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Five Years of DREAMS and What Lies Ahead

How to Address the Intersecting Crises of HIV, Gender Inequality, and Health Security

Author
Janet Fleischman

A report of the
CSIS Global Health Policy Center

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Introduction

"I decided to run away from home due to the abuse that I was receiving. I ran away from home with my boyfriend because I didn't have elsewhere to go to. After running to my boyfriend's house, I fell pregnant. He chased me out of his house and I didn't have anywhere to go. I was so disturbed . . . I didn't know what to do. No one could help me out until I met DREAMS. They really helped me."

— Grace Njobvu, a 23-year-old participant in DREAMS, Lusaka, Zambia.[1]

On December 1, 2014—World AIDS Day—the U.S. global AIDS coordinator at the time, Ambassador Deborah Birx, sounded the alarm on HIV infections in adolescent girls and young women (AGYW) and launched a bold initiative called DREAMS—**D**etermined, **R**esilient, **E**mpowered, **AI**DS-free, **M**entored, and **S**afe. The goal was to significantly reduce new HIV incidence among girls and young women in the highest-burden countries in sub-Saharan Africa and in Haiti, where they face a far higher risk for new HIV infection—2 to 14 times higher—than their male peers.[2] Despite the urgency of reducing HIV in this population to reach global goals for epidemic control, Covid-19 and new global efforts around health security threaten to divert the focus on this critical population. DREAMS is now at an inflection point, facing the risk that its progress on girls and young women will be reversed, along with decades of health and development gains for women and girls.

Led by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), DREAMS is an innovative and ambitious health program that focuses on a combination of structural, behavioral, and biomedical interventions to prevent HIV among AGYW, including gender-based violence (GBV) prevention and response, economic strengthening, reproductive health, and education support in 15 countries.[3] By combining health with protection and empowerment, DREAMS represents a multifaceted approach to addressing HIV prevention, gender inequality, and health security based on localized, community-centered programs. It was created as a public-private partnership with the Bill & Melinda Gates Foundation, Gilead Sciences, Girl Effect, Johnson & Johnson, and ViiV Healthcare.

After five years and over $1 billion invested, this is an opportune moment to examine the key achievements, barriers, and ongoing challenges of DREAMS, especially in light of the new challenges of the Covid-19 pandemic. The advent of the Biden-Harris administration, which has elevated a new framework for global health and gender issues, provides an unprecedented opening to advance a strategic vision around securing a healthy future for this growing population of women and girls. Such a vision should include curbing the HIV pandemic while also strengthening the Covid-19 response and advancing the development, prosperity, and stability of the participating countries—all central to U.S. national interests. A girl- and young women-centered

A girl- and young women-centered approach would be a powerful and effective strategy to comprehensively address HIV prevention; we have learned a great deal from DREAMS, which has set in place a framework and a set of interventions that have proved the value of this multisectoral approach. The U.S. government now needs to take this to the next stage.

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This report examines what lessons have been learned in the first five years of DREAMS and what the next five-year approach might be, including redressing the disruptions and costly damage imposed by Covid-19. Over the past year, we conducted interviews with over 80 key informants in DREAMS countries, in the United States, and in Europe, including adolescent girls and young women themselves, implementing partners, experts, national government officials, representatives of multilateral organizations, and U.S. government representatives, as well as with other analysts, funders, and observers of AGYW and HIV programs. We analyze how DREAMS has evolved and what its impacts have been, including what factors contributed to success or constituted barriers. To understand the global approaches to AGYW, including how DREAMS helped spark complementary efforts, the report also looks at the girls and young women focus of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, as well as the United Nations Program on HIV/AIDS (UNAIDS) and selected national responses. Finally, we discuss implications for U.S. policy, focused on what is needed going forward if DREAMS is to further drive down HIV infections and increase the health and agency of girls and young women more broadly, with recommendations for the new Biden-Harris administration and Congress. There is no question that a window has opened, due to the global Covid-19 pandemic and the advent of the Biden administration, to ask how we can achieve better results from integrated, coordinated approaches.

DREAMS has been successful in reaching millions of girls and young women in 15 countries with a multisectoral package of services, and those contributions to HIV prevention will continue to grow in the years to come. DREAMS has catalyzed a global focus on AGYW and HIV, including by UNAIDS and the Global Fund and by some national governments. Although directly attributing the DREAMS impact is complicated, DREAMS has contributed to a decline in HIV incidence among AGYW in all the DREAMS districts.

Yet DREAMS represents an expensive model that would be difficult for countries to replicate and sustain and has sparked criticism for operating in parallel to national and local mechanisms. Although the focus on girls and young women is supported rhetorically by most governments, in reality, few have mobilized domestic resources or high-level national commitment for targeted national programs, and many have felt sidelined by PEPFAR's approach. This situation is only exacerbated by the Covid-19 crisis, which further strains national and donor budgets while increasing the social and economic factors that put AGYW at risk of HIV in the first place.

While DREAMS has shown the importance of a multisectoral response, it also highlights the challenges

inherent in this approach and raises difficult questions about the alignment of investments between PEPFAR and other U.S. agencies, how to better monitor the impact of the services, and how to address the cycle of transmission and the male sexual partners. As Catherine Connor of the Elizabeth Glaser Pediatric AIDS Foundation, a PEPFAR implementer, put it: "There was a lack of services for this population, and we needed a holistic approach to crack it open . . . the value became easy to understand, you'd be hard-pressed not to see it—health, empowerment, literacy. But jumping from value to impact is harder; we still have no real understanding of why things worked in some areas."[4]

There is no question that a window has opened, due to the global Covid-19 pandemic and the advent of the Biden administration, to ask how we can achieve better results from integrated, coordinated approaches.

Despite its challenges and critics, DREAMS has proven to be a promising model that is uniquely suited to an adapted and reimagined U.S. strategy that moves toward more integrated approaches and away from siloed, vertical programs. By supporting girls and young women to be the healthy and empowered future leaders in their communities and countries and advancing broader health and development outcomes for this population, DREAMS could be a pivotal component of a new U.S. strategy. Serious questions do remain about whether DREAMS can go beyond proof of concept and become the kind of scalable, sustainable, and transformative program that countries can adopt and own. According to Dr. Linda-Gail Bekker, a leading HIV expert at the Desmond Tutu HIV Center at the University of Cape Town, "The hugest tragedy would be if we lose those five years. How do we quickly extract the main lessons and put it into an affordable package? Who will do it, how will they do it with the same quality and fidelity, and how do we scale up? The only way we'll feel impact is to reach the whole region."[5]

Key Recommendations for the U.S. Government on DREAMS

1. **PEPFAR should develop a roadmap for the next phase of DREAMS by identifying the most impactful and cost-effective combinations of interventions for AGYW and incorporating that into budget planning over the next five years.** This means strengthening data analysis around the package of DREAMS interventions to develop a minimum package that can be adapted for different contexts and age groups and investing in cost-effectiveness analyses of the multicomponent programs. To better monitor progress, adapt program design, and incentivize innovation, DREAMS should expand what it measures to capture the impact on other key outcomes for girls and young women beyond HIV—such as unintended pregnancy, GBV, and secondary school completion. The goal should be to develop a model for AGYW services that can be replicated and owned by countries—governments, civil society, and girls and young women—so that programs can be scaled up and sustained, building off the lessons learned from DREAMS and tailored to local needs.

2. **The U.S. government should launch a whole-of-government approach to AGYW.** The State Department should establish an interagency steering committee to strategically align investments around AGYW and improve coordination with national governments, multilateral organizations, and private sector partners to advance a multisectoral response. Although U.S. government programs in HIV and other health and development areas are organized in silos and funded separately, impact can be maximized by aligning and coordinating investments for girls and young women. This calls for improved country-level coordination and alignment of resources from U.S. government agencies around HIV, Covid-19, family planning and reproductive health, primary health care, education for girls, GBV prevention and response, and economic empowerment. Improved coordination is also necessary between the United States and other bilateral and multilateral donors, especially the Global Fund. This approach should focus on assisting national governments, with civil society engagement, to lead an integrated, multisectoral approach to AGYW programming. To support the governments and incentivize investments, innovative financing through impact investing and other public-private partnerships should be pursued.

3. **The Biden administration should work with Congress to prioritize funding for AGYW in the Covid-19 response.** The Covid-19 pandemic has revealed and exacerbated inequities faced by girls and young women through increased GBV, unintended pregnancies, lack of access to sexual and reproductive health (SRH) services, and loss of schooling and economic opportunities. As countries and communities struggle to address Covid-19, the U.S. should prioritize the need for a comprehensive response that builds on and adapts the existing DREAMS platforms as part of the Covid-19 response. This aligns with the new National Strategy for the Covid-19 Response and Pandemic Preparedness, which identifies the need to

mitigate the secondary impacts of Covid-19 on health and development for women and girls. The American Rescue Plan, approved by Congress, should make girls and young women a priority, including through the funds provided to PEPFAR, and Congress should ensure that the administration reports on its progress in addressing their needs.

4. **PEPFAR, the U.S. Agency for International Development (USAID), and other U.S. agencies should promote the engagement of AGYW in DREAMS,** ensuring that they are involved in determining the design, implementation, and monitoring of programs. Too often, girls and young women are excluded from decisionmaking in DREAMS, from community organizations, and from the deliberations of government ministries—including the Ministry of Health—reflecting discriminatory gender norms. Going forward, DREAMS should address this gap by working with girls and young women to establish AGYW advisory groups to provide an ongoing mechanism for input to implementers, communities, facilities, and governments.

5. **PEPFAR should decentralize services for AGYW. DREAMS has shown the value of bringing clinical services out of facilities and closer to the community and providing differentiated service delivery.** It has also shown that multisectoral interventions for AGYW can be provided through safe spaces and drop-in centers, including social, structural, and economic programming. DREAMS should expand such person-centered design approaches that decentralize services and make them more accessible to and convenient for girls and young women, including for SRH and pre-exposure prophylaxis (PrEP) and youth-friendly services with nonjudgmental providers. This also involves increasing girls' and young women's own power over their healthcare through improving access to self-care strategies, such as self-testing for HIV and self-injection for contraception.

6. **PEPFAR should work with other U.S. government agencies to expand integration of SRH and HIV and to prepare for new biomedical prevention technologies.** Girls and young women are often more concerned with getting pregnant than getting HIV, underscoring the importance of integration of SRH and HIV services as a way to overcome barriers to uptake. This will require developing integrated funding opportunities and indicators to measure progress. With PrEP being scaled up for girls and young women and new prevention technologies on the horizon, including long-acting, injectable cabotegravir (CAB-LA) and the dapivirine vaginal ring,[6] accelerating quality integration of services becomes even more essential for both HIV and SRH outcomes for girls and young women. If the full range of contraceptive commodities is not available for AGYW through HIV clinics, PEPFAR should fill these gaps by using its funds to procure contraceptives.

Background: Why AGYW Risk Factors Require a Multisectoral Response

Reducing HIV incidence in girls and young women is indispensable to curb the HIV epidemic in high burden countries. The disproportionate impact of HIV on this population is glaringly evident in sub-Saharan Africa, where an estimated 5,500 AGYW aged 15–24 years old become infected with HIV every week[7]—2 to 14 times higher than their male peers—and constitute 67 percent of new infections among young people.[8] These alarming data underscore that gender inequalities—and intersecting biological, behavioral, and structural factors—directly and indirectly fuel the heightened risk of HIV infection. This, in turn, has clear implications for the global response to HIV, since the goal of an AIDS-free generation will be impossible to achieve if girls and young women are not a central focus with strategies that address their multifaceted vulnerabilities. Dr. Ruth Laibon-Masha, CEO of Kenya's National AIDS Control Council, stated it succinctly: "The epidemic in Africa will never be won unless we address AGYW."[9]

Public health experts acknowledge that interrupting the cycles of HIV transmission is critical to controlling the epidemic. Researchers have shown that a pernicious cycle of transmission involves men aged 25–34 infecting AGYW aged 15–24, who then grow up and infect their longer-term partners aged 24–35, and the cycle continues.[10] The implications of these findings for health systems in the DREAMS countries are sobering: while women over 20 go to the clinics for maternal and child health services, women under 18 and young men rarely interact with the health system. "If you think you can intervene by using the current approach to health delivery, it won't work," noted Caprisa's associate scientific director, Professor Quarraisha Abdool Karim.[11]

Still, DREAMS has been criticized in the host countries and by many observers for not focusing also on adolescent boys and young men. PEPFAR contends that its focus is justified by the ongoing health disparities between girls/young women and boys/young men, noting that boys/young men have a highly effective HIV prevention intervention that has been implemented for years to the tune of billions of dollars before DREAMS—voluntary medical male circumcision (VMMC). At a 2017 CSIS event, Ambassador Birx took this criticism head-on: "We started our young men's program in 2009, with voluntary medical male circumcision and really aggressive prevention messaging, and at that time, no one asked us what we were doing for young women. But as soon as we launched DREAMS, everybody came and said 'what are you doing for young men?' So that still shows us how we are a bit prejudiced still in our thinking and in our programming."[12]

While the overall rate of new HIV infections in some of the hardest-hit countries has declined in recent years, a parallel trend involves the burgeoning youth

Girls in Kenya's Kisumu County are sensitized on HIV and violence prevention, as part of DREAMS.

PHOTO CREDIT: FLORENCE OGOLA/CATHOLIC RELIEF SERVICES

population, linked to the improvements in under-five child survival. These demographic trends are especially notable in sub-Saharan Africa and are often referred to as "the youth wave" or "the youth bulge." This means that the total number of AGYW is rising, and because they continue to experience unacceptably high HIV rates, this is leading to an unsustainable HIV treatment burden on their countries—for example, in South Africa, which has one of the world's largest HIV epidemics, approximately 45 percent of the population is under 25 years old. Given these realities, a recent book on HIV prevention among young people in southern and eastern Africa concluded: "Speeding up the reduction of new HIV infections and securing and protecting the sexual and reproductive health of young people becomes even more of an imperative to avoid these looming future challenges."[13]

A central challenge in HIV prevention is that there is no single intervention that works on its own, and prevention programs have to be tailored to the complexities of people's lives. To its credit, PEPFAR recognized the need for a multifaceted approach to address the risks that girls and young women face and to keep them HIV-free. Dr. Jennifer Kates of the Kaiser Family Foundation summarized why DREAMS is such a unique prevention program: "DREAMS provided proof of concept that you can approach a single health issue from a multisectoral lens and that the U.S. government can figure out how to do it. It hasn't been easy, but knitting together approaches, programs, and partners to address the complex lives of AGYW is a critical but rarely pursued strategy."[14]

The Launch of DREAMS

PEPFAR recognized gender-related factors in the early years of the program under the George W. Bush administration, which was reflected in the authorizing legislation passed by Congress in 2003, the United States Leadership Against HIV/AIDS, TB, and Malaria Act of 2003. The legislation required the administration to establish a comprehensive, integrated, five-year strategy and to include specific objectives, multisectoral approaches, and strategies to provide treatment and promote prevention, including a focus on the needs of women.[15] Under the Obama administration, the focus on women and girls increased, both through PEPFAR and through associated initiatives and programs at USAID and the State Department. PEPFAR adopted five cross-cutting gender areas and in 2010 launched a three-country GBV initiative.[16] PEPFAR also supported the first VACS—Violence against Children Survey—in Tanzania in 2011 and many other VACS since then.[17] All of this work was critical, but no single initiative focused specifically on the alarmingly high rates of HIV infection among AGYW.

In a major shift, PEPFAR launched DREAMS in December 2014 to significantly reduce new HIV infections in AGYW. At the time, this initiative seemed to be a radical departure from a very vertical program to a broad, multisectoral approach that would be far more difficult to demonstrate clear and quick concrete results. This signature initiative ran in parallel to other PEPFAR efforts to narrow the set of focal countries by disinvesting from areas with less HIV and was seen as something that could garner bipartisan support in Congress.

Speaking at a CSIS event on DREAMS in April 2015, Ambassador Birx delivered a stark message about the disproportionate burden of disease, citing studies showing 7,000 new infections per day in this population, including 50 percent prevalence of HIV among young women in rural South Africa by age 24. "This should be mobilizing all of the resources and the same focus that we put on Ebola . . . This is a crisis . . . An emergency requires risk-taking."[18] She further explained that the demographic shifts and rising youth population in sub-Saharan Africa—the "youth bulge"—meant that between 30 and 60 percent more girls were at risk than at the beginning of the epidemic and that the world did not have the resources to pay for the cost of treating this level of rising infections. "The very progress that we made on HIV/AIDS over the last 20 years is at risk right now because of our lack of engagement with young women."

With $210 million and highly ambitious goals for an initial two years, the DREAMS partnership aimed to address HIV risks for AGYW in high-burden "hot spots" in 10 countries in eastern and southern Africa by identifying where these young women are being

	Year 1	Year 2	Year 3 (COP 17)	Year 4 (COP 18)	Year 5 (COP 19)	Year 6 (COP 20)
Original DREAMS Countries						
Kenya	$19,742,670	$19,742,670	$29,242,670	$29,242,670	$29,242,670	$40,047,491
Lesotho	$7,017,660	$7,017,660	$10,017,660	$10,017,660	$10,017,660	$14,000,000
Malawi	$7,017,790	$7,017,790	$7,017,740	$8,517,740	$8,517,740	$20,000,000
Mozambique	$10,195,770	$10,195,770	$10,195,770	$10,195,770	$10,195,770	$35,000,000
South Africa	$33,323,381	$33,323,381	$33,323,381	$33,323,381	$33,323,381	$90,000,000
Eswatini (Swaziland)	$5,009,695	$5,009,695	$5,009,695	$5,009,695	$5,009,695	$14,219,584
Tanzania	$8,163,178	$8,163,178	$18,163,178	$18,163,178	$18,163,178	$25,000,000
Uganda	$15,717,403	$15,717,403	$15,717,403	$15,717,403	$15,717,403	$23,000,000
Zambia	$8,124,208	$8,124,208	$13,124,208	$13,124,208	$13,124,208	$30,156,723
Zimbabwe	$10,310,785	$10,310,785	$15,310,785	$15,310,785	$15,310,785	$40,277,472
DREAMS Innovation Challenge		$80,000,000				
Botswana			$4,792,016	$4,792,016	$4,792,016	$19,000,000
Cote D'Ivoire			$10,000,000	$10,000,000	$10,000,000	$16,000,000
Haiti			$2,000,000	$2,000,000	$2,000,000	$3,500,00
Namibia			$10,000,000	$10,000,000	$10,000,000	$20,000,000
Rwanda			$5,000,000	$5,000,000	$5,000,000	$10,122,200
South Sudan						$1,000,000
Total	***$124,622,540***	***$204,622,540***	***$188,914,506***	***$190,414,506***	***$190,414,506***	***$401,323,470***

SOURCE: AMBASSADOR DEBORAH BIRX, U.S. GLOBAL AIDS COORDINATOR, "THE DREAMS PARTNERSHIP," POWERPOINT PRESENTATION, DECEMBER 14, 2020.

infected, what is putting them at risk, and how to target programs accordingly. In addition to the original 10 countries, 5 DREAMS-like countries were added in fiscal year 2018, and South Sudan was added in Country Operational Plan (COP) 20, focused on transactional sex and GBV. The partnership's original goal was to reduce incidence in high-burden areas by 25 percent in two years and by 40 percent in three years. At the time, many questioned whether these targets were attainable or simply aspirational, but they represented a determined effort to do things differently.

"The very progress that we made on HIV/AIDS over the last 20 years is at risk right now because of our lack of engagement with young women."

— Ambassador Deborah Birx

DREAMS was conceived as a public-private partnership—with the Bill & Melinda Gates Foundation, Gilead Sciences, Girl Effect, Johnson & Johnson, and ViiV Healthcare—with each contributing resources, expertise, or support to advance the DREAMS program. As an interagency program through PEPFAR, DREAMS also included USAID, the CDC, and the Peace Corps.

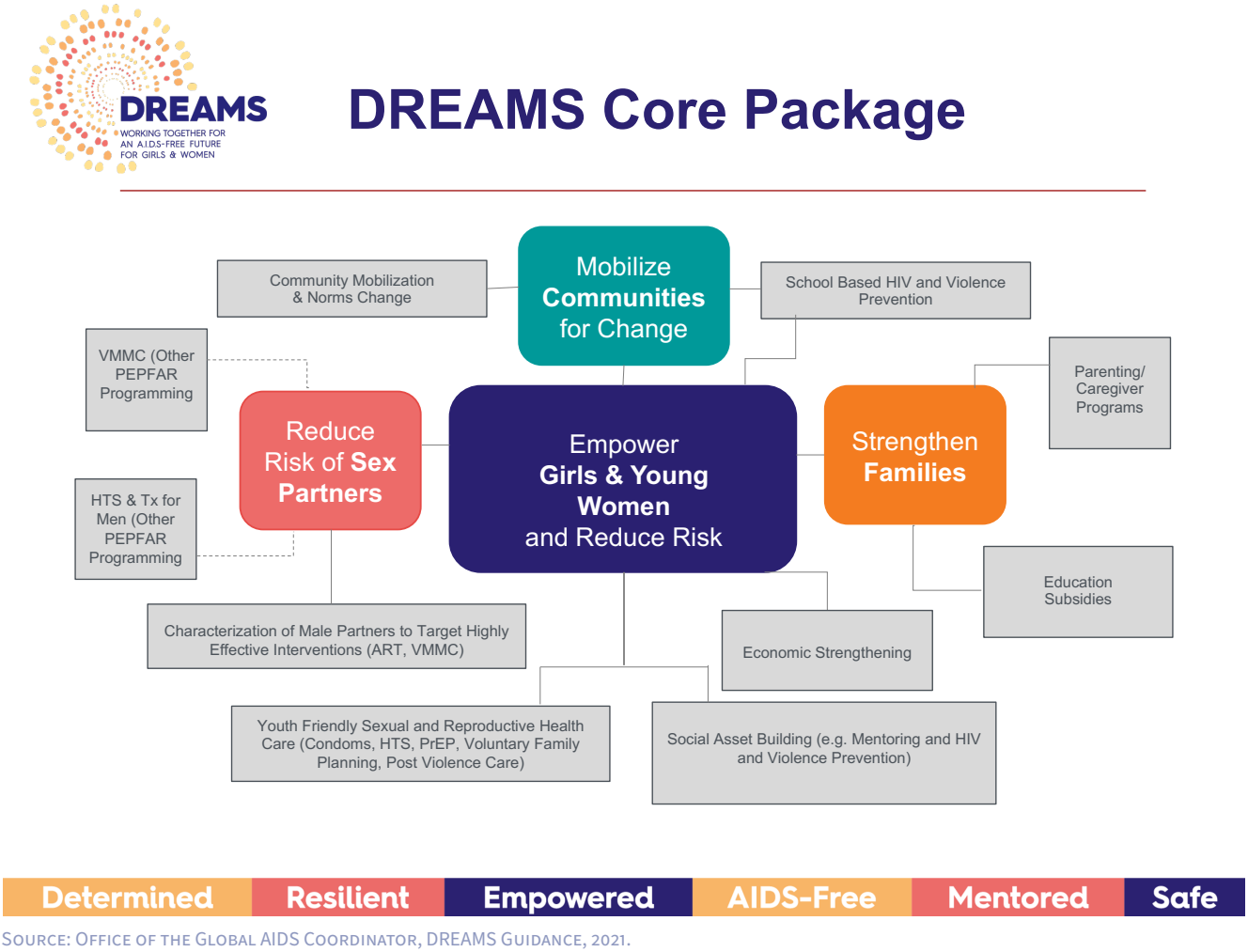
A defining feature of DREAMS is the core package of interventions, designed to address HIV risk and prevention at different levels. At the individual level, the aim was to reduce AGYW's risk of HIV, unintended pregnancy, school drop outs, and GBV. At the family level, DREAMS worked to support positive and effective caregiving for parents and guardians and targeted the sexual partners of girls and young women to increase access to HIV testing, VMMC,

and antiretroviral therapy (ART). At the community level, DREAMS worked to engage young men and to mobilize communities to change gender norms, especially to keep AGYW HIV-free and safe from violence.

Lucie Cluver, professor at the University of Oxford and the University of Cape Town who has done extensive work on AGYW, highlighted another unique characteristic of DREAMS: "One of the notable features of DREAMS was that it was designed based on the best available scientific evidence at the time. It has subsequently been adjusted as new evidence [about multisectoral approaches] has come out."[19]

The significance of DREAMS should not be underestimated. Emily Bass, a longtime AIDS advocate and author of a history of PEPFAR, explained: "DREAMS broke the mold of what PEPFAR could spend money on in a big, clear way, making it possible to build a program combining structural, behavioral, biomedical, the need for social capital, and bodily autonomy for women and girls."[20] This was a clear departure from PEPFAR's main focus on treatment and set DREAMS on a course to rapidly try to prove that a multisectoral, layered approach could have a measurable impact on HIV prevention in this high-risk population.

PEPFAR country teams determined where DREAMS should operate by targeting where AGYW were at the highest risk of HIV in otherwise high-risk geographic areas. Implementers conducted vulnerability assessments, relying on government social welfare information, community-based methods, and examination of survey data, including the prevention of mother-to-child transmission (PMTCT) and antenatal care (ANC) data for this age cohort and the rate of new infections. To identify which girls and young women should be invited to enroll in DREAMS, the implementers used screening tools to determine the most vulnerable girls, like the Population Council's Girl Roster tool. This tool has been improved over the years to include questions such as whether the AGYW were in school; whether they were falling two to three grades behind their peers or had dropped out; whether they had children when they were under 18 years old; and whether they had multiple sexual partners.



SOURCE: OFFICE OF THE GLOBAL AIDS COORDINATOR, DREAMS GUIDANCE, 2021.

A Multisectoral "Layered" Approach

The DREAMS core package provides a combination of multiple interventions critical for addressing the needs of girls and young women. This approach of combination prevention includes behavioral, structural, and biomedical interventions. The full program, which can last from several weeks to up to a year, covers topics beyond just HIV to increase self-confidence, assertiveness, and the ability to negotiate safer sex. One implementer from LVCT Health in Kenya summarized the importance of this approach: "The layered approach was one of the strengths of DREAMS and one of the most difficult to implement. It helped us to be able to look at and examine the different dimensions of risk and the needs of AGYW at risk, not just one dimension." She continued by noting the difficulty of implementing all the layers with fidelity and quality because often implementers were not accustomed to this approach.[21]

The key layers include economic strengthening, including financial literacy, especially for older AGYW (15–24); weekly meetings in safe spaces or girls clubs to build confidence, encourage social support between peers, and provide mentoring; curricula to address violence prevention delivered in schools and/or safe spaces; education support, including paying for school fees, school uniforms, and supplies; family planning to help AGYW avoid unintended pregnancy; PrEP; psychosocial support; and GBV services.

Implementation of layered services presents distinct challenges, especially where several implementing partners are operating and are supposed to refer AGYW between and among the different partners. One of the barriers to effective layering has been passive referrals and weak linkages between community and clinical components of DREAMS, with difficulties tracking referral completions, as well as between partners in general. Despite MOUs between partners that spell out what each partner is responsible for in a given facility or community, many gaps were evident due to a lack of clear coordination and communication. PEPFAR has improved guidance in this area to avoid the problem that implementing partners were not actively referring the DREAMS girls as expected—what they referred to as "passive referrals"—and is now using systematic criteria across countries and partners to address these issues, including by using unique identifiers in the tracking systems, which has helped improve the data on referrals. USAID and the CDC are also supposed to work with their implementing partners to improve coordinated delivery.

According to implementation science research conducted by the Population Council in Kenya, DREAMS improved the number of AGYW exposed to the primary package of interventions. The research identified some positive changes due to the effect of the layered interventions, with girls and young women describing how they received multiple services that increased their knowledge of HIV

and reduced HIV-related stigma. However, the council found mixed results in sexual behavior; while fewer girls reported two or more sexual partners and alcohol use before sex, fewer reported consistent condom use. Importantly, the council found a reduction in physical and sexual violence in Kenya and Zambia, increased use of health services relating to HIV and SRH services, and the ability to ask questions to health providers.[22]

A Learning Process

Although the structure of DREAMS was prescriptive, it evolved as an iterative, learning process. The original intention was to ramp up implementation quickly to reach the ambitious targets, but the process took considerably longer than expected, and program implementation wasn't really fully underway in all 10 of the original countries until 2016. Because DREAMS tried to get up and running quickly, it relied on many existing PEPFAR partners, including orphans and vulnerable children (OVC), PMTCT, and school-based partners, who often had little experience addressing the needs of AGYW, especially those involved in transactional sex with multiple partners. These issues contributed to lengthy delays in effective implementation.

In 2017, in an important decision, DREAMS was incorporated into PEPFAR's COPs as a way to institutionalize it as part of PEPFAR's core programming and to ensure sustained funding, as opposed to relying on special funding from headquarters. Because the U.S. ambassador in each PEPFAR country was responsible for the implementation of the COP, this included DREAMS.[23] This was an intentional effort to make the program an integral part of PEPFAR at the country level. Still, observers note, and PEPFAR officials acknowledge, that DREAMS has not been fully integrated into the broader work of PEPFAR's country programs in some of the DREAMS countries. This is due, in part, to the significant, ongoing divide between those focused on HIV prevention versus treatment—and even within prevention itself—to what many point to as undervaluing the specific focus on girls and young women.

Along the way, DREAMS learned from its own program reviews and experience of implementation, and a range of research and studies were incorporated into COP guidance and other DREAMS guidance. These included definitions of minimum packages of services according to age bands; an increased focus on violence prevention among 10–14-year-olds; incorporating a new indicator, AGYW_PREV, designed to promote active referrals between implementing partners as opposed to passive referrals that were undermining the impact of the layered approach; definitions around the completion of the DREAMS package and district saturation; and how to strengthen the capacities of DREAMS mentors.

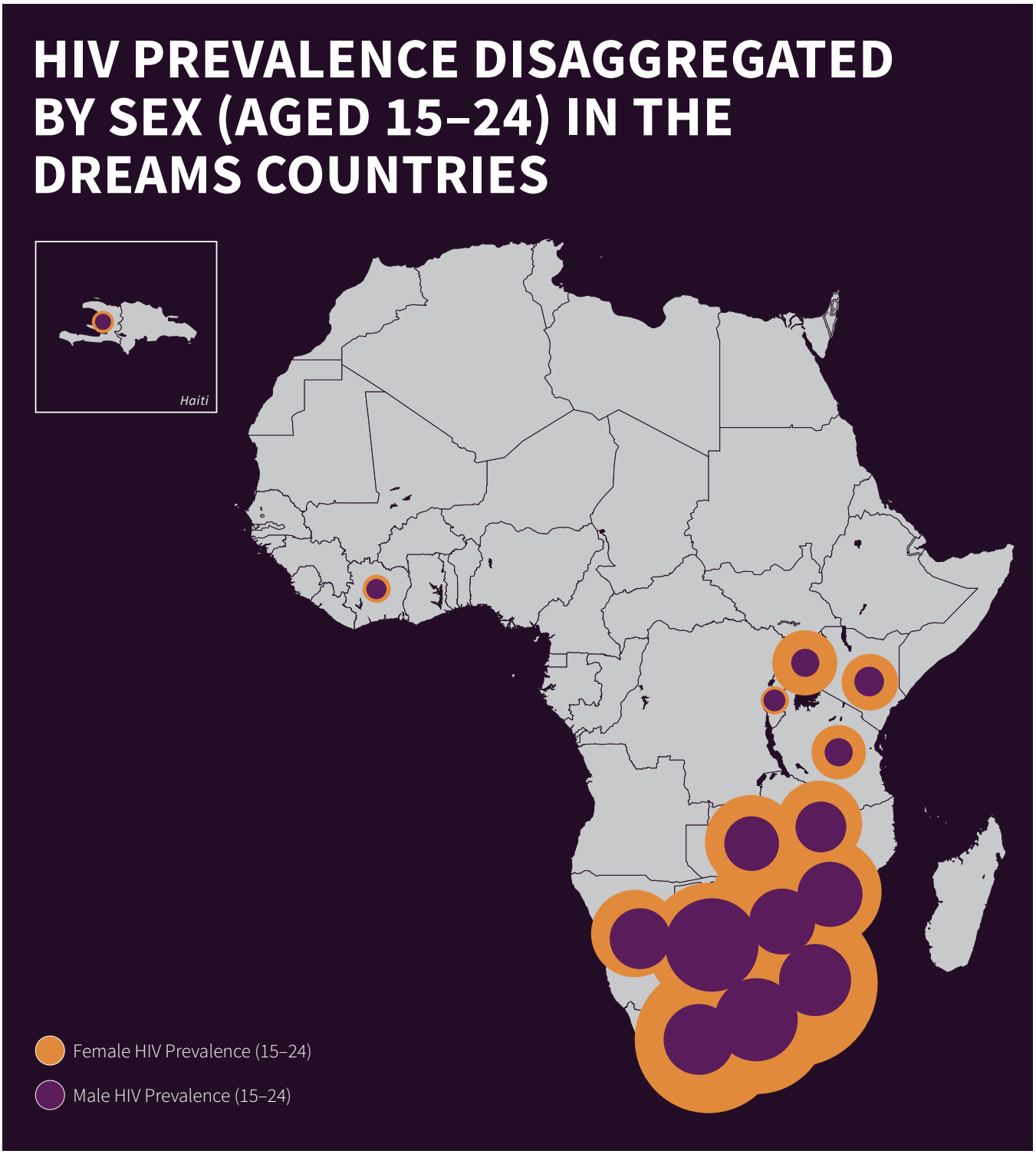
More recently, in 2020, DREAMS increased its geographic coverage and enhanced the economic strengthening component of the program.[24] That same year, DREAMS instituted minimum requirements, stipulating that all countries had to hire a DREAMS coordinator and a lead DREAMS ambassador in all regions, ensure that the databases to track layering are fully operatable and have unique identifiers to ensure quality data on layering and improve how the most vulnerable girls and young women are identified, increase economic strengthening programs based on the most recent research, and expand the number of at-risk AGYW on PrEP.

Expansion of Coverage, Resources, Monitoring

In COP 20, PEPFAR more than doubled the resources for DREAMS, from $190 to $400 million. This meant expanding from 115 to 202 districts, targeting over two million AGYW, and increasing the geographic footprint by adding 88 new districts in 10 countries. South Sudan also received limited DREAMS funding to address issues of economic strengthening and GBV prevention.[25] This represented another important decision by PEPFAR, though it came before the Covid-19 crisis emerged.

Although the level of funding did not increase across the board, every country received some additional funds for DREAMS, with the largest increases in South Africa, Mozambique, Zimbabwe, Eswatini, and Kenya. In some places, like Zambia, the new funding focused on taking the programming from partial to full geographic coverage in the areas where the program already exists. In Kenya, too, where not all counties were covered, the new funding focuses on getting to fuller coverage in the places where DREAMS is operating. In all countries, the increased funding and resources will be devoted to improving PrEP expansion and economic strengthening programs.

As PEPFAR expands DREAMS, the challenge of maintaining the fidelity of the interventions



SOURCE: "PEOPLE LIVING WITH HIV RECEIVING ART," UNAIDS, JUNE 30, 2020, HTTP://AIDSINFO.UNAIDS.ORG/.

inevitably arises, further exacerbated by the often intense pressure from PEPFAR headquarters on implementing partners to meet targets. Kelly Curran of JHPIEGO, a DREAMS implementer, emphasized the tension between quality and scale: "The challenge that implementers face is how to deliver a high quality, complex package at scale." In addition, she noted that DREAMS faces challenges in reaching the AGYW at highest risk: "the very highest risk [AGYW] are out of school and not in the formal workforce. They are the most hidden and the hardest to reach . . . This is the unfinished business—to reach the right girls and

young women who need DREAMS most since not everyone is equally at risk."[26]

Private Sector Engagement

The private sector partners contributed their expertise to strengthen the program's reach, impact, and effectiveness. These partners contributed over $55 million to DREAMS in financial and in-kind expertise. Though DREAMS is technically no longer a public-private partnership, since the contributions of the private sector have effectively ended, the input from the private sector partners helped DREAMS evolve. Lessons and contributions from the private partners included the importance of listening to girls and young women, market segmentation based on the different needs of girls and young women in different contexts, capacity building for community-based organizations, and PrEP drug donations.

The specific contributions of the private sector were as follows: the Bill & Melinda Gates Foundation funded implementation science research (through the Population Council) and the impact evaluation studies (through a team led by the London School of Hygiene & Tropical Medicine, LSHTM). Johnson & Johnson provided market segmentation analysis, promoted client-centered services by listening to girls and young women and adapting services to meet their needs, and supported peer-to-peer models, including through workshops with AGYW in 9 of the original 10 countries and through the DREAMS ambassadors. Gilead donated the PrEP drugs, and importantly, registered PrEP in all the DREAMS countries, a policy contribution that could pave the way for the introduction of new biomedical prevention technologies as well as generics. ViiV Healthcare provided capacity building to local community-based organizations to improve service delivery for AGYW and contributed to the DREAMS Innovation Challenge. Girl Effect, which spun off from the Nike Foundation, has worked in Malawi on brand creation, media, and communications through its Zathu program, which supported DREAMS by delivering messages on gender norms, equality, and friendship between girls and boys.

Private sector representatives saw value in the partnership with PEPFAR while acknowledging challenges in translating their theories and practices into program implementation. Some representatives of the private sector noted that the engagement with PEPFAR was far greater at the headquarters level than at the country level, where the private partners sometimes had difficulties getting support and engagement from the DREAMS country teams. Most private partners agreed that DREAMS provided an example of how the private sector could shift away from pure profit motives and the traditional corporate social responsibility toward a greater government and private sector complementarity.

DREAMS Innovation Challenge

The DREAMS Innovation Challenge was launched in February 2016 by PEPFAR, Johnson & Johnson, and ViiV Healthcare with $85 million in funding ($80 million of which was from PEPFAR). It piloted 46 interventions with the possibility of catalyzing DREAMS programming in six areas: strengthening capacity for service delivery in communities; supporting PrEP; keeping girls in school; providing a post-secondary bridge to employment; linking men to services; and analyzing data to increase impact. A particular focus of the Innovation Challenge was to fund indigenous African organizations, which comprised half of the 46 grantees funded by PEPFAR, nearly 40 percent of whom were new to PEPFAR. More than half of the grantees secured additional funding to continue their activities beyond the Innovation Challenge.

If the Innovation Challenge was developed to stimulate new ways for DREAMS to operate, there is little evidence that it operated for sufficient time to have real impact. Among the main challenges acknowledged by PEPFAR were the late start of implementation due to extended time for country buy-in by multiple stakeholders and the limited ability to show impact on structural interventions in such a short time frame.[27]

Impact Evaluation

The Bill & Melinda Gates Foundation supported the LSHTM to conduct an impact evaluation of DREAMS. The evaluation covered four settings: three with general population-based samples in urban and rural settings in Gem, in western Kenya, and a rural setting in KwaZulu Natal province in uMkhanyakude, South Africa; and one with a population of young women who sell sex in Zimbabwe. The evaluations in South Africa and Kenya indicated that the declines in HIV incidence among AGYW started before DREAMS implementation began,[28] largely due to the indirect effect of earlier investments in

HIV testing, ART, and VMMC, which "bent the curve" and for which PEPFAR deserves credit. The evaluations noted that DREAMS took time for such an ambitious program to be implemented and to scale up a complex package of interventions district-wide, which delayed its impact on further, faster declines in HIV incidence. The impact on HIV incidence by 2019 was also hampered because DREAMS didn't include PrEP for AGYW in the early stages—and PrEP is a highly effective prevention tool—or reach the young women at highest risk of HIV (such as those who sell sex, often for survival, in Zimbabwe).

The LSHTM acknowledged that the full impact on HIV incidence will undoubtedly take longer, and will be seen as adolescent girls grow up and DREAMS intensifies its most effective strategies. In the words of Isolde Birdthistle, a principal investigator of the study: "We found that DREAMS was most effective at reaching adolescent girls under age 19, before the age of peak HIV incidence risk. This phase is a 'window of opportunity' to reach adolescents early with knowledge, agency, skills and resources, so we won't know if DREAMS has protected them from HIV until they are older and in sexual partnerships. We have seen very encouraging impact of DREAMS along the pathway of protection, like improvements in knowledge of HIV status and condomless sex. This makes us optimistic that the huge effort and momentum behind DREAMS will yield positive change for young women."[29]

Adoption of New Indicators

PEPFAR has added an AGYW prevalence indicator to the monitoring, evaluation, and reporting (MER) data to track how many of the AGYW have received the core package and how many have also received secondary interventions. PEPFAR is creating country databases to track the delivery of these services with the aim of improving data use and targeting. AGYW_PREV is the new indicator to represent the concept of layering, and 2020 was the first year with good data to report. While MER won't clarify which layers are most important, it is supposed to show the extent to which partners are linking AGYW to services provided by other partners.

However, some U.S. agency representatives have criticized the current indicators for not adequately capturing the AGYW-related issues. For example, the MER indicator has been criticized on the grounds that it is too complex and doesn't get at the most important measurements, especially related to outcomes. One key informant proposed developing two to three indicators that are simple, don't increase the burden on implementers, and measure intermediate outcomes that are anticipated for layering and service delivery. The idea would be to look at smaller snapshots (e.g., the percentage of AGYW who were linked from PrEP to behavioral programs, and vice versa).[30] Another idea is to use indicators to understand and define the completion of DREAMS. "We've got to have a better exit strategy," a U.S. government official noted.

Examples and Evidence around Different Layers

Education for Girls

Evidence indicates that every year that a girl stays in secondary school is protective against HIV,[31] which is why DREAMS has worked to pay secondary school fees or educational subsidies for girls and young women (most DREAMS countries do not charge school fees for primary school) so they can continue their education. For primary school, AGYW and their families confront other costs, such as for books, uniforms, menstrual hygiene supplies, and transportation, some of which DREAMS can help support to keep the girls and young women in school. Since the need for educational support is so high, some DREAMS programs sought to pay a portion of school fees for more girls, while others paid the full amount for fewer girls. It should be noted, however, that school itself can be a risk factor for GBV, stemming from the risks in getting to and from school, as well as the risks at school itself from teachers and other students.

National policy barriers, like requiring school fees for secondary school, prevent many girls and young women from continuing their education. Another policy issue involves reentry policies, which prevent girls who have been pregnant from returning to school. Teenage pregnancy itself creates barriers for AGYW to overcome challenges, and their vulnerability is thus compounded by cutting them off from education. While many DREAMS countries have eliminated harmful reentry policies, this continues to be a policy barrier in Tanzania. On the U.S. side, an impediment to greater investment is that USAID focuses on quality basic education, not secondary school education for girls.[32]

Economic Strengthening

The factors that put girls and young women at risk for transactional sex are often rooted in the lack of economic empowerment and access to economic resources. When an AGYW doesn't have a way to get what she needs or wants—ranging from food to school fees, from shoes to cell phone airtime to menstrual hygiene supplies—she risks resorting to transactional sex with multiple partners, since her body may be what she considers her main commodity.

Until recently, the economic strengthening component of DREAMS was relatively weak, with a focus on savings and loan groups and homemaking (sewing; making bread, mats, other food, and some decorations; braiding hair). When a large number of girls all got engaged in those activities, they flooded the markets, which undermined the effort to build businesses and make profits. In addition, the DREAMS Innovation Challenge from 2016 to 2018 included a bridge to employment component but did not significantly impact DREAMS programs.

In COP 20 and 21, DREAMS expanded the economic strengthening layer, pushing for AGYW to get training for job readiness through internships, apprenticeships, and employment where possible, including through employment in DREAMS and broader PEPFAR programs. PEPFAR identified five economic strengthening models where strong evidence existed,[33] and it assembled an interagency group to review evidence and make recommendations to guide country plans and investments and to provide advice and technical assistance. By supporting access to technical colleges or vocational training and apprenticeships, AGYW have been able to train in areas that have traditionally been out of reach for them, like mechanics, plumbing, metal works, and becoming drivers.

Gender-Based Violence

Evidence shows a strong association between GBV and HIV acquisition; factors including harmful gender norms, dropping out of school, and economic disadvantage contribute to the vulnerability of girls and young women, and the experience of GBV both directly and indirectly increases the risk of HIV.[34] GBV takes many forms, including sexual, psychological, and physical abuse, often perpetrated by an intimate partner or ex-partner (IPV). In many DREAMS countries, studies show that alarming percentages of AGYW's first sexual experiences are rape and close to 40 percent have experienced ongoing sexual violence in the last 12 months.[35] This is supported by data collected through the Violence Against Children Surveys (VACS), a series of surveys supported by PEPFAR through the Together for Girls partnership.[36]

GBV prevention and response is central to the DREAMS package. Examples of GBV programming in DREAMS includes school-based HIV and violence prevention programs; post-violence care, including post-exposure prophylaxis (PEP), a short course of antiretroviral drugs taken within 72 hours to prevent HIV after possible exposure; programs for parents and caregivers about how to stop cycles of GBV; and social protection programs, including vocational training and financial literacy, to reduce economic dependency that can lead to GBV.[37]

Implementation science research done by the Population Council found that sexual violence was higher than it anticipated among AGYW in DREAMS, with 19 percent reporting sexual violence from their intimate partners within the past year and another 21 percent from non-intimate partners. The Council also found a strong relationship between relative power (i.e., the ability to make decisions in relationships and have autonomy) and experience of violence and showed a correlation between more power, less violence, more likely to use condoms, more likely to know your partner's HIV status, twice as likely to report sexually transmitted infection (STI) symptoms. In the second round of their research, the Council found reductions in reported violence in Kenya, Zambia, and Malawi.[38]

Key challenges in DREAMS and GBV work involve monitoring and referrals. It is clear that girls and young women who experience GBV in communities frequently don't report it, and even when they do, the follow-up is often weak and poorly documented—sometimes because the organizations supposedly providing such services are weak in communities and sometimes due to the stigma associated with GBV. The post-GBV clinical care provided through DREAMS involves referral for HIV services at the facility, where the AGYW can access HIV testing, PEP, and PrEP, STI screening and treatment, and psychosocial support, with referral for legal services. Whether these programs meet the girls' and young women's needs often depends on the strength of the implementing partners and the network of community-based organizations that provide support for GBV survivors.[39]

SRH-HIV Integration

Throughout the DREAMS countries, girls and young women are often more aware of and concerned about their risk of unintended pregnancy than their risk of HIV, which underscores the importance of using SRH information and services as an entry point for HIV prevention, including for PrEP. Unprotected sex and unintended pregnancy set up girls and young women for risk, often reflecting transactional sex. Given the data that pregnancy and breastfeeding constitute a time of exceptionally high risk of HIV acquisition, ensuring that integrated information and services are accessible for AGYW is essential to enable them to avoid pregnancy if they so choose or access HIV services if they are pregnant. Further evidence about the importance of HIV/SRH integration came in July 2019 from the ECHO trial—Evidence for Contraceptive Options in HIV Outcomes—which found no substantive difference in HIV risk for users of the three common contraceptive methods but also found very high rates of HIV incidence in all

three arms of the study. These results were especially significant for women and girls in southern and eastern Africa, where the study was conducted.[40]

Through its safe spaces, some DREAMS sites are working to ensure that integrated services are youth friendly, with trained healthcare providers, and some DREAMS programs are providing outreach services in communities. But DREAMS has had to confront the complexities of siloed SRH and HIV funding. The USAID family planning program and PEPFAR have tried workarounds to try to ensure that contraceptive commodities are available, but it is far from optimal and stockouts remain frequent. This stems from numerous barriers, including coordination with other donors who are providing family planning support, and the fact that in some DREAMS countries, such as South Africa, Eswatini, and Botswana, the United States no longer provides family planning commodities at all since those countries have "graduated" from U.S. family planning/SRH assistance.[41]

To be clear, there are no legislative restrictions preventing PEPFAR from purchasing contraceptives, as long as it contributes to HIV outcomes. Still, under both Democratic and Republican administrations, PEPFAR has resisted moving in that direction for fear of antagonizing more conservative members of Congress and faith-based organizations, who often conflate access to contraception with abortion. U.S. funding for international family planning does not include abortion because it is prohibited by U.S. law governing foreign assistance, including the 1973 Helms Amendment.[42] However, these ongoing political tensions have presented significant constraints toward progress on expanding SRH-HIV integration.

Pre-exposure Prophylaxis

The most important biomedical tool for HIV prevention, PrEP is a highly effective antiretroviral drug that has been shown to dramatically reduce the risk of HIV acquisition in people at risk. Girls and young women are an important target population for PrEP in high burden countries in southern and eastern Africa. PrEP is part of the DREAMS core package, and PEPFAR is increasing its investments in and targets for PrEP for AGYW in its 2021 COPs. In FY 2019, more than 54,000 AGYW were initiated on PrEP—up from 20,000 in FY 2018.[43] DREAMS is working to significantly scale up PrEP, which is highlighted in the new COP guidance.[44]

The importance of PrEP for girls and young women is undeniable, but expanding access has proven to be challenging to implement. Some of the relatively low uptake is due to sensitivities and stigma associated with PrEP, including perceptions and associated stigma that PrEP is for sex workers because they were targeted in the early phases of PrEP. Other factors are related to having to take a pill daily, side effects, and HIV-related stigma, as well as how PrEP is packaged and marketed for AGYW. In addition, PrEP programs are encountering issues with the continuation of PrEP for this population. Girls and young women overall have a higher risk perception for unintended pregnancy than for HIV, which reinforces the importance of integrating PrEP with SRH and family planning services. In findings presented at the International AIDS Society's AIDS 2020 Conference in July 2020, Jhpiego discussed opportunities for innovation with PrEP and the importance of ensuring that it was integrated as much as possible in other service delivery points, especially family planning services. When PrEP was mainly provided at HIV clinics, the service was more stigmatized. As Daniel Were, a project director with Jhpiego in Kenya, explained, "Unless we offer a comprehensive package, we miss out on opportunities."[45]

Despite the commitment of DREAMS to scale up PrEP and an increase in the targets, it continues to prove challenging to implement at scale, and new strategies will be necessary. One U.S. government official said that the PrEP scale-up "haunts" her because programs haven't figured out how to do that effectively yet. As one PEPFAR representative put it: "PrEP is the thing that is going to change incidence most quickly, and we haven't figured out the formula for scaling it up to AGYW in all 15 DREAMS countries."[46]

Modes of Implementation: Country Examples

"We don't need DREAMS in every country and in every community. But I think if the goal is to prevent HIV infection, then we do need to be thinking much more smartly about where to take this to scale . . . It can't be one size fits all, that what we need is a response that is much more customized to understanding why you have transmission and what can you do about altering that. And it has to be part of a comprehensive approach."

— Professor Quarraisha Abdool Karim[47]

DREAMS is being implemented in different ways in different countries, with lessons emerging from the strengths and weaknesses of the experiences. However, these lessons are not being routinely shared among the DREAMS countries. A key difference in models across countries involves whether implementation is coordinated among many different implementing partners or whether one partner delivers most of the package. While coordinated implementation was not as strong and suffered from weak or "passive" referrals between partners, some believe that model was more sustainable than asking one partner to deliver everything. In addition, during the initial phase of DREAMS, implementation of the full package proved challenging for implementers. As Jerry Okal, a researcher with the Population Council in Kenya, explained: "As expected in any new program, some aspects of implementation during the initial phase was shrouded in confusion, with hits and misses along the way, and not all of them on the same page."[48]

While some DREAMS programs have focused on getting AGYW to health facilities, others are working to bring health services to them in the communities. In Eswatini, for example, DREAMS on Wheels provided mobile HIV and SRH in communities because girls and young women faced obstacles in accessing services at health facilities. During the course of the two-and-a-half-year project, they reached more than 40,000 AGYW, providing integrated HIV, PrEP, and GBV services.[49] Other DREAMS projects are using a hybrid approach through training healthcare workers and creating youth-friendly spaces in the facilities staffed by nurses who are trained to work with girls and young women. Those nurses then go into communities to provide SRH services to DREAMS participants during one of their meetings, usually on a monthly basis. In this way, the benefits extend beyond the DREAMS participants to all AGYW seeking services, which also enables the nurses to identify vulnerable AGYW and screen them to enroll in DREAMS. DREAMS countries adopting a hybrid approach of facility- and community-based services include Lesotho and Namibia.

Another issue that impacts modes of implementation involves which U.S. agency has responsibility for the DREAMS program. Indeed, the challenges of

interagency cooperation, especially between USAID and the CDC, have been an unresolved feature of PEPFAR since its inception. In some countries, provinces were separated into USAID or CDC areas, with separate implementers. (In Zambia, for example, the CDC has 3 districts and USAID has 11.) In some cases, this interagency coordination, which also includes the Peace Corps, has presented challenges and turf battles. In many countries, USAID is usually the main agency involved in programming in development sectors that were part of DREAMS, while the CDC is usually the clinical partner. One representative of a U.S. agency explained that working across agencies is "unexpectedly challenging," saying that "the interagency process is good on paper, but in practice it is very difficult to carry out successfully."[50] One observer noted that the CDC usually partnered with the Ministry of Health, while USAID had better ties with other development ministries and with the Ministry of Finance.

Kenya

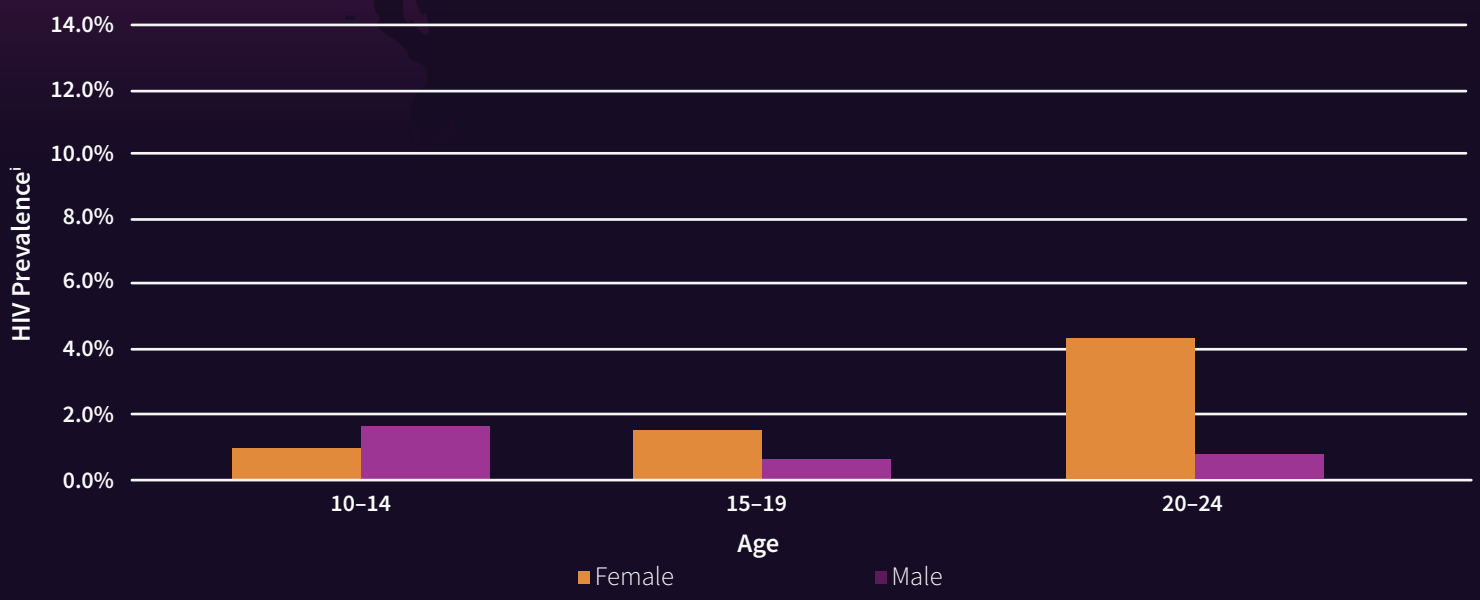
DREAMS in Kenya operates in both rural and urban settings, largely through safe spaces in communities or in the catchment area, or in rural areas, often at health facilities. At the safe spaces, AGYW can access information, education, and services. For some clinical services, including PEP, the AGYW are referred to the health facility and often escorted by a mentor, and there is supposed to be sensitized staff at the facility to provide the services. The program has found that AGYW often prefer to access services through the safe spaces rather than going to the health facility, especially for PrEP and HIV testing.[51]

DREAMS programs in Kenya operate through a main, prime partner responsible for implementing all the DREAMS components on its own or through local partners, which provide the behavioral interventions. By relying on one service delivery partner and reducing the number of sub-implementors, many observers noted improved coordination of the DREAMS components to increase coverage and layering. Key accomplishments include providing educational support to girls and helping them stay in school, offering vocational opportunities to increase their financial independence, and providing HIV testing and access to family planning services.[52] Kenya has also introduced a system where girls "graduate" after completing the DREAMS interventions, but there are still challenges with how best to transition AGYW out of the program. In western Kenya, PATH has been the prime partner since 2016 and began DREAMS with eight local partners, which was later reduced to four. According to PATH, this more concentrated group has reduced the cost of implementation while building local capacities for program implementation.[53]

PEPFAR has reported low program completion rates in Kenya,[54] which points to some of the challenges in completion of the multi-session program of interventions. In particular, the older AGYW—20–24-year-olds—did not show up consistently, given that many are married or in partnerships without supportive partners, often had children and other competing responsibilities, and faced challenges in getting transportation to the program sites. To address this, DREAMS developed opportunities for make-up sessions so the AGYW could complete the package of interventions and to enable them to attend with their children or to provide a space for them to play.

AGYW in Kenya face challenges with PrEP as well, often linked to the lack of supportive environments in their families and communities. In response, DREAMS has worked to sensitize communities, train AGYW to be PrEP champions, and work with service delivery partners to ensure that commodities are available. It also became clear that the economic strengthening component was most important to the older AGYW, and the program is devoting more resources to meet those needs, including through vocational training. However, the cash transfers that DREAMS used to provide were phased out in 2020 due to challenges with sustainability. DREAMS in Kenya has also faced challenges in coordination with county governments and sharing data with the government systems.[55]

KENYA



AGYW (18–24 years) reporting first sex as coerced – 24.3%[ii]

Lower secondary completion rate, female – 79%[iii]

Prevalence of recent intimate partner violence among women aged 15–19 – 23%[iv]

Prevalence of recent intimate partner violence among women aged 20–24 – 27.9%[v]

Percentage of women aged 20–24 years who were first married or in union before age 18 – 23%[vi]

Median age at first birth – 20.3 years[vii]

Percentage of girls, aged 15–19, who are in a marriage/union and have an unmet need for family planning – 23%[viii]

Percentage of girls, aged 20–24, who are in a marriage/union and have an unmet need for family planning – 19%[ix]

Source: Please reference the endnote section for complete citations.

Zambia

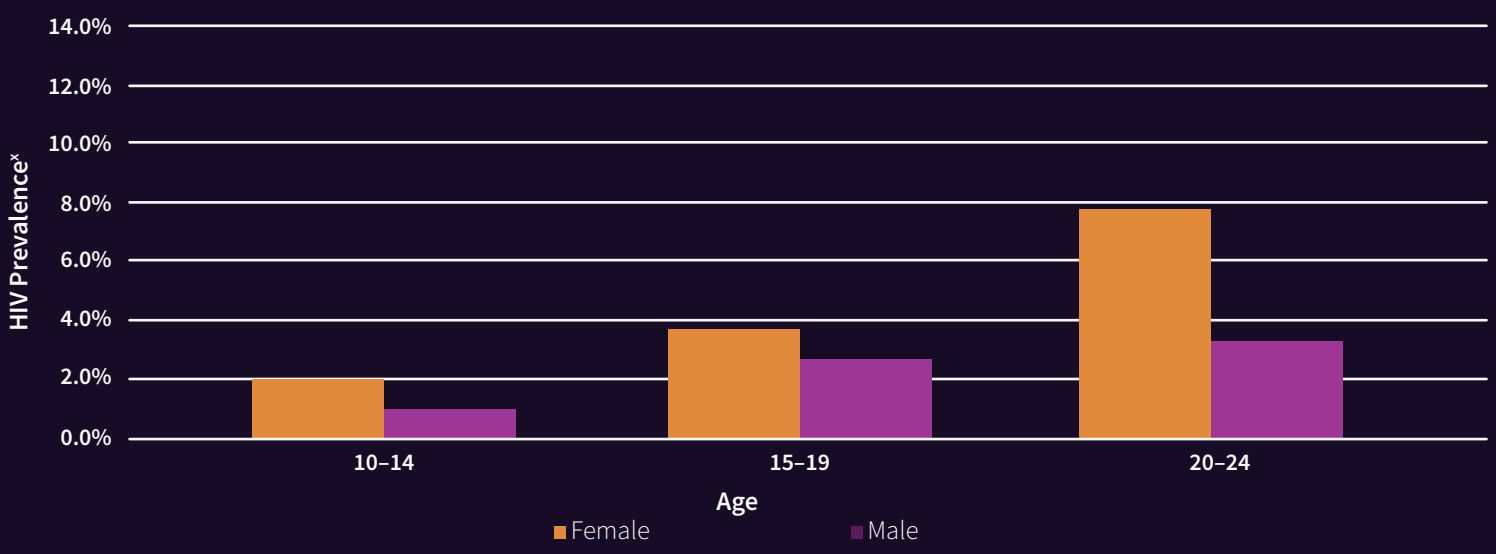
Zambia has developed a unique model structured around DREAMS centers, which provide safe spaces and service provision for the AGYW. In COP 20, DREAMS in Zambia expanded from 8 districts and 40 DREAMS zones to 14 districts and 98 DREAMS zones. Nearly 540,000 AGYW "graduated" from DREAMS between 2016 and the end of FY 2020 after completing the primary and secondary parts of DREAMS.[56] Each of the DREAMS centers is located in a converted house, near the health facility in that zone. The DREAMS centers are normally open seven days a week, but with Covid-19 restrictions, the days of opening were reduced. For example, during the first Covid wave in early 2020, DREAMS centers were only open two days a week to offer high-impact services like family planning, PrEP, condoms, and referrals to GBV services. The centers returned to opening seven days a week but with adherence to infection prevention measures, and mentors continue checking in with the AGYW through mobile phones.

In COP 20, DREAMS in Zambia expanded from 8 districts and 40 DREAMS zones to 14 districts and 98 DREAMS zones.

In each center, clinical services are provided to the AGYW, with public sector nurses who provide short-term family planning methods once or twice per week and HIV testing every day.[57] For long-acting reversible contraceptives (LARCs), including implants, AGYW are referred from the DREAMS centers to the health facility. PrEP is provided in 21 centers, with plans to scale up elsewhere.[58] While providing PrEP at the centers raises sustainability issues in providing it outside health centers, it addresses AGYW's concerns about seeking services at health facilities. Some post-GBV support is provided at the DREAMS centers, but GBV cases are referred to another partner, the Stop GBV program, for legal support, shelter, and other services. The DREAMS centers organize sessions around a local adaptation of the Stepping Stones curriculum, a gender and HIV program that focuses on building safe relationships and reducing GBV. Condoms are available at the center, and economic opportunities are organized, such as savings groups, scholarships, vocational skills training, business startup support, and sewing cooperatives that produce menstrual pads and now Covid-19 masks. The Zambia DREAMS program has added another component focused on mental health support, given the amount of trauma experienced by the AGYW and the weakness of mental health services in the country, and piloted a program based on Strong Minds, an evidence-based curriculum developed in Uganda.

The Zambia program faces a range of challenges, including the disconnect with the national government on leading a multisectoral response and problems in coordinating with the Global Fund. DREAMS in Zambia is seen as a costly model that is not sustainable, and the direct impact is complicated to measure. Some stakeholders also lament that DREAMS is only focused on girls and young women and that boys are being left out.

ZAMBIA



AGYW (18–24 years) reporting first sex as coerced – 26.2%[xi]

Lower secondary completion rate, female – 50.8%[xii]

Prevalence of recent intimate partner violence among women aged 15–19 – 26.7%[xiii]

Prevalence of recent intimate partner violence among women aged 20–24 – 29%[xiv]

Percentage of women aged 20–24 years who were first married or in union before age 18 – 29%[xv]

Median age at first birth – 19.2 years[xvi]

Percentage of girls, aged 15–19, who are in a marriage/union and have an unmet need for family planning – 25%[xvii]

Percentage of girls, aged 20–24, who are in a marriage/union and have an unmet need for family planning – 22%[xviii]

Source: Please reference the endnote section for complete citations.

South Africa

In October 2020, PEPFAR announced that it was expanding its DREAMS coverage from 4 to 24 health districts and tripling the funding to over $90 million, making it the country with the largest DREAMS investments. The new emphasis will be on economic strengthening, skills training, job readiness, and accelerating access to PrEP,[59] as well as preventing and responding to GBV.

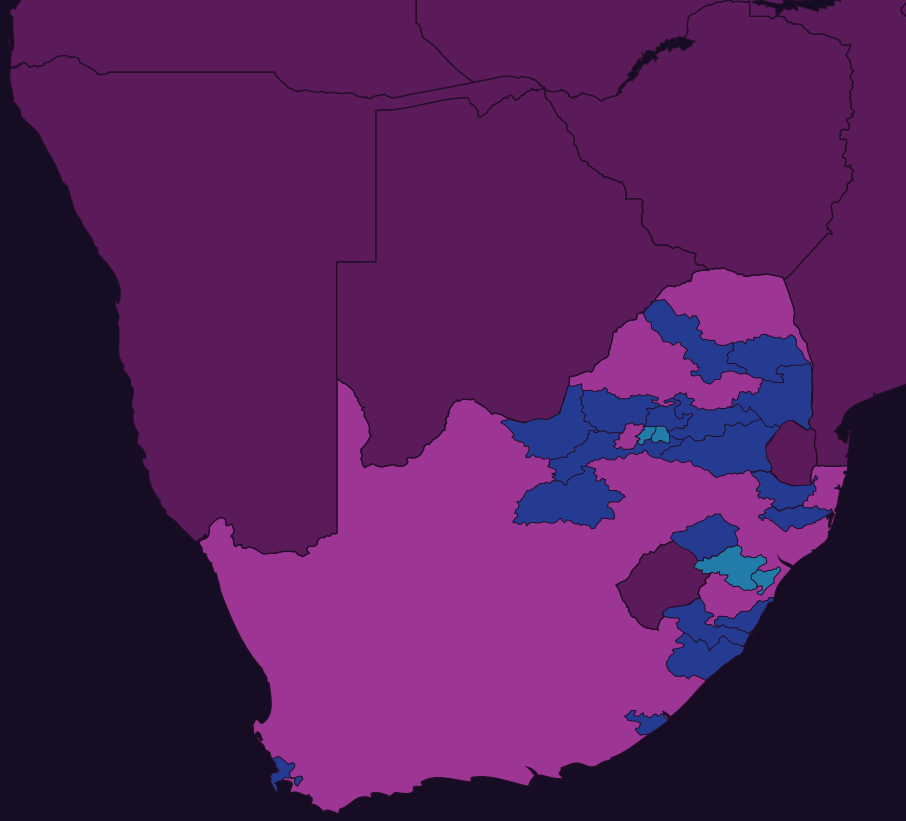
DREAMS in South Africa has shown successes in contributing to slight declines in HIV incidence among AGYW, and evaluations have shown that exposure to the layered interventions was associated with positive outcomes for AGYW, including HIV testing, knowledge of HIV, and access to contraceptives. In particular, DREAMS enabled more AGYW to be linked to HIV testing, PrEP, GBV services, and contraceptives. School-based programs have been a notable feature of DREAMS in South Africa since school enrolment is very high, and often services were brought to schools or AGYW were referred to services from schools. Although DREAMS is a community-based program in South Africa, schools in many DREAMS districts proved to be an important platform for DREAMS activities and increased coverage of AGYW.[60]

More than other DREAMS countries, the South Africa program has worked with government departments to build on and strengthen existing systems. This is especially evident in the work with the Department of Basic Education. The goal is to create conditions for financial and program sustainability, despite numerous political and territorial challenges.

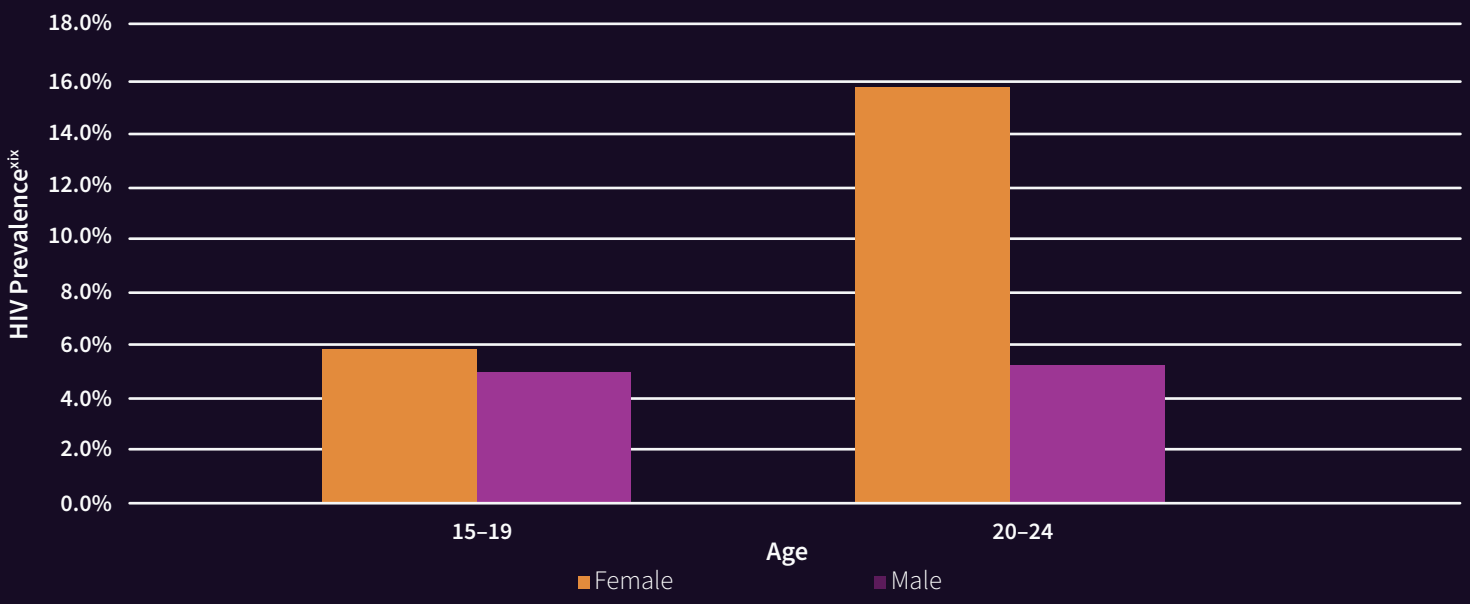
Despite these successes, DREAMS implementation in South Africa has been "complicated and rocky," as one researcher put it. Coordination has been a persistent challenge, with 10 to 12 implementing partners delivering different parts of the package. Many of these partners had never worked together and across different sectors before, and ensuring that AGYW were referred between and among partners proved challenging. DREAMS was implemented differently in different districts and interventions were delivered differently by the various partners, which resulted in a lack of uniformity. Despite significant investments, DREAMS in South Africa continues to face challenges in tracking layered services and meeting the need for GBV services. Covid-19 has particularly disrupted the DREAMS program, causing a 49 percent decrease in completion of the DREAMS primary package. However, South Africa registered a 61 percent increase in PrEP initiations for AGYW during 2020.[61]

PEPFAR announced that it was expanding its DREAMS coverage from 4 to 24 health districts and tripling the funding to over $90 million, making it the country with the largest DREAMS investments.

SOUTH AFRICA



Current DREAMS area New in COP20/FY21



Lower secondary completion rate, female – 83.4%[xx]

Prevalence of recent intimate partner violence among women aged 15–19 – 30.1%[xxi]

Prevalence of recent intimate partner violence among women aged 20–24 – 30.7%[xxii]

Percentage of women aged 20–24 years who were first married or in union before age 18 – 4%[xxiii]

Median age at first birth – 21.3 years[xxiv]

Unmet need for family planning among sexually active women, aged 15–19 – 31%[xxv]

Unmet need for family planning among sexually active women, aged 20–24 – 28%[xxvi]

Source: Please reference the endnote section for complete citations.

Impact of Covid-19 on AGYW Programs

"Covid is probably the greatest risk of HIV infection that we've seen in 20 years."[62]

— Lucie Cluver

Covid-19 is having profound impacts on girls and young women themselves and on DREAMS programs, with many activities suspended and the pandemic fueling the very risks that AGYW face for HIV. Girls and young women and their families are sometimes reluctant to let the girls go to the safe spaces, and Covid-19 restrictions make it difficult for mentors to communicate with their DREAMS girls. The economic fallout has given rise to increased transactional sex, and efforts to decongest health facilities means that AGYW may not access services for HIV, STIs, and family planning. In countries around the world, Covid-19 has led to an increase in cases of GBV, fueled by strains at the household level and the fact that schools were closed for so long. According to Patrick Fine, president of FHI360, "The pandemic has changed everything with respect to a comprehensive approach to prevention and treatment of HIV—not only the public health aspect, but it's broadened to think about the impact of the social and economic shocks and aftershocks for years to come."[63]

In its January 2021 National Strategy for the Covid-19 Response and Pandemic Preparedness, the Biden administration recognized the necessity of mitigating the secondary impacts of Covid-19 on health and development outcomes for women and girls. The strategy specifically mentions the need for the U.S. government to recommit to sexual and reproductive health and rights and to advance gender parity, diversity, and inclusion.[64]

Programs have worked to mitigate the impact of the Covid lockdowns through providing online and social media messages (including WhatsApp, SMS, and Facebook) and sometimes home delivery of drugs and testing, but these measures do not replace the DREAMS services. For clinical services, including SRH and HIV, the pandemic has created disincentives to go to health facilities, a situation even more acute for SRH and youth-friendly services. The shift to online or virtual forums has presented particular challenges for AGYW since at-risk AGYW often do not have smartphones or cell phones to participate in such virtual programs, or cannot afford airtime or data, or they rely on the phones of their families or boyfriends, which raises important privacy and confidentiality concerns. Accordingly, efforts by mentors and peer educators to stay connected with the AGYW participants become more challenging and require redoubled efforts to maintain those connections and ensure that the AGYW can access available services. "Technology is a double-edged sword," Daniel Were of JHPIEGO in Kenya explained. "Not all AGYW have access to phones, many use their partners' or their mother's phone, which is a huge challenge for programs . . . We push to be tech savvy, but it might also be a risk driver."

PEPFAR has put out guidance on Covid, including for AGYW. This included maintaining contact to the extent possible with DREAMS participants via phone/SMS/WhatsApp/digital platforms and following local guidelines for group activities and gatherings, but where feasible, DREAMS services should be offered with appropriate social distancing.[65] PEPFAR has emphasized that maintaining contact with AGYW is a priority during this time, and mentors and facilitators who work with DREAMS should have access to cellphone airtime so they can continue activities through digital platforms to keep AGYW engaged. PEPFAR has recommended that PrEP services be moved out of health clinics and that implementers use virtual options when possible.

Going forward, DREAMS will need to develop a plan to regain the momentum and ground lost due to Covid-19. This will require serious rethinking of approaches; while current data on the full impact of Covid-19 is still thin, the impacts are believed to be very grave, not transitory or ephemeral, and the operating environment is going to be very different.

The economic fallout has given rise to increased transactional sex, and efforts to decongest health facilities means that AGYW may not access services for HIV, STIs, and family planning.

Dr. Linda-Gail Bekker reflected about how to tell the story in a different way, now that we've seen how fragile the services are: "What should we do differently with Covid, but with the inherent successful ingredients from DREAMS?" She continued: "How do we hit the ground running?"[66] Some of the key pieces she identified were bringing services to young people where they are—in school, through mobile services, and in communities as well as through health facilities. She also addressed the critical issue of funding, saying: "There's a drive to fit into historical, facility based, nurse based services—a one dimensional structure. We need to cut loose, be community based, involve other cadres, including peers. How do we do it?"[67]

Multilateral, Regional, and National Responses on AGYW and HIV

Attention to AGYW and HIV has risen in recent years, accompanied by new political awareness and commitments on AGYW from national, regional, and multilateral actors. Key global health institutions, including UNAIDS, UNICEF, the United Nations Population Fund (UNFPA), and the World Health Organization (WHO), have all exhibited high-level political will on the issues of AGYW and HIV, but that was not accompanied by any targeted funding. The African Union has also produced numerous policy documents related to youth, including AGYW, as well as sexual and reproductive health and rights.[68]

She Conquers in South Africa was a three-year national campaign targeting 15–24-year-old AGYW, which was supposed to take DREAMS beyond the priority districts to the whole country. Launched in 2016, She Conquers became the umbrella under which DREAMS and the Global Fund operate in the country. Other notable national initiatives include Malawi's strategy on AGYW, though it has yet to be effectively implemented. Most countries still struggle with instituting real policy change to address gender inequalities and harmful gender norms because national policymakers themselves often reflect the judgmental attitudes toward AGYW, especially around young women and sexuality. A stark example of this reality is in Tanzania, where the former president overrode an effort to allow girls who had been pregnant to return to school.[69]

The Global Fund

The Global Fund is a financing entity that supports and finances country efforts to combat AIDS, TB, and Malaria, and its strategy includes a focus on gender and human rights barriers. In its 2017–2022 strategy, the Global Fund committed to supporting programs focused on AGYW, including advancing sexual and reproductive health and rights.[70] As part of this, the Global Fund has been trying to incentivize and push countries further on the issue of girls and young women and has increased its investments five-fold. As the Global Fund begins consultations to develop its new strategy that will begin in 2023, its support for AGYW and gender equality should be a central element of its work, especially in high burden countries in southern and eastern Africa.

The Global Fund's work on girls and young women has evolved in recent years, centered around two types of catalytic investments. For the 2017–19 cycle, the Fund launched a matching funds program, using $55 million to support countries to scale up services for AGYW in 13 countries, with the goal of reducing HIV incidence among 15–24-year-old AGYW by 58 percent by 2021. Another $55 million in matching funds is included in the current allocation, with the goal of reaching one million AGYW.[71] The Fund will invest an additional $140 million to address structural barriers faced by AGYW,[72]

At Kanyamedha DREAMS Safe Space in Railways Ward, Kisumu, Kenya, a clinician discusses the PrEP initiation process with a young woman.

PHOTO CREDIT: AFYA ZIWANI/SARETTO ALICE

including promoting behavior change and increasing access to biomedical interventions, like PrEP.

A second type of investment came in 2018 when the Global Fund launched the HIV Epidemic Response (HER) fund, which aimed to mobilize partnerships with the private sector on AGYW and HIV in 13 focus countries in eastern and southern Africa. The HER Fund ended in December 2020, but the Global Fund says that AGYW and gender equality remain a priority of the Private Sector Engagement Department.[73] In 2020, the Global Fund approved $8 million for the Strategic Initiative on Adolescent Girls and Young Women (AGYW-SI). This initiative aims to ensure that Global Fund investments support countries to invest in girls and young women, including scaling up prevention technologies and commodities in SRH platforms and improving grant performance through capacity building of implementers. [74]

The Global Fund's record of support for country programs on girls and young women has been mixed. In the first phase of AGYW work, roughly from 2016–19, the Global Fund programming was not as structured on a core package as DREAMS was. However, beginning with its new phase in April 2020, the Fund is moving toward a similar core package of interventions. In many countries, it has had weak coordination across programs and often limited capacity in its principal recipients. Like DREAMS, its ability to track what services were offered to which AGYW has also been difficult. In some countries, the Global Fund programs are adopting biometric systems to improve data quality. In South Africa, for example, the Global Fund is working in 10 priority districts and 12 subdistricts, but it has been difficult to ensure program continuity through the government and the country coordinating mechanisms (CCMs). The Global Fund also supported South Africa's national campaign, She Conquers. Since the Global Fund operates from Geneva and does not have an on-the-ground presence, it is not built to manage complex programs, including those for girls and young women.

Many observers have expressed concern that if the Global Fund is unable to reach its goal of reducing incidence by almost 60 percent, this focus on AGYW will be deemed a failure. Similarly, if the matching funding strategy isn't seen to produce results, the Global Fund "might not have the appetite to invest."[75] As one observer put it: "Some of the Global Fund investments are more distill, more structural support for girls not coupled with HIV prevention."[76]

Challenges for DREAMS

Despite its many achievements, many challenges remain for DREAMS. Some of these challenges relate to the hard, long-term work of addressing harmful gender norms which lie at the core of the risks AGYW face. DREAMS also faces many of the same challenges as PEPFAR does more broadly, notably the intense pressure from headquarters on implementing partners to get results—sometimes at the cost of building the necessary partnerships and connections with host governments. DREAMS has also struggled with the interagency process, which sometimes devolves into turf wars over funding and responsibilities and leads to difficulties coordinating programs either at the country level or at headquarters. Other challenges include the following areas.

Data and Evidence of What Works and How

DREAMS was not designed to answer the question about what a minimum package of interventions might be, what parts of the current package could be strengthened to best address the needs of different age groups and contexts, and what the cost implications would be. DREAMS was specifically designed to address the broader set of biological, behavioral, social, and structural factors that influence HIV risk since the narrower HIV-only vertical approaches had not been successful. However, as interest in the DREAMS approach expands, additional evidence is needed to unpack if there are possibilities to streamline or tailor a multisectoral package to meet AGYW's diverse needs and maximize HIV outcomes.

Multicountry research and evaluation efforts were supported by the Bill & Melinda Gates Foundation as part of their contribution to DREAMS. "Everyone is hungry to know how to tailor the 'best' or most effective package of activities in different geographic contexts or with different subpopulations, but funding is not currently available to answer those questions," explained Julie Pulerwitz of the Population Council.[77] However, in recent years, many donors, including PEPFAR, have moved away from collecting implementation or operational evidence around what's working and what's not, even though this information is critical as programs expand to other countries or are taken up by other donors such as the Global Fund or national ministries of health. While PEPFAR is monitoring big data sets to track who is being reached, there is little appetite at the moment to generate evidence with global, regional, and local lessons. Accordingly, ongoing measurement of the DREAMS impact, and determining what can be attributed to DREAMS as opposed to other interventions, remains difficult and complicated.

PEPFAR reports DREAMS progress in terms of numbers of AGYW reached and having completed the DREAMS package and declines in "new diagnoses" among AGYW attending antenatal clinics from DREAMS sites. While

DREAMS is often described as focusing on reducing HIV incidence among AGYW, the decline in new diagnoses at antenatal care (ANC) clinics is meant to be a marker of incidence because HIV transmission often occurs around the time of sexual debut or first pregnancy.[78] In addition, PEPFAR officials acknowledge that it is difficult to determine the denominator but contend that the new diagnoses in ANC clinics helps provide real-world data that can show whether the programs seem to be working. That said, new HIV diagnoses in ANC are a different indicator and reflect those AGYW who are already pregnant, and therefore by definition already had unprotected sex. Critics of the way DREAMS has been implemented and measured have called this indicator a meaningless marker, since you have no idea of what the denominator is.

Coordination with U.S. Agencies and with Host Governments

The DREAMS model brings in numerous stakeholders, implementing partners from USAID and the CDC, different ministries from the national government, local authorities, and community-based organizations, as well as coordinating geographic locations with the Global Fund. While many DREAMS country teams believe that coordination has improved over time, it still remains challenging. Given the multisectoral nature of DREAMS, it is critical to engage a range of government ministries and local government mechanisms.

National government officials have often considered DREAMS to be parallel activities not integrated into government systems. The importance of coordinating effectively with national governments was expressed by Hasina Subidar, who headed She Conquers in South Africa: "Ultimately, what's offered has to be driven by the needs of the country—health, education, social development—the key departments dealing with challenges need to give clear direction."[79] Since one metric of whether the initiative holds prospects for enduring impact is whether the host governments take on ownership and invest in it, these considerations should be a part of DREAMS country strategies and engagement with host governments going forward.

In Kenya, DREAMS faced criticism from the government for building programs separate from government systems and adopting a one-size-fits-all approach. "The way it was implemented, as soon as the money is not coming through, it will collapse, since it hasn't harnessed or leveraged existing national systems," according to Nduku Kilonzo, former executive director of the National AIDS Control Council.[80] Overall, she pointed to the fundamental problem of fragmentation of financing in the way partners are organized and the way donors fund projects.

Engaging Male Partners

Girls and young women do not exist in isolation, and empowering young women only to send them back to the same environments is unlikely to produce sustainable impacts. Accordingly, interventions for AGYW have to be accompanied by targeted programs to reach their male partners and their families. Efforts have focused on reaching young men with testing, so that they can be linked to treatment if they are positive and offered VMMC and counseling on condom use and prevention if they are negative. The need to focus on younger age groups of girls and boys is also critical, with the aim of instilling health-seeking behaviors and equitable gender norms before they become sexually active. While PEPFAR has launched another public-private partnership focused on men called MenStar,[81] which works to expand HIV diagnosis and treatment for men, it does not have a specific focus on prevention for adolescent boys and young men.

Changing Gender Norms

The gender norms and social drivers that underlie girls' and young women's risk of HIV constitutes a central, long-term challenge for DREAMS. The process of changing the community-level, cultural attitudes toward women's and girls' leadership and empowerment and the stigma surrounding young women and sexuality is not easy or fast. A blog by Angeli Achrekar, the principal deputy global AIDS coordinator, in July 2020 summarized these issues: "AGYW too often learn that they are not worth educating, that they are most valuable inside their parents' or husband's home, that violence is a part of life to be expected and silently endured, that sex is a taboo topic even when one is young and pregnant, and that most jobs in most industries are for men. These deeply entrenched and often intractable norms are significant barriers to AGYW staying HIV negative."[82]

These norms are also reflected in the attitude of healthcare workers and the lack of youth-friendly services. In many

A safe space session with young women 20–24 enrolled in DREAMS at the Matero Main DREAMS Center, in Lusaka, Zambia.

PHOTO CREDIT: PACT ZAMBIA

situations, girls and young women face judgmental attitudes from healthcare providers, especially around HIV and SRH services that indicate that the young women are sexually active and often unmarried. These attitudes can constitute barriers to access for SRH, HIV, and STI services.

Sustainability, Cost, and Transition to Local Partners

DREAMS is an expensive model, which raises questions about how it can be expanded and sustained by the host governments and how the core package of services can be integrated into what national ministries are doing. Efforts to ensure that DREAMS programs are embedded in local systems are essential or the risk is, in the words of Gina Dallabetta from the Bill & Melinda Gates Foundation, "when the funding ends, there won't be any lattice there to build on."[83] National leaders and implementing partners are well aware that if the DREAMS and Global Fund funding is removed, the services won't continue. This remains a huge issue with great consequence for the viability of DREAMS going forward.

As DREAMS is poised to transition to local partners in 2021, the program faces challenges in ensuring that quality is maintained and that the new partners are given the necessary technical support and capacity strengthening to continue the interventions. The implementing partners have struggled to meet the level of quality required and to produce the reporting and data required by PEPFAR, and those tasks will not be any easier for local organizations who often have less experience in working with the U.S. government.

Implications for U.S. Policy

The confluence of the dual pandemics of HIV and Covid-19, both exacting high tolls directly and indirectly on AGYW and threatening years of progress, has injected new urgency into the need to address the health and development crises faced by AGYW. At the same time, this is a complicated moment of transition for U.S. policy, with an amalgam of agendas on global health security, global health and development, and gender policy, along with resetting and restabilizing existing programs to better fit new realities. In this context, PEPFAR is well placed to demonstrate the value of DREAMS without overstating its successes or understating its weaknesses.

The Biden-Harris administration has an opportunity to advance a strategic vision around securing a healthy future for the growing population of girls and young women as key to the response to HIV and to Covid-19. This fits directly into the administration's stated focus on gender equity and would generate returns for U.S. national interests in the broader prosperity, stability, and health security of these countries. This includes reaching long-standing U.S. goals on global health, poverty reduction, economic development, conflict prevention, and humanitarian response. Such an approach should build on the existing platform of DREAMS, adapting and amplifying its focus on AGYW as a priority health and development initiative for the U.S. government. To be successful, this will require a determined effort by the administration to work with the U.S. Congress to elevate attention and ensure sufficient funding, while also engaging the national governments and other bilateral and multilateral donors.

The advent of the Biden-Harris administration provides a new framework within which to develop a robust U.S. strategy on the health and development needs of AGYW. With new structures being created within

In countries battling HIV epidemics, efforts to tackle the health and economic impacts of Covid-19 will not succeed without also addressing the fundamental challenges of HIV and gender inequality, which increase risk and vulnerability, especially for AGYW.

the executive branch—notably the new White House Gender Policy Council and new, senior positions on global health and global health security at the National Security Council, in addition to new leadership at the State Department, USAID, CDC, and PEPFAR—the administration has an opportunity to make a focus on AGYW a central priority, building on proven interventions and innovative financing mechanisms. This includes mobilizing resources for women's and girls' economic empowerment through the U.S. International Development Finance Corporation—and expanding public-private partnerships—to include impact investing and social impact bonds.

High-level U.S. leadership will be essential to carry this forward and will require administration officials and congressional champions to demonstrate commitment and engagement to recognize and accelerate what has worked and what U.S. investments have already achieved. This also means that the U.S. will have to operate with greater multilateralism and humility, learning from communities, governments, and AGYW themselves, and joining them as a supportive partner.

A key question is whether the administration and Congress can stimulate a whole-of-government approach, going beyond PEPFAR to ensure that other U.S. agencies provide essential cross-agency expertise and resources. In areas relating to social and economic support—including education for girls, GBV prevention and response, economic empowerment and livelihood support, SRH services, and food security—PEPFAR may not be the best equipped to address these issues. Since AGYW constitute a critical population for achieving longer-term global health and development goals, other U.S. agencies should be engaged to take ownership of different aspects of DREAMS programming. The U.S. Congress has a critical role to play in ensuring the resources and flexibility to fund continued innovation to address HIV prevention and to implement longer-term programming.

Although some conservative members of Congress and faith-based organizations may push back against programs that improve access to SRH information and services for AGYW, often linked to differing views on abortion, this should not be a barrier for action on AGYW. A broad, bipartisan coalition in the United States supports access to women's health services—from availability of a range of contraceptive methods to maternal healthcare, to cervical and breast cancer screening, to STI and HIV prevention and treatment—as well as access to programs to support education for girls to prevent and respond to GBV, and to prevent child marriage. The DREAMS platform can be leveraged to advance U.S. and global goals in all these areas. Whether DREAMS remains an area of bipartisan cooperation in the current, deeply polarized congressional environment, however, remains to be seen and will require strong external and internal champions.

While Covid-19 and vaccine distribution will dominate U.S. global health policy in the near term, these issues do not exist in a vacuum. In countries battling HIV epidemics, efforts to tackle the health and economic impacts of Covid-19 will not succeed without also addressing the fundamental challenges of HIV and gender inequality, which increase risk and vulnerability, especially for AGYW. To launch such a timely and targeted response, the Biden-Harris administration should build on the existing platform of DREAMS, adapting and amplifying its focus on AGYW as a priority health and development initiative.

About the Author

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ENDNOTES

1 Grace Njobvu, interview with CSIS, June 2020.

2 Ambassador Deborah Birx, U.S. Global AIDS Coordinator, "The DREAMS Partnership," PowerPoint presentation, December 14, 2020.

3 The 10 original DREAMS countries were Eswatini, Kenya, Lesotho, Malawi, Mozambique, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe, and then five more were added—Botswana, Côte d'Ivoire, Haiti, Namibia, and Rwanda. DREAMS is doing some programming in South Sudan on GBV and transactional sex.

4 Catherine Conner, vice president of public policy and advocacy, EGPAF, interview with CSIS, October 5, 2020.

5 Linda-Gail Bekker, deputy director of the Desmond Tutu HIV Center at the University of Cape Town and CEO of the Desmond Tutu HIV Foundation, interview with CSIS, June 10, 2020.

6 See AVAC, "Landmark Trial in East and Southern Africa Finds Injectable PrEP Safe and Effective for Cisgender Women," Press release, November 9, 2020, https://www.avac.org/press-release/landmark-trial-finds-injectable-prep-safe-and-effective; International Partnership for Microbicides, "Two Large Studies Show IPM's Monthly Vaginal Ring Helps Protect Women Against HIV," Press release, February 2016, https://www.ipmglobal.org/publications/two-large-studies-show-ipm's-monthly-vaginal-ring-helps-protect-women-against-hiv.

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8 "DREAMS Partnership," U.S. Department of State, https://www.state.gov/pepfar-dreams-partnership/.

9 Ruth Laibon-Masha, CEO of Kenya's National AIDS Control Council (NACC), interview with CSIS, November 10, 2020.

10 Tulio de Oliveira et al., "Transmission networks and risk of HIV infection in KwaZulu-Natal, South Africa: a community-wide phylogenetic study," *Lancet HIV* 4 no. 1 (January 2017): e41-e50, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5479933/.

11 Quarraisha Abdool Karim, interview with CSIS, Durban, South Africa, February 13, 2019.

12 Amb. Deborah Birx, presentation at CSIS event, "U.S. Approaches to Preventing HIV in Adolescent Girls and Young Women" (Washington, DC, July 20, 2017), https://www.csis.org/events/us-approaches-preventing-hiv-adolescent-girls-and-young-women-lessons-malawi.

13 Kaymarlin Govinder and Nana K. Poku, eds., Preventing HIV Among Young People in Southern and Eastern Africa: Emerging Evidence and Intervention Strategies (London: Routledge, 2020), https://www.taylorfrancis.com/books/preventing-hiv-among-young-people-southern-eastern-africa-kaymarlin-govender-nana-poku/e/10.4324/9780429462818.

14 Jennifer Kates, senior vice president and director of global health and HIV policy, Kaiser Family Foundation, interview with CSIS, September 30, 2020.

15 For example, in its report to Congress, the administration was expected to include a "description of specific strategies developed to meet the unique needs of women," including empowering women in interpersonal situations; empowering young people and children, including orphans and victims of the sex trade, rape, sexual abuse, assault, and exploitation; encouraging men to be responsible in sexual behavior; increasing women's access to employment opportunities, income, productive resources, and microfinance; and educating women and girls about the spread of HIV/AIDS. The legislative earmark required that 33 percent of all prevention funds be used for abstinence-until-marriage programs, which affected PEPFAR's ability to design effective and balanced prevention programs for women and girls. In addition, the formulation "abstinence until marriage" did not reflect that marriage itself could be a risk factor because married women are often unable to protect themselves or to negotiate condom use, and could hamper efforts to prevent the practice of child marriage. The legislation also included a requirement that funding recipients have a policy opposing prostitution, which many observers feared would undermine outreach efforts to sex workers, an extremely high-risk group.

16 The areas are increasing gender equity in HIV/AIDS activities, including maternal and reproductive health systems; addressing male norms and behavior, including at school and the workplace; reducing violence and coercion; increasing women's and girls' access to income and productive resources and education; and increasing women's and girls' legal rights and protection. The GBV initiative, which focused on Tanzania, Mozambique, and the Democratic Republic of Congo (DRC), was an

interagency effort to integrate activities to address GBV into existing HIV programs at the health facility and community levels, as well as at the national policy level.

17 See "Violence against Children and Youth Surveys and the U.S. President's Emergency Plan for AIDS Relief," CDC, https://www.cdc.gov/violenceprevention/childabuseandneglect/vacs/pepfar.html.

18 Amb. Deborah Birx, speaking at CSIS event, "Addressing HIV Risk in Adolescent Girls and Young Women," (Washington, DC, April 17, 2015), https://www.csis.org/events/addressing-hiv-risk-adolescent-girls-and-young-women.

19 Lucie Cluver, email correspondence with CSIS, February 21, 2021.

20 Emily Bass, interview with CSIS, July 2, 2020.

21 Wanjiru Mukoma, former executive director of LVCT Health, interview with CSIS, November 4, 2020.

22 Jerry Okal, researcher, Population Council in Kenya, interview with CSIS, June 5, 2020.

23 Birx presentation at "U.S. Approaches to Preventing HIV."

24 Janet Saul, presentation for PEPFAR DREAMS meeting, "DREAMS," December 14, 2020.

25 Ibid.

26 Kelly Curran, senior director for HIV and infectious diseases, JHPIEGO, interview with CSIS, June 4, 2020.

27 PEPFAR, "DREAMS Innovation Challenge," communication from PEPFAR, January 2021.

28 Isolde Birdthistle and Sian Floyd, presentation at PEPFAR meeting on DREAMS, "What is the evidence of DREAMS' Impact? Findings from an independent evaluation of DREAMS in 4 settings," London School of Hygiene and Tropical Medicine, December 2020.

29 Isolde Birdthistle, correspondence with CSIS, February 25, 2021.

30 Another indicator is GEND_GBV, which counts post-violence care service delivery for post-rape or emotional/physical violence. However, service delivery points have to offer a minimum package of services or they can't be counted; that means that if they don't provide PrEP or emergency contraception, for example, they can't be counted. The result is that the GBV services that are counted are mostly clinical- and facility-based, which excludes community-based GBV services. Similarly, the PrEP indicator has been criticized: neither PrEP_NEW, which measures the number initiated on PrEP during the reporting period, nor PrEP_CURR, which measures the total number receiving PrEP during the reporting period, measures continuation on PrEP. Unlike ART, it wouldn't be expected that AGYW would continue on PrEP for their entire lives (unless they are in a discordant relationship that lasts through the rest of their lives), and the current indicators don't measure the success of the PrEP program in changing the risk profile of AGYW based on how long they stayed on PrEP. There is supposed to be a link between the OVC indicators and DREAMS since they measure service delivery and HIV status for OVC, but that too is complicated since in some countries, like South Africa, only USAID has PEPFAR funding for OVC programs, so the CDC doesn't report on OVC indicators. Finally, the indicator KP_PREV measures the number of key populations (KPs) reached with individual or group prevention interventions designed for a target population. DREAMS too can serve KPs, focused on AGYW who are sex workers. But in some countries, like South Africa, it's illegal for minors to sell sex, so under the Sexual Offenses Act, anyone witnessing sex with a minor would be required to report it, which makes programs shy away from that.

31 Jan-Walter De Neve, Günther Fink, S V Subramanian, Sikhulile Moyo, and Jacob Bor, "Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment," *Lancet Global Health* 3, no. 8 (August 2015): e470-e477, https://pubmed.ncbi.nlm.nih.gov/26134875/.

32 In 2019, the U.S. government launched an innovative, $90 million program in Malawi to address access to secondary education for young people, including AGYW. Through the Secondary Education Expansion for Development (SEED) project, PEPFAR joined with the CDC, Peace Corps, and USAID to finance the construction of 96 new classrooms in 30 overcrowded secondary schools and the construction of 200 community secondary schools. The goal is to improve both education and health outcomes, including reducing HIV. In launching the project, the U.S. ambassador emphasized the importance for AGYW: "Keeping girls in school helps reduce HIV infection rates by over 36 percent. It prevents child marriage and early pregnancy. It increases economic self-sufficiency and prosperity. SEED will serve as a powerful partner to the U.S. Government's

DREAMS initiative, which is designed to reduce HIV infections among the most vulnerable girls and young women." U.S. Embassy in Lilongwe, "Secondary Education Expansion for Development (SEED) Groundbreaking," U.S. Embassy Malawi, October 8, 2019, https://mw.usembassy.gov/secondary-education-expansion-for-development-seed-groundbreaking/.

33 The guidance centered on five models: ELA (BRAC), Siyakha (Bantwana), WINGS+ (AVSI), Vusha Girls (ACWICT), PI (personal initiative), and STEP (Leuphana University).

34 "Girls Who Dream," Together for Girls, https://www.togetherforgirls.org/girls-who-dream/.

35 Birx presentation at "U.S. Approaches to Preventing HIV."

36 The Together for Girls (TfG) partnership promotes country-led data collection, coordinated action, and advocacy. Since 2009, TfG has worked to address violence against children and women, with particular attention to sexual violence in adolescence. Under the TfG model, governments are supported to conduct a national household Violence Against Children Survey (VACS) and to use the data to mobilize action through policies and programs that embed the issue across sectors and partners. Every DREAMS country either has or will have a VACS by the end of 2022.

37 "Girls Who Dream," TfG.

38 Sanyukta Mathur, Jerry Okal, and Julie Pulerwitz, "Implementing a Multi-Sectoral HIV Prevention Program: Insights from the DREAMS Implementation Science Portfolio" (presentation at PEPFAR DREAMS annual meeting, December 14, 2020).

39 In some countries, GBV one-stop centers have been established, such as at the University Teaching Hospital in Lusaka, Zambia. The goal of these centers is to provide a full range of GBV services, including legal and psychosocial support, often referring and accompanying the AGYW to health facilities for medical services such as post-exposure prophylaxis (PEP). But such centers face many challenges; the psychosocial services, including mental health services, remain very weak. One-stop centers in capital cities are often inaccessible for AGYW survivors because the centers are far from where the AGYW live. Accordingly, as one USAID representative noted, the number that access the one-stop centers is "dismally low."

40 The trial enrolled 7,829 HIV-negative, sexually active women aged 16–35 in Eswatini, Kenya, South Africa, and Zambia. After an informed consent process, each woman was randomly assigned one of the three contraceptive methods. The women were tested for HIV every three months and referred to HIV treatment if they tested positive. Meanwhile, they were provided with HIV counseling.

41 "FP/RH Priority, Assisted, and Graduated Countries," USAID, https://www.usaid.gov/global-health/health-areas/family-planning/countries.

42 The Helms Amendment (1973) prohibits the use of U.S. foreign assistance to pay for abortion as a method of family planning or to motivate or coerce any person to seek abortion. The Kemp-Kasten Amendment (1985) prohibits funding to any organization that supports or participates in coercive abortion or involuntary sterilization. The Tiahrt Amendment (1998) prohibits the use of targets, quotas, or financial incentives in family planning projects. See "The U.S. Government and International Family Planning & Reproductive Health: Statutory Requirements and Policies," Kaiser Family Foundation, June 30, 2020, http://kff.org/global-health-policy/fact-sheet/the-u-s-government-and-international-family-planning-reproductive-health-statutory-requirements-and-policies/.

43 PEPFAR, *The President's Emergency Plan for AIDS Relief 2021 Annual Report to Congress* (PEPFAR, 2021), https://www.state.gov/wp-content/uploads/2021/02/PEPFAR2021AnnualReporttoCongress.pdf.

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45 Daniel Were, JHPIEGO, interview with CSIS, September 16, 2020.

46 Interview with PEPFAR representative, October 15, 2020.

47 Quarraisha Abdool Karim, interview with CSIS, June 22, 2020.

48 Jerry Okal, interview with CSIS, December 15, 2020.

49 EGPAF, interview with CSIS, November 12, 2020.

50 Interview with a U.S. agency representative, October 9, 2020.

51 USAID Kenya, interview with CSIS, February 11, 2021.

52 Ibid.

53 PATH implements DREAMS in Homa Bay, Kisumu, and Migori counties. Its results include: Between October 2017 and March 2019, 41,432 AGYW completed DREAMS primary package; 5,315 received school fees in FY 2018 and 5,191 were supported to continue in secondary school in FY 2019; the creation of more than 200 safe spaces; and improved access to youth-friendly family planning, HIV, and GBV services. In FY 2018, none of the more than 65,000 AGYW seroconverted, and in FY 2019, only one of the nearly 28,000 AGYW seroconverted. By contrast, in 2017, new infections among 15–24-year-olds in those three counties represented 26 percent of the national total. See: "The Power of DREAMS: HIV Prevention for AGYW in Western Kenya," USAID and PEPFAR, https://path.azureedge.net/media/documents/DREAMS_Kenya_Overview_branded_FINAL.pdf.

54 PEPFAR characterizes the most vulnerable AGYW as "being out-of-school, orphaned, inconsistent condom use, having more than one sexual partner in the last six months, having sex with older men or engaging in transactional sex/sex work, having an STI, being married early, and experiencing some form of violence." See: PEPFAR, Country Operational Plan (COP/ROP) 2020, Strategic Direction Summary (PEPFAR, July 2020), https://www.state.gov/wp-content/uploads/2020/08/Kenya-COP20-SDS-Final.pdf.

55 USAID Kenya, interview with CSIS, February 11, 2021.

56 Misozi Siwela and Lovemore Nkhoma, PACT Zambia, interview with CSIS, June 4, 2020.

57 DREAMS staff have been trained with USAID on regulations and guidelines for family planning. Any AGYW below the age of 16 requires the consent of a parent or guardian.

58 Siwela and Nkhoma interview.

59 U.S. Mission South Africa, "U.S. PEPFAR Expands DREAMS Program, Investing R1.4 billion in South Africa's Young Women," Press release, October 15, 2020, https://za.usembassy.gov/u-s-pepfar-expands-dreams-program-investing-r1-4-billion-in-south-africas-young-women/.

60 Kaymarlin Govinder and Gavin George, HEARD, University of KwaZulu Natal, interview with CSIS, February 10, 2021.

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71 Caya Lewis Atkins, The Global Fund, email correspondence with CSIS, December 8, 2020.

72 "Women and Girls," The Global Fund, https://www.theglobalfund.org/en/women-girls/.

73 According to the Fund, the private sector partners include ViiV Healthcare, Fondation Chanel, Comic Relief U.S., the Absa Group, and The Coca-Cola Company.

74 Lewis Atkins email correspondence. Currently, the main contributions from the private sector include ViiV Healthcare, which supports HER Voice Fund, a civil society initiative to support AGYW in the 13 focus countries and to support AGYW leadership; Fondation Chanel, to

support women and girls in francophone West Africa; Comic Relief U.S., which provided $3 million to support South Africa to reach over 26,000 AGYW with HIV testing and PrEP; Comic Relief UK, which provided $3 million for AGYW in Malawi; the Absa Group, which will focus on GBV and finance initiatives for AGYW in South Africa; The Coca-Cola Company, which is supporting the Girls Champ initiative on behavior change for youth in Eswatini.

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COVER PHOTO

A DREAMS ambassador at Nyalenda DREAMS Safe Space in Nyalenda Ward, Kisumu County.

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