy. Male and female condoms still have an important place in combination prevention, but their effectiveness and acceptability has not been sufficiently high to end the HIV epidemic as a public health problem.

ii. **The dapivirine-releasing monthly intravaginal ring** has been developed as an HIV prevention method for women. Two phase III trials have recently been completed in Africa and findings have shown a modest reduction in HIV incidence among users of the active compared with the placebo ring. The reduction in risk was greatest in those study sites with highest adherence to product use, and in older women. The reduction in risk among younger women (under age 25) was disappointing and further studies are ongoing to generate more product safety information and a better understanding of women's willingness and ability to use the rings consistently over an extended period. Other products, such as a combined ring that could provide protection against HIV and unplanned pregnancy, are in the pipeline and may be entering clinical effectiveness testing in the next two to three years. These may be more convenient and acceptable to women and their partners than methods that protect against HIV alone.

iii. **Oral pre-exposure prophylaxis (PrEP)** with the combination antiretroviral tenofovir disoproxil fumarate and emtricitabine (Truvada®) has been shown to be effective to prevent HIV infection. Studies conducted among men who have sex with men (MSM) in Europe, the Americas and Africa, among HIV serodiscordant couples, and among heterosexual men and women in Africa (23–26); showed over 80% protective efficacy when the product was used as indicated, and a sharp drop in effectiveness with lower adherence to the prescribed daily dosing schedule. The lowest usage rates in studies of at-risk women were noted in the youngest women (27). WHO first issued guidance in 2012 for projects to demonstrate feasibility and acceptability of PrEP among MSM populations and serodiscordant couples, followed in 2015 by a more general recommendation that oral PrEP should be offered as an additional prevention choice for all people at substantial risk of HIV infection, defined as those living in a setting where annual HIV incidence exceeded 3%. Demonstration projects are under way or planned in nine African countries, focusing primarily on sex workers, MSM and serodiscordant couples. Only Kenya and South Africa are launching demonstration projects among young women or adolescent girls and several additional DREAMS focus countries are considering including PrEP in their interventions. As of May 2016, Kenya and South Africa were the only developing countries that had approved Truvada® for prevention,<sup>17</sup> it being available elsewhere only for treatment.

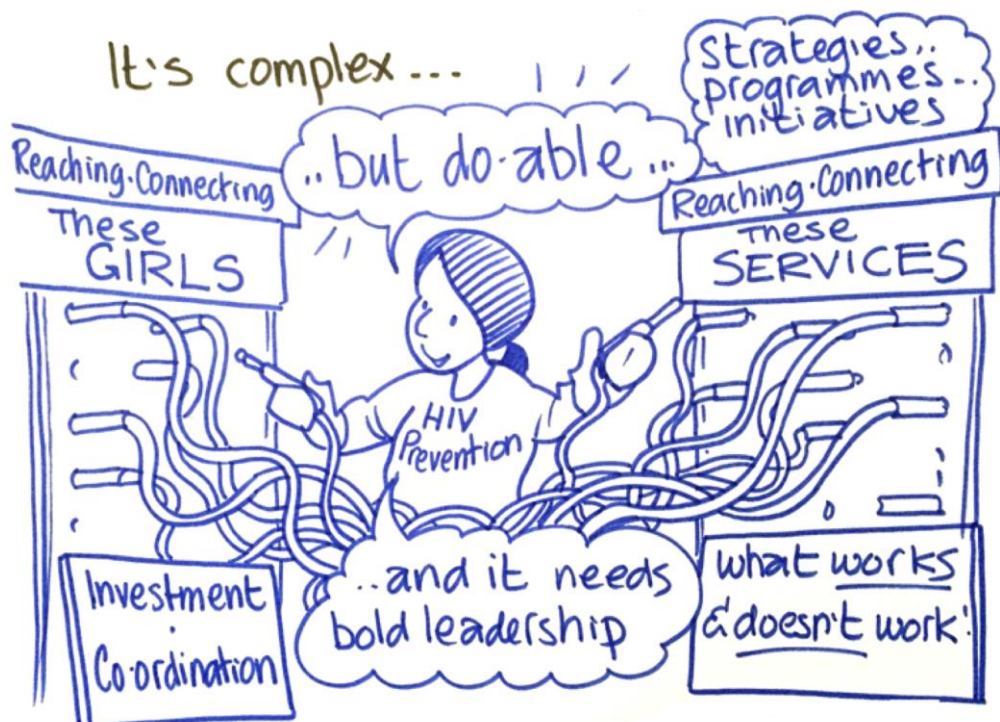
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<sup>17</sup> For further information, see: <http://www.prepwatch.org/advocacy/country-updates/>

iv. **The Microbicide Product Introduction Initiative (MPii)** includes five interconnected projects on ARV-based HIV prevention product introduction and access, which run from 2015 to 2020.<sup>18</sup> These projects are designed to accelerate introduction and uptake of new HIV prevention methods, especially for young women. Currently, the focus is on introduction of oral PrEP but the MPii projects may also consider the dapivirine ring, once licensed. Experience gained with introduction of these products could potentially accelerate introduction and expansion of other HIV-prevention products currently in the pipeline, such as long-acting injectable HIV prophylaxis (envisaged to be used in a similar way to long-acting injectable contraception) or novel HIV entry inhibitors.

#### 1.4 Biological vulnerabilities of adolescent girls

Phylogenetic studies of linked HIV transmission networks in a rural community in South Africa showed that young women under age 23 years usually acquired HIV infection from men on average about eight years older than themselves, but older women aged 24–29 acquired infections from men similar in age to themselves (28). This is partly due to social and cultural factors that lead to such patterns of sexual behaviour, but there are also data to suggest that AGYW are more biologically susceptible to HIV infection than older women. Relevant factors include persistent subclinical genital inflammation, possible co-infection with HSV-2 and/or human papillomavirus (HPV), high prevalence of bacterial vaginosis, use of douching and intravaginal drying agents, and widespread use of long-acting injectable hormonal contraceptives, which have been implicated by several epidemiological studies conducted in the region (29). Further information on this important and rapidly evolving subject was presented at the International AIDS Conference (IAC) in Durban, South Africa, in July 2016 (30).



<sup>18</sup> For further information, see: <http://www.prepwatch.org/policies-and-programs/usaid-supported-initiatives/>

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## 2. Four priority topics in support of ASRH and HIV prevention

Discussions from Day 1 of the meeting clearly indicated that behavioural, biomedical and structural components were important to consider together when delivering HIV-prevention interventions to AGYW. On Day 2, several examples of successes from ASRH programmes were presented, including Ethiopia's successful reduction of child marriage and adolescent pregnancy (31), and improvements in SRH knowledge and behaviours and access to SRH services among Ugandan youth (32–34). The example of reducing teenage pregnancy in England is highlighted here as challenges to SRHR for AGYW is not just an issue for low- and middle-income countries (LMICs) (see Box 1).

### **Box 1: Teenage pregnancy decline in England**

The experiences of developing and implementing the successful Teenage Pregnancy Strategy for England 1999–2010 might be applicable in other settings for addressing high teenage pregnancy rates, as well as in settings with high HIV incidence to improve HIV prevention in AGYW (35). In 1998, the teenage pregnancy rate for England was among the highest in Europe: 46.6 pregnancies per 1000 women aged 15–17 years. The aim to halve the under-18 conception rate within 10 years was achieved through this programme. The comprehensive strategy was framed around four main themes: coordinated action at national and local levels; improved prevention for girls and boys through education and access to contraception; outreach to young people and their parents via a communications campaign; and coordinated support for young parents. After the mid-programme review, the 10 key factors for an effective local strategy were identified, as implemented in high-performing areas. These are shown in Figure 1, with strong leadership (national and local) and accountability at the centre.

While all elements contributed to successful implementation, several factors were described as particularly relevant to addressing high HIV incidence in young people. These included:

- Political support for the strategy was strong at all levels, from senior politicians and policy-makers (dubbed the “BIG Ps”) to parents and young people (the “little ps”).
- Involvement of young people – the ultimate beneficiaries of the programme – was integral to effective development, implementation and monitoring of the programme.
- Creating and maintaining youth-friendly services ensured that services were accessible and welcoming for their intended clients.
- It was important to ensure a balance between general provision of sex and relationships education to all adolescents and provision of special, focused support to vulnerable young people.
- An iterative approach meant that the reasons for observed successes, challenges and failures during implementation were explored, and the programme was subsequently refined to focus the available resources on those areas or issues requiring further support.
- A comprehensive, multisectoral approach was crucial to success, rather than intervention efforts being confined within a single sector or domain.

**Figure 1: Teenage Pregnancy Strategy for England (1999–2010): 10 key factors for an effective local strategy**



Source: Hadley et al., 2016 (35).

Building upon these successful examples of policies and programmes, four topics that are relevant and remain a challenge to improving HIV prevention among AGYW were explored in more detail:

- i. gender-based and intimate partner violence (GBV and IPV);
- ii. accurate and appropriate comprehensive sexuality education (CSE);
- iii. comprehensive SRHR; and
- iv. safe and supportive environments.

Across topics, a consistent focus was placed on evidence and programme experiences that have demonstrated some element of success for AGYW. The most relevant issues and key points discussed at the meeting are summarized here in turn per topic.

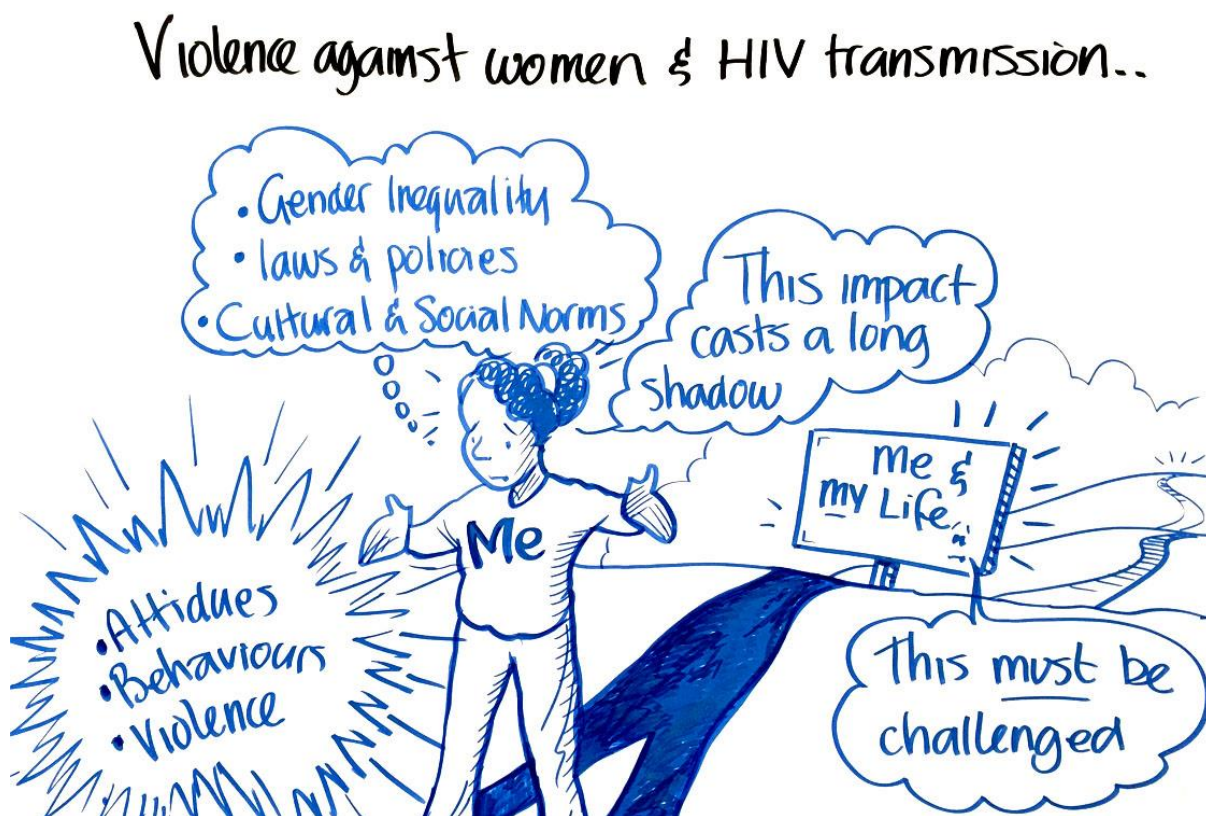


## 2.1 Eliminating gender-based and intimate partner violence

Violence against women and girls takes many forms, with IPV the most common. Globally, 30% of women have experienced physical and/or sexual violence by an intimate partner, and the numbers are similar for young women aged 15–24 years who have ever had partners (36). For many, violence begins early: lifetime prevalence of childhood sexual abuse is 18% for girls and 8% for boys (37).

Multiple complex pathways connect GBV/IPV with SRHR, including HIV in particular. Due to the connecting pathways, efforts to eliminate GBV/IPV have the potential to also improve SRHR and HIV prevention among AGYW. A WHO/UNAIDS programming tool contains *16 ideas for addressing violence against women in the context of the HIV epidemic*, including ideas for empowering women and girls through multisectoral programmes; transforming cultural and social norms related to gender; integrating violence against women (VAW) and HIV services; and promoting and implementing laws and policies related to VAW, gender equality and HIV (38). There are also a number of WHO tools for training health-care providers to recognize and address GBV (39).

A recent review of evidence from 61 interventions addressing IPV and sexual violence among adolescents points to three promising approaches: school-based programmes that address dating violence; community-based interventions to promote gender-equitable attitudes; and interventions aimed at children and adolescents who have been maltreated and at their parents. Programmes with longer-term investments and repeated exposure to ideas seem to be more effective than single-session, one-off interventions. The review notes a need for more programme experience in a wider range of countries and settings, and more rigorous research to evaluate interventions over time (40).



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Following are summaries of key information from presentations about the SASA! Programme which started in Uganda, as well as about efforts to address violence against women in India and Kenya.

### SASA!

SASA! is a community mobilization approach for preventing VAW and HIV, which started in Uganda.<sup>19</sup> SASA! works through a network of volunteer community activists and addresses various aspects of power through a phased approach:

- “Power within” taps into the volunteers’ own experiences and builds confidence.
- “Power over” engages men and women to acknowledge and think critically about men’s power over women.
- “Power with” strengthens leadership skills and connections between community members.
- “Power to” fosters the power to make positive change, through trying new behaviours and celebrating change.

Addressing power directly is provocative, but it may also help to defuse defensiveness and allow participants to connect with personal experience. In Kampala, SASA! has trained over 400 men and women in the community who have led more than 11 000 activities such as community discussions, door-to-door conversations, training sessions, film showings, poster discussions and other events. These activities have reached more than 260 000 community members in six parishes.

The results of a cluster randomized controlled trial in four SASA! intervention communities and four control communities in Uganda showed a number of positive changes among both women and men, including significant declines in social acceptance of IPV, and significant increases in social acceptance of the idea that a woman can refuse sex (41, 42). In the intervention communities, there were also fewer reports among women of past-year experience of physical IPV and sexual IPV, and those who did experience violence were more likely to receive supportive community responses. Men also reported past-year concurrent sexual relationships significantly less often compared with men in the control communities. The study used cross-sectional surveys of a random sample of community members aged 18–49 at baseline (N = 1583) and again four years after the intervention started (N = 2532). Importantly, positive changes were not limited to people who had been directly exposed to the programme, suggesting social diffusion of changed attitudes and behaviours within a community. SASA! was effective in changing what people believe and how they behave, demonstrating that violence is preventable within a programme time frame of a few years. The approach is now being adapted and implemented in the control communities and other settings in Uganda, as well as in 20 other countries around the world.

### India

Most programmes addressing violence in India are undertaken by nongovernmental organizations (NGOs), and relatively little strong evidence exists on programme effectiveness. The government health system recently implemented a programme in Bengaluru (Bangalore) integrating IPV prevention and response programmes into primary health care settings, mainly in the context of

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<sup>19</sup> “Sasa” is a Kiswahili word meaning “now”. For further information on SASA!, see: <http://raisingvoices.org/sasa/>

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postnatal, antenatal and immunization services. Providers were trained to identify cases, provide initial assistance and to refer women to other services in the community. Capacity-building and evaluation were provided by RTI International and St John's Research Institute. A quasi-experimental evaluation suggested that the intervention improved providers' and women's knowledge, attitudes and practices. Providers felt more capable and responsible for addressing GBV and IPV. Women became more aware of different forms of violence, they reported being asked about their domestic situation and were confident that the clinic was capable of providing help. This study demonstrated that integration of IPV prevention and response strategies into existing health-care platforms is feasible, acceptable and has the potential to be scaled up to the national level. A multi-stakeholder commitment to addressing VAW is key to a comprehensive and effective response.

## Kenya

The Kenyan Constitution recognizes that GBV is a violation of human rights. A number of intersecting circumstances predispose women in informal settlements to violence, including IPV in the context of marriage or relationships between young people, violence between parents and children, and violent acts of strangers. The Kenyan AIDS Strategic Framework notes that young women aged 15–24 are over three times more likely to be living with HIV (3%) than men of the same age (1.1%), and they are also over three times more likely to be exposed to sexual violence than young men (43).

Women fearing violence are less able to protect themselves from STIs including HIV because they are usually unable to negotiate safe sex or to refuse unwanted sex. Young women can be even more at risk: almost all instances of first sexual intercourse among adolescents are reportedly unplanned, forced and/or unprotected. Fear of violence or abandonment can also discourage women from getting tested for HIV. Actions to address GBV and HIV must be integrated and multisectoral, including: education (including life skills training starting in elementary school), with a focus on access, quality, transition and retention; HIV testing and general counselling services; involvement of elders to help change social norms around GBV, wife inheritance and other issues; full implementation of the government's adolescent policy supported by sufficient resources; and special attention to those who may be doubly vulnerable, such as young and disabled women.

## Discussion points

- **Working with men:** This can be an important and effective strategy. A number of programmes including SASA! and Stepping Stones<sup>20</sup> work with both women and men. A recent paper reviewed work with men to prevent violence (44), but the evidence overall remains limited. In addition, the majority of the evidence comes from programmes in well resourced settings and from studies with only short follow-up periods.
- **Community-based versus health-care facility-based approaches:** In LMICs, the health system is not well positioned or equipped to respond to VAW, though this may be changing in some settings. Implementing the WHO's "Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children" will require identifying which issues are best tackled in the community and which at the health system level, as well as deciding how best to conceptualize programmes based on local availability of resources.

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<sup>20</sup> For further information, see: <http://salamandertrust.net/project/stepping-stones-programmes/>

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- **Transforming unhealthy social norms:** Discussing, unpacking and challenging gender norms, such as those relating to violence and masculinity, is critical and should start as early as possible with adolescents. Should they have unhealthy views about gender roles, sexuality, health and violence, targeted and supportive health interventions and teachers at schools can help transform such views.
  - **Evidence-based programming:** Demonstrating and documenting what interventions are effective in the field of violence prevention and response is relatively new, and current programmes continue to innovate and adapt based on context and need. Recent rigorous studies have demonstrated some significant effects on attitudes and behaviours. Together this experience and evidence is generating lessons as to which approaches are most effective and how they can be adapted for other settings. For example, working with groups tends to be more effective than working with individuals, and it is generally better to engage communities with broader topics as points of entry, such as power rather than violence (38, 45). The field is now poised to adapt and evaluate innovative combinations of programme components in different settings through demonstration projects. It is important to balance the need to generate more evidence with the imperative of acting on what we already know has impact.

## 2.2 Delivering accurate and appropriate comprehensive sexuality education

Sexuality education is defined as “an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information”; objectives of sexuality education programmes may include: “to increase knowledge and understanding; to explain and clarify feelings, values and attitudes; to develop or strengthen skills; and to promote and sustain risk-reducing behaviour” (46). There is clear evidence that CSE does not foster early or increased sexual activity, but well designed and well conducted sexuality education can result in positive changes in sexual behaviour and reduce negative health outcomes. However, only a small number of countries have scaled up CSE, and even then the most vulnerable adolescents have not been reached and many teachers find it difficult and uncomfortable to provide CSE (47). A review conducted in six countries showed that school-based sexuality education programmes can be cost-effective with respect to reduced adverse health outcomes and health-care costs, particularly when combined with youth-friendly provision of SRH services, but evidence is limited (48). There is a large gap between policy and implementation of CSE, as well as a dearth of documentation of programmes, challenges, costs and impact. However encouraging evidence has emerged that brief sexuality communication delivered to adolescents and adults in primary health care settings can have a significant impact on health behaviour and outcomes, particularly with regard to reducing STIs and high-risk sexual behaviour, as well as improving knowledge, attitudes and behaviours (49).

Below are summaries of information presented at the consultation about CSE initiatives in Nigeria, Finland and Zimbabwe, as well as the United Nations Educational, Scientific and Cultural Organization (UNESCO) Ministerial Commitment on CSE and SRH services for adolescents and young people in Eastern and Southern Africa (ESA), followed by some key discussion points.

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## Nigeria

Among Nigerian adolescents there is a high incidence of unwanted pregnancies following early initiation of sexual activities. A programme implementing an effective CSE programme in Nigeria was conceived and implemented, centred around the needs of Nigerian adolescents, in order to give them a voice, improve gender norms, and ensure a safe and healthy transition to adulthood. Key elements of the intervention included capacity-development, curriculum development, and ensuring broad-based policy and political support. This broad-based support was achieved through building networks of NGOs, community leaders, and local and federal government representatives to discuss and agree on key messages about how best to discuss sex and sexuality within the society. Adopting a headline of “family life education” in preference to “sexuality education” was one way of garnering support in a society where sexuality is not generally publicly discussed. This facilitated the development of a core curriculum on “family life and HIV education” with federal and state government funding, which received broad support and was subsequently implemented through the school system, including appropriate training and retraining of teachers. Other initiatives to address out-of-school adolescents and provide youth-friendly services are also part of the programme (50).

## Finland

Sexuality education was compulsory in all schools in Finland from the 1970s, supported by an effective network of nurses based in schools. However, an economic downturn in 1992 led to a reduction of available resources and transfer of responsibility to local municipalities and subsequent cuts in preventive health services and all educational sectors. A subsequent rise in abortion rates over the period 1995–2000, particularly among adolescents aged 15–19 years led to a reassessment of the policy and development of a health education curriculum that was introduced by specialized teachers in all schools, along with an increase in the number of teaching hours. This reversed the upward trend in abortions (51). The key lesson for meeting participants was that even in settings with strong and supportive environments for ASRH, it is important to monitor key indicators and be prepared to adapt and revise policies and strategies as necessary.

## Zimbabwe

The importance of youth representation and involvement in CSE – both at the grass-roots level with training and advocacy, as well as at the policy level – remains an essential element of success. In Zimbabwe, keeping AGYW in school was an important route to improving their SRHR, but this needed to be accompanied by appropriate CSE for pupils, and by involving the young people in training and information dissemination on sexuality.<sup>21</sup> Furthermore, CSE needs to be extended to out-of-school young people as well as those in tertiary education.

## The UNESCO Ministerial Commitment on CSE and SRH services for adolescents and young people in Eastern and Southern Africa (ESA)

The **UNESCO Ministerial Commitment** was endorsed by 20 countries in the region in December 2013 (52). While UN institutions assisted with facilitation, the process was owned and implemented by the countries themselves. Experience to date revealed that implementing school-based comprehensive sexuality and HIV-prevention education has been difficult in these countries – the

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<sup>21</sup> For further information, see: <http://youthleadglobal.org/afriyan/>



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most challenging issues, such as sexual behaviour, sexual health and condom use, are not being addressed, or are being addressed too late, and teachers are not confident to teach these complex and sensitive issues. Teachers' own personal values or concerns about talking with young people about these topics are a major barrier. Of particular concern is the weakness of core gender and rights elements of national CSE programmes. A limitation of school-based programmes is that they do not reach out-of-school adolescents, including marginalized adolescents living in extreme poverty, married girls and girls who engage in transactional sex for their economic survival.

### DREAMS partnership

In 10 sub-Saharan African countries that are part of the DREAMS partnership, CSE is part of the core intervention package being implemented to reduce HIV infections among AGYW. It is hoped that this will improve implementation and foster better community engagement in the package of interventions. No impact on STI or HIV incidence rates has been seen to date, but the partnership was only launched in 2014. It is hoped that implementation will be of sufficient quality and coverage that measurable impact will be seen.

### Discussion points

- **Groups to reach:** Delivering sexuality and relationships education in schools is an important component of CSE. It is also important to work in parallel with out-of-school young people, and to provide easy and convenient preventive health services for all young people. Places providing such services can also be venues where young people can access information. It was also mentioned that there are unique opportunities for integrating several CSE elements focused particularly on adolescent boys in ESA countries where voluntary medical male circumcision (VMMC) programmes are being implemented. These programmes are transitioning from the emergency, catch-up phase of circumcising adult men to a sustained phase of offering circumcision to smaller annual birth cohorts of adolescent boys. Integration and linkages between the educational and circumcision services should be developed in the priority countries that are scaling up VMMC to ensure maximum benefit.
- **Appropriate content and settings for CSE:** The appropriate level and content of CSE for different groups and in different settings is difficult to agree on, particularly with regard to linking the necessary educational topics with access to health service interventions. It is important to build the capacity of teachers and facilitators to deliver appropriate content in different settings in order to reach young people where and when they are receptive to receiving new and sensitive information.
- **Substance abuse:** CSE must also cover substance abuse, which is an important factor contributing to reckless sexual behaviour.
- **Measuring impact:** When considering how to measure the impact of CSE interventions it is important to recognize that CSE is likely to lead to benefits across multiple outcomes, some of which are difficult to capture and quantify, and not all of which are directly on the pathway to reduced STIs or HIV infections. This complexity makes it difficult to advocate for the allocation of resources to CSE in the context of discrete vertical programmes strongly focused on particular results favoured by donors and/or governments. Moreover, donors and other investors must be prepared for long-term commitments as interventions need adequate time to mature and bring about measurable impact.

- **Barriers:** CSE is a sensitive and highly politicized issue, at individual, community, country and global levels. This underlies the slow progress towards implementing programmes and the lack of consensus on global commitments. This often results in a piecemeal approach to implementation, as in Poland, for example, where a short course on “family education” is included in the school curriculum, but more complex and controversial issues, such as violence and sexual pleasure, are not addressed.
- **Discomfort related to CSE:** The discomfort generated by CSE – among parents, teachers and other community members – needs to be addressed. It is important to understand how best to package the critical elements of CSE in ways that are acceptable to different communities and cultural groups. While fully “comprehensive” sexuality education is considered most likely to succeed, there is no consensus on which elements constitute an absolute minimum core package of interventions.
- **Advocacy and communications:** Ensuring strong advocacy and community support for CSE is a critical element for success. One approach is to create a joint information and advocacy hub, using social media and other channels, that provides a platform for sharing information and experiences. This can be managed and populated by well informed young people and peer groups together with more experienced professional staff, as required.



### 2.3 Ensuring comprehensive SRHR

Comprehensive SRHR policies, programmes and service delivery remain essential to HIV prevention for AGYW. In high HIV incidence settings, there remains a range of challenges that have compromised the SRHR of AGYW. Examples were presented from programmes supporting health

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workers' training as a way to increase access to services and to create demand and improve uptake of services.

A 2015 review identified effective strategies to provide ASRH services and increase demand and community support (53). Training and supporting health workers, making health services friendly to adolescents, and conducting outreach education to generate demand for services among adolescents and to build community support for provision of ASRH services all contribute to increased service utilization by adolescents – but these elements must be implemented together. At the same time, there is limited evidence that delivering health services outside health-care facilities is effective, but multipurpose youth centres are not effective in increasing service utilization.

A complementary review of what does not work in ASRH programming found that when programmes are adapted for use elsewhere or for scale up, even effective programmes are often delivered with inadequate fidelity; they may focus on training or information provision, for example, but neglect other programme components (54). Training health workers is a widely used approach to improve ASRH, and in many settings it is the only approach, but training alone does not improve health worker performance. Judgmental and disrespectful health-care providers remain a critical barrier to the utilization of ASRH services. Some health-care providers are aware that these attitudes present a barrier, and that inadequate skills and knowledge hinder their ability to provide such services (55).

It is essential not to repeat what has not worked in reaching young people. Firstly, it is important to stop building separate services for adolescents – these are not necessary, scalable or sustainable. One-off training is also insufficient to ensure that health workers develop adolescent-friendly attitudes and approaches. Adolescents are a heterogeneous group and no single approach will meet their needs or preferences. Programmes should seek to involve adolescents more meaningfully in the programme design and implementation. Programmes should also monitor and evaluate the results and use the information to strengthen the programmes and inform other programme approaches. Finally, health service provision should be linked to complementary interventions.

Below are summaries of efforts to provide comprehensive SRH services and support AGYW's rights to SRH services in Ethiopia, South Africa and India, followed by a list of the key discussion points.

## Ethiopia

Ethiopia's recent efforts to meet the SRH needs of adolescents and youth have led to notable improvements in some key demographic and health indicators. This was brought about by innovation, evaluation and applying the available evidence to improve services, as well as collaboration between the NGO and government sectors to take the programme to scale.

Between 2000 and 2014, the contraceptive prevalence rate increased from 3% to 40% among adolescent girls (aged 15–19 years) and from 5% to 47% among young women (20–24 years).<sup>22</sup> To enable sustainable scale-up of youth-friendly services (YFS), Pathfinder worked to institutionalize YFS within government policies and guidelines. In 2006, a visit the *Geraçao Biz*, a multisectoral Adolescent and Youth Sexual and Reproductive Health (AYSRH) programme in Mozambique, by a delegation of representatives from Ethiopian government ministries, reproductive health-focused

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<sup>22</sup> Presentation by M. Asnake, Pathfinder International, 28 April 2016: "Meeting the sexual and reproductive health needs of adolescents and youth".

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civil society partners and youth associations, prompted the development of a similar YFS initiative in Ethiopia. First, a pilot implementation of YFS was implemented at 20 public health-care facilities and lessons from this experience informed the efforts to scale up to the current level of 248 public health-care facilities, which are linked to peer educators from youth clubs and youth centres. Some facilities are increasingly serving married adolescents to address the unmet need for contraception and other SRH services in this group. These facilities provide a range of services that include: contraceptive counselling and a full range of methods; HIV counselling and testing, including provision of or referral to antiretroviral therapy (ART) services; gynaecological examinations; counselling, treatment and referral for sexual abuse and violence; syndromic management of STIs; pregnancy care and referral for delivery; post-abortion care; prevention of mother-to-child transmission of HIV; and other medical services.

From 2009 to 2015, 2.5 million adolescents and youth received services at participating facilities. Starting in April 2014, detailed data were collected on the types of services provided. These data show what proportion of the YFS clients received which SRH services: condom supplies (23.2%); contraceptives other than condoms (22.8%); HIV testing (16.6%); STI treatment, post-abortion care, ART, and other social services (less than 3% combined). Almost 35% of the YFS clinic attendees received other services, including treatment for other non-SRH medical services.

A number of factors contributed to the relative success of this programme to support YFS:

- The government took the lead and committed to implementing strong supporting policies and programme plans, including a Youth Policy, the AYSRH Strategy and Minimal Service Standard, and YFS National Guidelines. The government also committed to making the programme an integral part of the health system, and it has been taken to scale. This avoided the problem faced by many excellent programmes that end when specific donor or NGO funding ends.
- The government extended the health system support through the training of 38 000 health extension workers – two for every village with a population of at least 5000 – most of whom are young women.
- The programme also benefited from availability of unusually extensive and reliable data, sourced from family folders kept at the community level to inform programme design and adaptation.
- A national health insurance programme – that includes coverage for family planning and HIV – is aiming to reach at least 80% of the districts in Ethiopia.

### South Africa

Engagement of adolescent boys from a young age may also facilitate successful comprehensive SRHR programmes and policies. In South Africa, a programme run by the Aurum Institute in Tembisa township provides psychosocial support for boys aged 15–19 undergoing voluntary medical male circumcision (VMMC) and for young people living with HIV currently on ART.<sup>23</sup> Some of the challenges with VMMC programmes are that they reinforce traditional and sometimes harmful notions of masculinity. Undergoing VMMC can be conflated by some with becoming an adult man, which can mean taking on men's roles including those associated with promiscuity and with

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<sup>23</sup> For further information, see:

[http://www.auruminstitute.org/index.php?option=com\\_content&view=article&id=44&Itemid=551](http://www.auruminstitute.org/index.php?option=com_content&view=article&id=44&Itemid=551)

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aggressive behaviour. The programme has actively worked to counter these notions through creating awareness around issues of healthy masculinity/manhood and gender equality, and by addressing peer pressure. Participating boys are given questionnaires prior to the programme to determine their perceptions of issues around GBV, masculinity and VMMC. Sessions include information and discussions about topics such as: reasons for undergoing VMMC; defining manhood and masculinity; what it means to act like a man or a woman (gender roles, norms and stereotypes); how certain attitudes can lead to GBV; consent and coercion in sexual intercourse, including defining rape, exploring readiness for sex and the effect of peer pressure; and correct, consistent condom use. The questionnaire is administered again after the intervention.

## India

Know Your Body, Know Your Rights is a youth-led programme for increasing access to and understanding of information on gender, sexuality and rights among young people currently being implemented in New Delhi, and in rural and peri-urban programme areas of the YP Foundation.<sup>24</sup> The programme aims to empower young people to advocate for and access information on gender, sexuality, SRH, HIV and youth-friendly health services. It runs CSE workshops, complemented by activities such as outreach campaigns on different issues, and auditing medical centres with respect to the availability of youth-friendly SRH services. It also provides young people with leadership opportunities, such as developing and facilitating the peer-education model on CSE, and advocating for SRH issues with policy-makers.

Over 70% of participants are girls and young women and more than 95% are aged 10–25 years. They are grouped by age, and the facilitators are also young. Young people of different backgrounds interact with each other, sharing common and also unique experiences. Most of the participants are unmarried, attend school and live with their parents, but a considerable number do not have access to the formal education system, and some do not live with parents, having been forced into early marriage, since the pressure to marry usually builds up after girls reach the age of 15 or 16, in families with very low incomes. Many of the participants also have little or no mobility, face gender-based discrimination and/or violence at home or outside, and do not have safe spaces to talk about their sexuality and sexual health.

In the CSE workshop space, which allows them to talk about their bodies, desires and aspirations, these AGYW showed considerable personal growth and increased knowledge of SRHR issues. For example, the percentage of participants who could correctly identify different modes of HIV transmission increased from 28% to 66% after the CSE curriculum was implemented. Participants, especially AGYW, have emerged from the sessions with a strong sense of bodily integrity and ability to assert their need for youth-friendly health services. It was noted, however, that the CSE programme was not always enough to ensure these young people could retain the information. This limitation points to a need for more sustained engagement with young people with regard to their access to information and YFS, which could be achieved through improved services, sustained investment in youth leaders and empowering more young people to articulate their desires, aspirations and demands for comprehensive SRHR on public forums.

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<sup>24</sup> For further information, see: <http://www.theypfoundation.org/know-your-body-know-your-rights/>



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## Eastern Europe and Central Asia

Providing access to comprehensive and linked SRHR/HIV programmes is also important for sex workers and other key populations. Programmes should be comprehensive, empower the community and engage young female sex workers.<sup>25</sup> There was a dearth of evidence on effectiveness of preventive interventions in people under age 18 years, despite early initiation into sex work being associated with a greater risk of physical and/or sexual violence and HIV infection. Young people who sell sex also have a higher number of sexual partners, more frequent unprotected sex and fewer skills for negotiating condom use. In this population, HIV transmission might also be exacerbated by the intersection of injecting drug use and sex work as well as unsupportive legal and policy environments.

To begin to address this dearth of evidence, UNFPA and the International Planned Parenthood Federation collaborated to conduct focus group discussions with young key populations (sex-workers, MSM, people who inject drugs, transgender people, people living with HIV, and also former detainees and orphanage graduates) in eight eastern European and Central Asian countries. The discussions addressed: the social and cultural context; access to and availability of SRHR and HIV services; the legal context and discrimination; and participation and rights.

### Discussion points

- **YFS that are truly youth friendly:** Developing adolescent- or youth-friendly services (YFS) does not necessarily require establishing new or separate services, but rather ensuring that existing providers and facilities are welcoming and friendly for young people. Multipurpose youth centres often have good general health outcomes, but they are not effective for providing ASRH services. Some YFS that are more oriented to the interests of adolescent boys and young men may become unfriendly or even unsafe for AGYW. On the other hand, many programmes aimed at improving ASRH have reached AGYW, but few have reached adolescent boys and young men. There is clearly a need for action at the community, health system and service delivery levels. Health systems need to be held accountable for ensuring that programmes that purport to be youth friendly meet standards for quality of care.
- **Building community support:** The programme in Ethiopia worked with gatekeepers to build community support. The programme continues to work on health-care provider buy-in through defining services that can be provided through basic primary health services, and ensuring that nurses, who manage most of the clinical services, are responsible for mentoring, supervising and working with community health workers.
- **Targeted programming to reach those in greatest need:** To reach AGYW at risk of HIV and prevent HIV infection, programmes must be based around the needs of AGYW themselves, and should build demand for programmes and interventions based on their needs, desires and realities. This requires considering not just a girl's age and whether or not she is in school and whether she is married or single, but also whether or not she lives with her parents, and is at risk of sexual or other violence or other risks at home or elsewhere. Developing comprehensive SRHR programmes and services is complex, time-consuming and costly, with the added difficulty that those who are hardest to reach are those in greatest need who are most likely to benefit from effective interventions.

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<sup>25</sup> For further information, see: <http://www.unfpa.org/resources/rapid-assessment-tool-sexual-and-reproductive-health-and-hiv-linkages>

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## 2.4 Building safe and supportive environments

To promote SRHR and prevent HIV, AGYW require safe and supportive environments free from violence, exploitation and abuse. Even if service providers are trained to work with young people and are sympathetic, they often face legal barriers such as a minimum age at which clients can be supplied with contraceptives, or rules that under-age clients are not entitled to confidentiality. AGYW in particular face additional barriers in accessing HIV/AIDS information and services, such as: limited mobility and autonomy in making health-related decisions (including whether to become pregnant); prioritization of the health needs of male family members over their own; lack of access to economic resources; care-giving responsibilities; and a culture of silence and shame related to SRH, including HIV-related needs.

The creation of a safe and supportive environment, which often requires the support of political and religious leaders, also needs to be linked to opportunities and support to develop life skills (especially well designed, curriculum-based, adult-led interventions in schools; and interventions that target young people using existing structures and organizations).

### Brazil

There is considerable variation in the age at sexual initiation and use of condoms and contraceptive methods among adolescents in Brazil depending on the type of school that AGYW attend, whether they reside in urban or rural areas, and what region of the country they live in. Younger adolescents and those living in northern Brazil seem to be most vulnerable to the consequences of unprotected sexual intercourse (56). The main factors limiting adolescent contraceptive use are not related to lack of knowledge, but rather cultural and social factors. The national response to the 44% rise in HIV prevalence in AGYW between 1995 and 2005 included development of youth-friendly physical environments (youth centres, shelters for homeless youth, schools and health-care facilities), institutional support from city administrations, the Ministry of Health, universities and NGOs, as well as “virtual supportive environments”, such as online platforms for expert support, peer support and shared learning experiences and social media groups. In addition, spaces were created to encourage dialogue between adolescents and adults, so that the views and concerns of adolescents can be listened to and heard. However, there has been no formal evaluation of these programmes targeting young people, costs and/or impact (some generic evaluations of related programmes in Brazil include those by Chofakian et al. [57], Santos et al. [58], Marinho et al. [59]).

### Uganda

The Link Up project aims to improve the SRHR of 1 million young people affected by HIV across five countries in Africa and Asia: Bangladesh, Burundi, Ethiopia, Myanmar and Uganda.<sup>26</sup> The project design was based on five key elements, including: ensuring properly trained providers; youth-centred service provision; peer learning and peer education; safe spaces for young people to share, learn and access services; and leadership by young women. An estimated 940 000 young women have been reached by the project’s services. One key factor in the project’s success was the focus on training for providers to address negative attitudes and preconceived ideas that hindered the development and implementation of YFS, and also undermined the utilization of YFS. From the perspective of young people, who are the intended clients and beneficiaries of the project’s

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<sup>26</sup> For further information, see: <http://www.aidsalliance.org/our-priorities/current-projects/28>

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educational interventions and services, it is most important to create safe and supportive spaces where young people can talk about SRHR issues that are of primary concern to them, and where they can access SRH services.

### South Africa

Within the ACTIVATE! Change Drivers programme in South Africa, “a network of more than 2000 young leaders”,<sup>27</sup> the emphasis is on the importance of working with women as partners in a collaborative manner, not just as beneficiaries of an intervention. As part of the IMBIZOS initiative to engage with young people in rural and often isolated communities, safe spaces are created where young people can come together and discuss issues of common concern. While social media communication tools were critical to foster and maintain dialogue and discussion, this did not substitute for face-to-face communication, which remained important.<sup>28</sup>

### The All in to #EndAdolescentAIDS initiative

This initiative, convened by a leadership group that includes UNICEF, UNAIDS, UNFPA, WHO, PEPFAR, the Global Fund, the MTV Staying Alive Foundation, and the adolescent and youth movement represented by the HIV Young Leaders Fund/the PACT and Y+, helps to operationalize the range of interventions necessary to deliver effective HIV-prevention interventions to young people in southern Africa in a way that meets their needs and expectations and ensures that no one falls through gaps.<sup>29</sup> Although considerable information is available about what to do, the challenge is now to bring the interventions to scale to ensure true impact. The work of the All-in initiative is focused on sharpening national programmes and interventions through identifying data needs, monitoring implementation, and providing information so that resources can be focused on delivering what works and eliminating what does not work. The results of this framework and assessments could contribute to the development of an investment case for adolescents, with costs and time-bound impact targets so that the return on investment can be quantified.<sup>30</sup>

### Discussion points

- **Key remaining challenges:** reaching people in rural, remote and disadvantaged communities where access to and literacy with social media was limited; ensuring the necessary opportunities for face-to-face contact and access to relevant health services and support; and the costs of creating and maintaining such programmes and services.
- **Refugees and internally displaced people:** These challenges are magnified for internally displaced people and those living in refugee camps.
- **Data collection and use:** There was strong support in the group to ensure that programmes implementing services for AGYW collect usable data on what was implemented, the challenges and the successes. Many relevant programmes are struggling to scale up because political and financial support is lacking; if data on similar programmes were available, it would be easier to

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<sup>27</sup> For further information, see: [www.activateleadership.co.za](http://www.activateleadership.co.za)

<sup>28</sup> Presentation by N. Mjwana, ACTIVATE!, 28 April 2016: “Connecting to the sexual and reproductive health and rights needs and priorities of young women”.

<sup>29</sup> For further information, see: <http://allintoendadolescentaids.org/>

<sup>30</sup> Presentation by S. Bhardwaj, UNICEF, 28 April 2016: “Reaching the tipping point”.

make the case that such programmes are worthwhile and represent good investments for governments and development partners.

- **Prioritize HIV prevention:** The HIV community is very focused on expanding knowledge of HIV status and ensuring that those with HIV infection are on suppressive ARV therapy (in support of the UNAIDS 90–90–90 treatment target for 2020)<sup>31</sup>, and AGYW are one of the critical populations to engage and retain in HIV care and treatment services. But in this population group, it is most important to prioritize the skills and tools to prevent HIV infection. Identifying supportive environments and defining a service package to retain young women in effective HIV-prevention services will be critical if HIV programmes are to reach their prevention targets as well as testing and treatment targets.
- **Community agents:** Given the success of some community health worker programmes, and the recognition of the critical role that other issues – such as gender norms and stigma – play in the health and well-being of AGYW, it would be useful to explore developing a new cadre of community agents focused on these complementary issues.



<sup>31</sup> 90–90–90 refers to 90% of people (children, adolescents and adults) living with HIV know their status, 90% of people living with HIV who know their status are receiving treatment and 90% of people on treatment have suppressed viral loads; this is part of the fast-track to end the epidemic by 2030 (15).

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## 3. The way forward, opportunities and priorities

### 3.1 Smart investments: Working together to make a difference in HIV prevention

Many global funding and health agencies are now reorienting their policies and programmes to include a more holistic approach to addressing HIV among AGYW. On the third and final day of the meeting, a panel of speakers representing key organizations reflected on the evolution of this work and how they can work together to make smarter and more impactful investments. The global community's investment is currently inadequate to meet the needs of AGYW and therefore a special funding source may be needed. While adolescence is a time of vulnerability, it is also a time of huge potential and opportunity such that investments can bring lifelong dividends.

Recognizing that the HIV epidemic will not be controlled unless prevention is scaled up in parallel with treatment, modelling exercises conducted by UNAIDS show that about one quarter of all AIDS funds should go into prevention if the epidemic is to be ended as a public health threat by 2030. Smart investments in prevention include condoms, PrEP, male circumcision and “packages” for AGYW such as those outlined in the DREAMS guidance (60). Sufficient evidence already exists to justify expanding this package of interventions beyond a few districts in those countries where HIV incidence in AGYW is very high.

**With “AIDS exceptionalism” declining, there is an imperative and an opportunity to think about investments from different perspectives.** Just as HIV outcomes are not an adequate measure of the impact of programmes to address GBV, HIV programmes should not be expected to bear the full cost of more widespread interventions within and outside the health system.

Below are brief descriptions of the relevant activities of the key organizations represented at the meeting, as presented.

**The Bill & Melinda Gates Foundation** has an adolescent working group comprising different programmes at the Foundation, but it does not have a formal adolescent strategy or dedicated budget. The Foundation co-founded *The Lancet* Commission on Adolescent Health and several recent Grand Challenges exploration grants are at the intersection of HIV and SRH. The Foundation is supporting some work on decision journey maps on the life course of young women aged 16–20 years, and is bringing in experts on behavioural economics and commercial segmentation to understand whether these young women would use PrEP, condoms and/or other products for HIV prevention. The programmes being supported are complex and multi-layered, mirroring other areas of discussion at this meeting about the complexity of monitoring impacts of multisectoral programmes, or of discrete programmes like education or GBV that may have multiple positive effects.





The new **Global Fund** Strategy 2017–2022: *Investing to end epidemics* was recently approved by its Board (April 2016). The new Strategy gives a prominent role to reproductive, maternal, newborn, child and adolescent health with a focus on building resilient and sustainable national health systems. Rights-based SRHR/HIV linked services for AGYW that include HIV prevention and care, contraception, safe abortion, services for GBV, HPV, with a particular focus on lesbian, gay, bisexual, transgender and intersex (LGBTI) and other socially marginalized adolescents form a key component of this new approach. Outcomes in these areas have been elevated to “strategic objectives” and the Global Fund will now invest in multisectoral and multi-intervention programmes. The Global Fund is already piloting these approaches through reprogramming investments in Zambia and Swaziland.

**UNAIDS**, while not a funding organization, works to track funding in the AIDS field and influences how these funds can best be invested. A new report estimated that US\$ 26 billion per year is needed to meet the ambitious HIV prevention and treatment targets, although available funding is no longer increasing (2). At the time of this meeting in April 2016, UNAIDS negotiations around funding were expected to intensify at the UN’s 2016 High-Level Meeting on Ending AIDS (UN General Assembly, 8–10 June 2016)<sup>32</sup>, at which UNAIDS for the first time set *programmatic* targets for prevention, and these have subsequently been included in the resulting *Political Declaration on HIV and AIDS: On the fast-track to accelerate the fight against HIV and to end the AIDS epidemic by 2030* (15).

**UNFPA** has long worked across sectors to address SRHR and HIV for AGYW, including issues such as CSE, GBV and child marriage. It supports integrated and linked responses to SRHR and HIV and co-convenes with WHO the interagency working group on SRHR/HIV Linkages.

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<sup>32</sup>For further information, see:

<http://www.unaids.org/en/aboutunaids/unitednationsdeclarationsandgoals/2016highlevelmeetingonaids>

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**UNICEF** supports many strategies and teams, in relation to adolescents, with the overall objective of balancing the need for rigorous evidence with simplifying this information to make a clear case for investment; this is a real challenge in multisectoral work. UNICEF works on policy, programming and practice together and increasingly moves beyond pilot programmes to taking interventions to scale.

**USAID** supports work in family planning as well as HIV through many mechanisms, among them investment in HIV vaccines, microbicides and other HIV-prevention research, together with implementing VMMC and elimination of mother-to-child transmission (eMTCT). Its extensive implementation science portfolio aims to inform the best and quickest ways to roll out technologies. USAID also plays a significant role in supporting PEPFAR and specifically the DREAMS partnership, and in supporting work on sex workers and lesbian, gay, bisexual and transgender (LGBT) communities through LINKAGES (Linkages across the Continuum of HIV Services for Key Populations Affected by HIV)<sup>33</sup>. Adolescents and young people form an important part of the Educational Quality Improvement Program (EQUIP)<sup>34</sup>, a new award, focused on simplifying delivery of ART and keeping people living with HIV on treatment.

### 3.2 Discussion

New mechanisms or structures may be needed to drive cross-sectoral work on AGYW forward, ensure that diverse and specialized expertise is used, and that programme development, implementation and reporting are streamlined. The DREAMS and MPii partnerships are already stimulating such mechanisms in selected countries. Careful planning will be needed to ensure that work does not become overly complex and unwieldy. Already, different funding agencies can require multiple guidelines, tools, review mechanisms and reporting, which can create inefficiencies and barriers to building a clear and actionable evidence base.

Although managing this diverse work within countries can be challenging, countries also have a responsibility to manage donor expectations and programme implementation in order to avoid duplication, and to ensure no critical gaps remain between programmes.

Cross-sectoral work is desirable from a programmatic perspective, but it needs to be conceptualized and managed strategically. Integration is not always feasible, necessary nor sensible across all areas that influence the lives of AGYW, but needs to be put in place where needed, for instance in service delivery. Programmes should seek strategic points of convergence. If addressing the HIV epidemic is the primary driver, efforts should focus on countries and specific locations with high incidence of HIV among AGYW.

The AIDS response, including the efforts of civil society organizations (CSOs), must continue to evolve. What was initially a largely community-based response was driven into health-care facilities when ART first became widely available. By contrast, prevention of HIV, GBV and IPV, and promotion of good SRH are essentially multisectoral activities with many elements based in the community and involving CSOs.

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<sup>33</sup> For further information, see: <https://www.fhi360.org/projects/linkages-across-continuum-hiv-services-key-populations-affected-hiv-linkages>

<sup>34</sup> For further information, see: <http://www.equip123.net/>

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New programmes for AGYW should strive for innovation while also drawing on the solid evidence base relating to the factors that underpin women’s empowerment: access to and control over economic resources, contraception and education. Investments in such programmes will improve women’s ability to negotiate safer sex and mitigate risk, thus generating wider benefits for women’s, children’s and family health.

There is a tension between the requirements of new multisectoral strategies that will reduce adolescents’ risks of HIV, GBV and IPV, and improve their SRHR, and the more readily accessible vertical, project-based funding and reporting mechanisms. These vertical, siloed operational approaches make it difficult to build and sustain the civil society mechanisms necessary to work on complex, multisectoral interventions such as CSE and GBV prevention and support, which require long-term investments to develop, implement and demonstrate effects. The potential and impact of these programmes – whether implemented in a high-income or low-income country – would not have been demonstrated in 3–5 year reporting cycles. Successful NGO and CSO programmes should be valued and supported over the long term, with inputs of technical experts, to help drive adaptation and scale-up.

A clear business case should be developed for investing in adolescent SRHR that includes HIV interventions. Given the demographic bulge of young people about to enter their reproductive years, there is a strong argument for investing now in creating safe and secure environments for their growth into adulthood where they can have access to the resources to meet their SRHR needs. Investing in the uptake of PrEP and other HIV prevention as well as investing in prevention of GBV and provision of CSE has the potential to yield dividends in terms of a healthy population.

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## 4. Conclusions and key messages

### 4.1 Conclusions: priority policy and programmatic actions

The third Sustainable Development Goal (SDG 3) — to ensure healthy lives and promote well-being for all at all ages — and the important advances at the policy level for both SRHR and HIV, including the UN Global Strategy for Women’s, Children’s and Adolescents’ Health (GSWCAH), mark a new beginning for the global development agenda where it is increasingly becoming critical from economic, political and health systems perspectives to stop operating under the siloed, vertical approaches, and focus instead on SRHR/HIV linkages and integration. Strengthened focus on SRH/HIV linkages will support the achievement of joint outcomes, by going beyond disease-specific interventions to a holistic perspective promoting well-being; this is in line with the GSWCA to adopt an integrated, multisectoral approach and cross-sectoral collaboration.

The existing ways in which investments are justified and impacts measured favour vertical, siloed programmes, rather than interventions that have benefits in terms of several outcomes. This traditional vertical funding model for global health investing does not support cross-sectoral programming or civil society-based solutions. Multi- and cross-sectoral programmes and investments may be more sustainable. There are some positive moves to invest in broader-based interventions and measure a wider range of health outcomes, including the PEPFAR DREAMS partnership and the Global Fund’s 2016 strategy. It will be interesting to see what impact can be achieved and whether the broad-based approach will continue to be supported.

This change in thinking is also necessary if the world is transitioning from international donor-driven programming to domestic funding, including social protection mechanisms. Donor funding is primarily vertical and narrowly focused, while domestic funding tends to be primarily cross-sectoral, based in primary health care structures and with priority placed on preventive rather than curative services. It remains to be seen whether donors will follow with fiscal resources for strengthening health systems, building civil society institutions to support and demand improved health outcomes.

Findings presented from a number of available studies are encouraging, but all the initiatives that show the most potential for success need to be scaled up beyond pilot and demonstration projects.<sup>35</sup> Focusing only on averting the greatest number of HIV infections per fiscal sum invested is not going to drive the necessary broad-based research needed to reach targets to fast-track the end the AIDS epidemic by 2030.

It is interesting to consider how much the England teenage pregnancy strategy cost and what value-for-money metrics were (or might have been) applied when considering whether to invest in the programme. Could such a programme ever be funded in an LMIC?

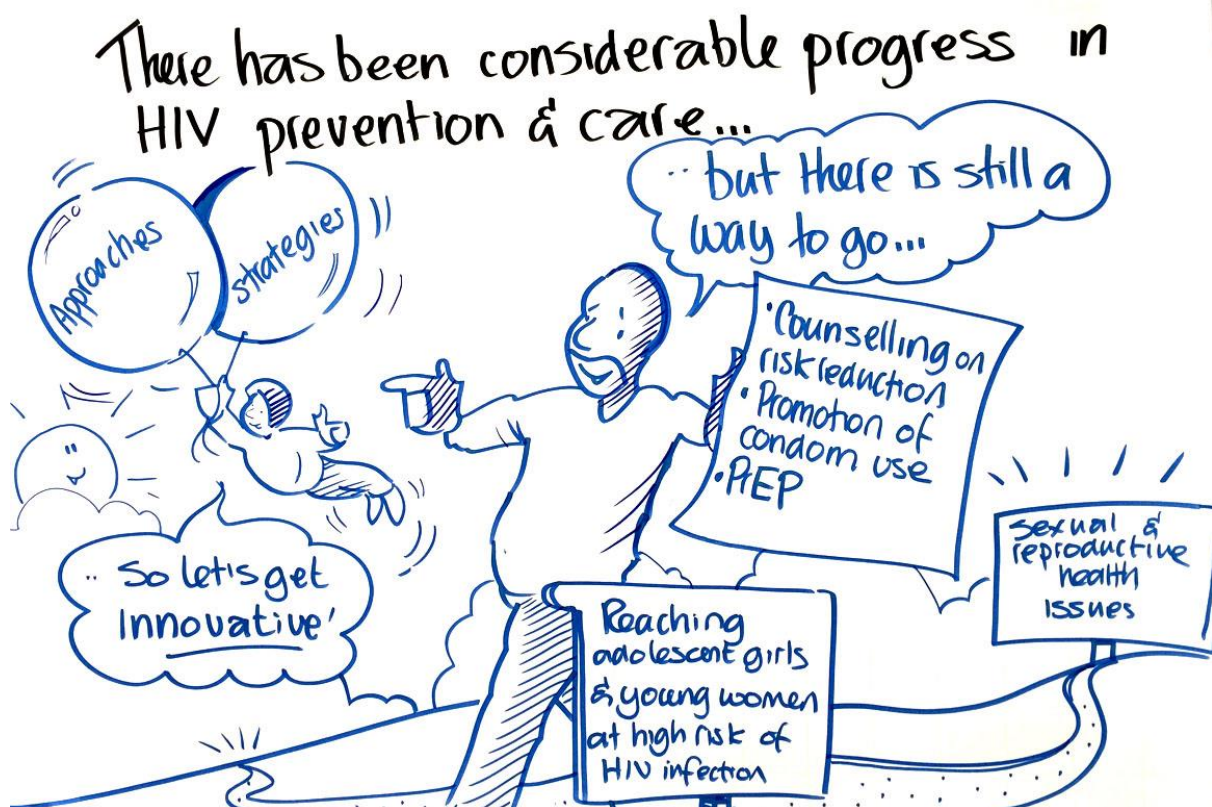
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<sup>35</sup> This issue was the focus of a “Global consultation to draw out lessons learned from the first generation of scaled-up adolescent sexual and reproductive health programmes”, held in Geneva, 4–6 April 2016. That meeting was organized by WHO in conjunction with the Implementing Best Practices (IBP) Initiative, USAID, UNFPA, Evidence to Action (E2A) Project, Pathfinder International and the Bill & Melinda Gates Foundation. Report currently in development (September 2016).

Additional points to consider:

- Defining the target population and eligibility criteria for PrEP, the dapivirine ring and other HIV prevention interventions requires care and attention, and may need re-evaluation, even after introduction.
- The delivery strategy will need to be fine-tuned to the available resources (fiscal and programmatic) for a high-performing, sustainable and equitable programme.
- The cost of HIV biomedical interventions and delivery (training health-care providers) remains a major barrier for uptake, particularly in LMICs.
- Sustained investments in social mobilization and community involvement are required for building high acceptability and uptake of programmes.
- Programme coverage must be monitored based on the needs and ages of AGYW clients/beneficiaries.
- Integrated/linked approaches are an opportunity that requires taking a long-term view and substantial investment or funding and time to involve a wide variety of stakeholders.

In conclusion, the WHO Department of Reproductive Health and Research global consultation on “Lessons from sexual and reproductive health programming to catalyse HIV prevention for young women” provided a valuable opportunity for a broad array of experiences and opinions to be shared and debated. Participants from six continents and many disciplines brought the urgency of the SRHR agenda to the fore in the context of HIV prevention for AGYW.





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**(W)rap up: an excerpt**

**WHO: Lessons from SRH programming to catalyze HIV prevention for young women**

By Jillian Gedeon, MSc, Program Officer and Co-Founder, International Youth Alliance on Family Planning (IYAAP), Canada

The AIDS epidemic has multiple facets.  
Youth can solve the problem with core assets.  
Like confidence, caring, character, and more.  
They're internal change agents who work at the core.

Gender inequality plays a huge role.  
In GBV and IPV – it's taking a toll  
On HIV rates, but SASA is the plan  
[only] If we work together hand in hand.

...

Interventions should be packaged – never alone.  
Both leadership and action – gotta be bold.  
Youth-friendly services? Scalable and tall.  
And let's stop saying "One size fits all".

No more piece-mealing. We need to be holistic.  
It's not just about HIV – let's be realistic.  
Our lives are intersectional. Everything's a factor.  
Economy, schooling, family are all actors.  
Talking to you donors. Time to make investments  
In our girls, in our women and our future presidents!

Watch the (w)rap online at the HRP Video Library YouTube channel:

[https://www.youtube.com/watch?feature=player\\_embedded&v=NjEkDXa6LNs](https://www.youtube.com/watch?feature=player_embedded&v=NjEkDXa6LNs)

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## 4.2 Key messages

### 1. Implement evidence-based, rights-based and equitable interventions that can reduce risk and augment protection for AGYW

Interventions that enable young women to have control and choice over their SRHR can break the cycle of disadvantaged gendered relationships, reduce pervasive GBV and IPV and thus also reduce HIV acquisition among AGYW. Promising, successful and potentially sustainable interventions of this type include those that:

- enable girls to stay in school, delay early marriage and eschew unwanted pregnancy;
- nurture economic independence through academic and vocational training;
- provide well designed and correctly implemented CSE programmes in schools and venues that reach out-of-school youth;
- improve access to HIV testing and comprehensive SRH services, including condom distribution and screening and treatment for STIs and other reproductive tract infections (RTIs);
- meaningfully engage young women throughout the development, implementation and evaluation of policies and programmes, to improve programme quality and policy relevance;
- effectively engage boys and young men around risk reduction issues, including healthy sexuality and respectful relationships with girls and women, to change gender norms and behaviour;
- eliminate unequal legal, economic and social barriers to access information, services and commodities; and
- enforce zero tolerance for coercion, violence and discrimination in any form.

### 2. Strengthening the evidence base

Evidence-based policies and programmes are required in order to confirm and lengthen the above list of promising and effective interventions.

For example, AGYW may be at increased risk of HIV infection, especially when the vaginal microbiome is disturbed through infection and harmful practices like douching. Yet, surprisingly little is known about the impact of reproductive tract infections and inflammation on the risk of HIV infection. Further research on the biological vulnerability of AGYW in addition to research on behavioural, social and gender-related factors affecting this population will lead to other potentially effective interventions to introduce and improve the uptake of HIV prevention.

In addition to implementing the successful interventions, it is also vital to discontinue interventions that clearly do not work so that resources can be shifted to support evidence-based practices. For example, abstinence-only education programmes have not made any measurable impact.

### 3. Meaningful change through intersectoral collaboration

Linking promising approaches in SRHR and HIV requires long-range vision and long-term investments that facilitate cross-sectoral programmes. While not every programme or policy can cover all aspects of SRHR, including HIV, the responsibility for achieving comprehensive and positive SRHR outcomes falls upon all stakeholders. Although there are no “magic bullets”, meaningful reductions in HIV acquisition among AGYW can be achieved through greater integration of SRHR and HIV interventions in a way that empowers young women to exercise their rights to access optimized and holistic SRH services. The most promising interventions are those that are innovative and multisectoral, integrating health/prevention, education and social protection/gender empowerment.

For example, the implementation of new biomedical interventions for HIV prevention, such as pre-exposure prophylaxis (PrEP) for AGYW, will only be successful and sustainable within a context that combines the provision of prevention products with education and gender-empowerment.

Intersectoral collaboration is vital . . .



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## Annex A: Meeting agenda

### Lessons from sexual and reproductive health programming to catalyse HIV prevention for adolescent girls and young women

Brocher Foundation, Hermance, Geneva, Switzerland

27–29 April 2016

Wednesday 27 April 2016

Time	Topic	Speakers/Moderators/Chairs
12:00 – 13:30	LUNCH	
13:30 – 15:30	<p>Welcome remarks and introductions</p> <p>Goal, objectives and expected outcomes</p> <p>Challenges faced by girls and women at risk of HIV</p> <p>Epidemiological context and rationale of reaching adolescent girls and young women with HIV prevention</p> <p>Structural drivers of the HIV epidemic in young women: How well have we done in reaching girls and young women with HIV prevention?</p> <p>Discussion</p>	<p><b>Moderator: James Kiarie (WHO/Reproductive Health and Research [RHR]/Human reproduction)</b></p> <p>Ian Askew (WHO/RHR/HRP)</p> <p>Manjulaa Narasimhan (WHO/RHR/Human reproduction)</p> <p>Margaret Bolaji (Population and Reproductive Health Initiative, Nigeria)</p> <p>Elizabeth Bukusi (Kenya Medical Research Institute, Kenya)</p> <p>Lori Heise (London School of Hygiene and Tropical Medicine, United Kingdom)</p>
15:30 – 16:00	TEA/COFFEE BREAK	
16:00 – 16:15	Connecting to the sexual and reproductive health and rights needs and priorities of young women	<p>Nomtika Mjwana (ACTIVATE! Change Drivers, South Africa)</p> <p>Mariana Mancilla (Balance, Promoción para el Desarrollo y Juventud A.C., Mexico)</p>
16:15 – 17:00	<p>Opportunities at global policy level:</p> <ul style="list-style-type: none"> <li>Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030)</li> <li>Global Financing Facility (GFF)</li> <li>WHO Global Health Sector Strategies for HIV, viral hepatitis and STIs</li> <li>Global plan of action on violence against women and girls, and against children</li> <li>Framework for Accelerated Action for the Health of Adolescents (AA-HA!)</li> </ul>	<p><b>Moderator: Sten Vermund (Vanderbilt University, United States of America [USA])</b></p> <ul style="list-style-type: none"> <li>Rajat Khosla (WHO/RHR)</li> </ul>

Time	Topic	Speakers/Moderators/Chairs
	<ul style="list-style-type: none"> <li>• <b>DREAMS initiative</b></li> <li>• <b>FP 2020</b></li> <li>• <b>UNAIDS strategy</b></li> <li>• <b>Global Fund replenishment</b></li> </ul>	<ul style="list-style-type: none"> <li>• Heather Watts (Office of the U.S. Global AIDS Coordinator)</li> <li>• Gina Dallabetta (Bill &amp; Melinda Gates Foundation)</li> <li>• Malayah Harper (UNAIDS)</li> <li>• Heather Doyle (The Global Fund to Fight AIDS, Tuberculosis and Malaria)</li> </ul>
	<b>Discussion</b>	
<b>17:00 – 18:00</b>	<b>Biomedical interventions for HIV prevention:</b>  <b>Condoms for combination prevention</b>  <b>Dapivirine ring, microbicides, multipurpose prevention technologies</b>  <b>Oral PrEP demonstration projects</b>  <b>Microbicide Product Introduction Initiatives (MPii)</b>  <b>Biological vulnerability of adolescent girls and young women to HIV infection</b>  <b>Discussion</b>	<b>Moderator: Sinead Delaney (Wits Reproductive Health and HIV Institute [WHRI], South Africa)</b>  Ian Askew (WHO/RHR/HRP)  Zeda Rosenberg (International Partnership for Microbicides, USA)  Michelle Rodolph (WHO/HIV)  Nagesh Borse (USAID, Office of HIV/AIDS)  Cheryl Baxter (Centre for the AIDS Programme of Research in South Africa, South Africa)
<b>18:00 – 19:00</b>	<b>RECEPTION</b>	

Thursday 28 April 2016

Time	Topic	Speakers/Moderators/Chairs
09:00 – 09:30	<p><b>Examples and factors for success:</b></p> <ul style="list-style-type: none"> <li>• Trends in HIV acquisition and risk factors among youth, and prevention policies in Uganda, 1999–2011</li> <li>• Teenage pregnancy declines in the United Kingdom</li> </ul>	<p><b>Moderator: Venkatraman Chandra-Mouli (WHO/RHR/Adolescents and at-risk populations)</b></p> <p>Caroline Jeffrey (Liverpool School Tropical Medicine, United Kingdom)</p> <p>Roger Ingham (Centre for Sexual Health Research, University of Southampton, United Kingdom)</p>
09:30 – 11:00	<p><b>Gender-based and intimate partner violence</b> Context, country examples, young person's perspective, UN response</p> <p><b>Discussion</b></p>	<p><b>Moderator: Susan Wood (International Women's Health Coalition, USA)</b></p> <p>Claudia García-Moreno (WHO/RHR/Adolescents and at-risk populations)</p> <p>Maureen Kangere (Raising Voices, Uganda)</p> <p>Suneeta Krishnan (Research Triangle Institute Global, India)</p> <p>Mary Mwangi (Sexual and Reproductive Justice Coalition, Kenya)</p> <p>Claudia García-Moreno (WHO/RHR/Adolescents and at-risk populations)</p>
11:00 – 11:30	<b>TEA/COFFEE BREAK</b>	
11:30 – 13:00	<p><b>Accurate and appropriate comprehensive sexuality education</b> Context, country examples, young person's perspective, UN response</p> <p><b>Discussion</b></p>	<p><b>Moderator: Connie Celum (University of Washington, USA)</b></p> <p>Venkatraman Chandra-Mouli (WHO/RHR/Adolescents and at-risk populations)</p> <p>Uwem Esiet (Action Health Incorporated, Nigeria)</p> <p>Matti Perry (WHO/RHR/Adolescents and at-risk populations)</p> <p>Nyasha Phanisa Sithole (My Age Zimbabwe Trust, Zimbabwe)</p> <p>Jenelle Babb (UNESCO)</p>
13:00 – 14:00	<b>LUNCH</b>	
14:00 – 15:30	<p><b>Comprehensive sexual and reproductive health and rights</b> Context, country examples, young person's perspective, UN response</p>	<p><b>Moderator: Martha Brady (Population Council, USA)</b></p>



Time	Topic	Speakers/Moderators/Chairs
	<b>Discussion</b>	<p>Venkatraman Chandra-Mouli (WHO/RHR/Adolescents and at-risk populations)</p> <p>Mengistu Asnake (Pathfinder International, Ethiopia)</p> <p>Refilwe Mophosho (Aurum Institute, South Africa)</p> <p>Shirin Choudhary (YP Foundation, India)</p> <p>Ilya Zhukov (UNFPA)</p>
<b>15:30 – 16:00</b>	<b>TEA/COFFEE BREAK</b>	
<b>16:00 – 17:30</b>	<p><b>Safe and supportive environments</b> Context, country examples, young person’s perspective, UN response</p> <p><b>Discussion</b></p>	<p><b>Moderator: Frances Cowan (University College London [UCL], United Kingdom, and Centre for Sexual Health and HIV/AIDS Research [CeSHHAR], Zimbabwe)</b></p> <p>Rajat Khosla (WHO/RHR)</p> <p>Ulysses Panisset (Federal University of Minas Gerais, Brazil)</p> <p>Luisa Orza (ATHENA Network, United Kingdom)</p> <p>Nomtika Mjwana (Sexual and Reproductive Justice Coalition, South Africa)</p> <p>Sanjana Bhardwaj (UNICEF)</p>
<b>17:30 – 17:45</b>	<b>Key points from Day 2 discussions</b>	Jillian Gedeon (International Youth Alliance for Family Planning, Canada)

## Friday 29 April 2016

Time	Topic	Speakers/Moderators/Chairs
09:00 – 10:30	<b>Way forward for sustainable and equitable programmes</b>	Michalina Drejza (International Federation of Medical Students' Associations, Poland)
	<b>Smart investments: Working together to make a real difference in HIV prevention</b>	<b>Moderator: Linda-Gail Bekker (Desmond Tutu HIV Centre, South Africa)</b>
	<b>Discussion</b>	Roundtable: <ul style="list-style-type: none"> <li>• Gina Dallabetta (Bill &amp; Melinda Gates Foundation)</li> <li>• Robert Ferris (USAID)</li> <li>• Viviana Mangiaterra (Global Fund)</li> <li>• Asha Mohamud (UNFPA)</li> <li>• Sanjana Bhardwaj (UNICEF)</li> <li>• Karl Dehne (UNAIDS)</li> </ul>
10:30 – 11:00	<b>TEA/COFFEE BREAK</b>	
11:00 – 11:30	<b>Opportunities at global policy levels: What can be done to further support, develop and strengthen HIV prevention programmes</b>	<b>Moderator: Sten Vermund (Vanderbilt University, USA)</b>
	<b>Discussion</b>	
11:30 – 12:30	<b>Summary priority policy and programmatic actions to impact HIV prevention – Review of key messages</b>	Rapporteurs: Liz McGrory, Tim Farley, Graham Ogilvie (consultants to WHO/RHR)
	<b>Discussion</b>	
	<b>Next steps</b>	Manjulaa Narasimhan (WHO/RHR/Human reproduction)
	<b>Closing remarks</b>	Ian Askew (WHO/RHR/HRP)
12:30 – 14:30	<b>LUNCH</b>	

HRP: UNDP/UNFPA/UNICEF/WHO/World Bank Special programme of research, development and research training in human reproduction

RHR: Department of Reproductive Health and Research (WHO)

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## Annex B: Participants

### Experts

**Mengistu Asnake**

Pathfinder International  
Addis Ababa, Ethiopia

**Cheryl Baxter**

Centre for the AIDS Programme of Research in  
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Durban, South Africa

**Linda-Gail Bekker**

Desmond Tutu Foundation  
Cape Town, South Africa

**Margaret Bolaji**

Population and Reproductive Health Initiative  
Zaria, Kaduna State, Nigeria

**Nagesh Borse**

Office of HIV/AIDS  
United States Agency for International  
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Washington, DC, United States of America (USA)

**Martha Brady**

Population Council  
New York, NY, USA

**Elizabeth Bukusi**

Kenya Medical Research Institute (KEMRI)  
Nairobi, Kenya

**Connie Celum**

International Clinical Research Center  
University of Washington  
Seattle, WA, USA

**Shirin Choudhary**

The YP Foundation  
New Delhi, India

**Frances Cowan**

Centre for Sexual Health and HIV/AIDS Research  
(CeSHHAR)  
Harare, Zimbabwe

**Gina Dallabetta**

Bill & Melinda Gates Foundation  
Seattle, WA, USA

**Sinead Delany**

Wits Reproductive Health and HIV Institute  
(WRHI)  
Johannesburg, South Africa

**Heather Doyle**

Gender, Strategy, Investment & Impact Division  
(SIID)  
The Global Fund to Fight AIDS, Tuberculosis and  
Malaria  
Geneva, Switzerland

**Michalina Drejza**

International Federation of Medical Students'  
Associations (IFMSA)/International Youth  
Alliance for Family Planning (IYAFP)  
Wielkopolska, Poland

**Uwemedimo Esiet**

Action Health, Inc.  
Lagos, Nigeria

**Robert Ferris**

Office of HIV/AIDS  
USAID  
Washington, DC, USA

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**Jillian Gedeon**

International Youth Alliance for Family Planning  
(IYAFFP)

Ottawa, Canada

**Lori Heise**

London School of Hygiene and Tropical  
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London, United Kingdom

**Roger Ingham**

Centre for Sexual Health Research

University of Southampton

Teenage Pregnancy Knowledge Exchange

Southampton, United Kingdom

**Caroline Jeffery**

Liverpool School of Tropical Medicine

Liverpool, United Kingdom

**Maureen Kangere**

Raising Voices

Kampala, Uganda

**Suneeta Krishnan**

Research Triangle Institute Global India Private  
Limited (RTI)

New Delhi, India

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Balance Promoción para el Desarrollo y  
Juventud A.C.

Ciudad de México, Mexico

**Viviana Mangiaterra**

Global Fund to Fight AIDS, Tuberculosis and  
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Geneva, Switzerland

**Nomtika Mjwana**

Sexual and Reproductive Justice Coalition

Johannesburg, South Africa

**Refilwe Mophosho**

Aurum Institute

Johannesburg, South Africa

**Mary Wanjiku Mwangi**

U-TENA Youth Organization

Nairobi, Kenya

**Luisa Orza**

ATHENA Network

London, United Kingdom

**Ulysses Panisset**

Federal University of Minas Gerais

Belo Horizonte, Brazil

**Zeda Rosenberg**

International Partnership for Microbicides

Silver Spring, MD, USA

**Nyasha Phanisa Sithole**

African Youth and Adolescents Network  
(AfriYAN)

Harare, Zimbabwe

**Sten Vermund**

Vanderbilt University

Nashville, TN, USA

**Heather Watts**

The U.S. President's Emergency Plan for AIDS  
Relief (PEPFAR)

Washington, DC, USA

**Susan Wood**

International Women's Health Coalition (IWHC)

New York, NY, USA

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## UN Agencies

### **Joint United Nations Programme on HIV/AIDS (UNAIDS)**

**Karl Dehne**

Chief, Prevention

**Malayah Harper**

Chief, Gender Equality and Diversity Division

**Hege Wagan**

Senior Gender Equality Adviser

### **United Nations Educational, Scientific and Cultural Organization (UNESCO)**

**Jenelle Babb**

Section of Health and Global Citizenship  
Education

### **United Nations Children's Fund (UNICEF)**

**Sanjana Bhardwaj**

Chief Health and Nutrition

### **United Nations Population Fund (UNFPA)**

**Asha Mohamud**

ASRH Policy Advisor

Eastern and Southern Africa

**Ilya Zhukov**

HIV and Young Key Populations

HIV/AIDS Branch, Technical Division

### **Office of the United Nations High Commissioner for Human Rights (OHCHR)**

**Ruben Brouwer**

Associate Expert in Human Rights

Women's Rights and Gender Section



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## World Health Organization

### Department of Reproductive Health and Research (RHR)

Avni Amin

Rajat Khosla

Ian Askew

James Kiarie

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Natalie Maurer

Venkatraman Chandra-Mouli

Manjulaa Narasimhan

Sofia Dambri

Matti Parry

Mario Festin

Lale Say

Claudia García-Moreno

### Department of Maternal, Child and Adolescent Health (MCA)

Valentina Baltag

David Ross

### Department of HIV (HIV)

Michelle Rodolph

Julie Samuelson

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### WHO African Regional Office

Symphice Mbola Mbassi

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