PEPFAR DREAMS Guidance

Updated March 2021

Determined | Resilient | Empowered | AIDS-Free | Mentored | Safe

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Why DREAMS

Adolescent girls and young women (AGYW) face an increased vulnerability for HIV acquisition when compared to their peers. Globally, there are 20 million women living with HIV (1), and young women age 15-24 are two to 14 times as likely to acquire HIV than males of the same age, dependent on country (2)(3) Around 5,000 young women become infected with HIV each week and in sub-Saharan Africa, girls and young women account for four out of five new HIV infections among youth age 15-24 (2)(1). Additionally, data show AGYW are a priority population to target in order to reduce new infections to reach HIV epidemic control (1)(2)(3).

Routine HIV prevention activities have not been effective in reaching this subpopulation. An evidence-based and comprehensive program is necessary to prevent new infections for an AIDS-free generation.

What is DREAMS?

In order to prioritize AGYW's health and wellbeing, and reach HIV epidemic control, PEPFAR announced an ambitious public-private partnership, the Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe (DREAMS) partnership, on World AIDS Day in 2014. DREAMS is currently implemented in 15 countries in partnership with the Bill and Melinda Gates Foundation, Girl Effect, Gilead Sciences, ViiV Healthcare, and Johnson & Johnson. DREAMS success depends on collaboration and coordination with national and local government officials and other relevant stakeholders and community partners including AGYW themselves. DREAMS targets vulnerable AGYW (10-24 years) in communities with a high burden of HIV who are at an increased risk of acquiring HIV due to various demographic, geographic, behavioral, and structural reasons. The DREAMS core package is an evidence-based/informed, age-appropriate, comprehensive package of biomedical, behavioral, and structural interventions across multiple sectors shown to mitigate the risk factors that may lead to HIV infection. Additionally, DREAMS provides contextual interventions to shift community norms and perceptions in order to create an enabling environment that supports HIV prevention.

DREAMS, delivered in partnership with the country's government and relevant stakeholders, provides a comprehensive package of core interventions to address key factors that make adolescent girls and young women particularly vulnerable to HIV. These include behavioral factors (i.e. multiple sex partners, condom-less sex), and family dynamics and structural barriers (i.e. gender-based violence, exclusion from economic opportunities, and a lack of access to secondary school). This model suggests a variety of

interventions in order to synergize the approach to reduce risk of HIV and mitigate the factors that lead to HIV (i.e. school drop-out, alcohol use/misuse, unprotected sex) (5) (6) (7). These specific interventions will be explored in more detail throughout this document.

This document details the process for planning, implementing, monitoring and evaluating a DREAMS program, and makes reference to other documents found on PEPFAR SharePoint and/or in the appendix. It utilizes findings from literature, evidence-based best practices, and specific DREAMS studies.

DREAMS Program Implementation

Evidence-based decisions, government buy-in, stakeholder engagement and programming for impact are necessary in planning a DREAMS program. Globally accepted literature and guidance must be thoroughly understood and adapted to a country context in agreement with stakeholders, implementers and DREAMS ambassadors as AGYW representatives. By working within government structures and by prioritizing AGYW within all levels of planning and implementation, DREAMS aims to be effective and sustainable (5).

This section covers stakeholder engagement, geographic and demographic prioritization and core package planning.

Who needs to be involved: Working with stakeholders, governments and AGYW to build DREAMS

PEPFAR resources alone will not be sufficient to permanently reduce the vulnerabilities of AGYW to achieve an AIDS-free generation. Policy, structural, and system reforms within the current local health, education, and judicial systems are necessary to ensure the sustainable impact of these interventions.

PEPFAR has learned several important lessons for ensuring that DREAMS programs are poised to sustain the gains made in reducing new HIV infections. These lessons include leveraging key stakeholders, decision makers and DREAMS AGYW (i.e., program participants, ambassadors, mentors) to assure buy-in and input. Given the nature of the DREAMS core package, multi-sectoral stakeholder political will and shared responsibility are essential for success and sustainability, as this is likely dependent on integration into existing government-supported systems and structures.

Government engagement and leadership in planning and management of HIV activities is essential, both at the beginning and throughout the program cycle. Multi-sector engagement, including engaging government leadership, leveraging political will and utilizing task sharing through direct commitments, is essential to the DREAMS Partnership. This extends to other key leaders and stakeholders as well. It is crucial to work directly with other donors such as Global Fund and relevant UN agencies to reach more AGYW across all platforms. Collaborative planning and decision making between the government, key stakeholders including civil society, and donors (PEPFAR, Global Fund and UN) enables governments to lead and commit vital resources to these efforts, while improving complementary programming across donors.

Country team and HQ engagement with AGYW living with HIV and AGYW who are vulnerable to acquiring HIV informs our programming and makes it more responsive. A key component of DREAMS are DREAMS ambassadors. DREAMS ambassadors are current or former DREAMS participants who play a variety of roles including recruiting AGYW, providing interpersonal support of AGYW during service

delivery, and representing AGYW and fellow DREAMS participants in local, national, and global meetings. DREAMS ambassadors are selected by implementing partners based on leadership skills, interest in advocacy and local knowledge of the community.

Beginning in COP20, country teams are required to work with partners to hire DREAMS Ambassadors as district-level coordinators to lead DREAMS coordination and promotion at the provincial, regional and/or district level (depending on context). For example, this local coordinator helps streamline communication between facility and community partners, PEPFAR and other donors, government bodies and AGYW for efficiency and overall programmatic impact. These coordination efforts are meant to empower AGYW and ensure that AGYW input remains at the center of design, implementation, and coordination of DREAMS.

Policy, structural, and system reforms within the current health, education, and judicial systems are often necessary to ensure the sustainable impact of these interventions. For example, ensuring universal access to primary and secondary education for girls regardless of whether they are pregnant or have children is essential to achieving DREAMS outcomes. Additionally, advocating for accessible family planning is important since restricting access to contraception hinders DREAMS goals. Providing equitable family planning services can be leveraged as part of a partnership with local government. In the justice sector, enforcement of existing laws prohibiting child marriages, statutory rape/defilement and female genital mutilation (FGM), and ensuring that AGYW at risk for child marriage and/or FGM have legal protection, may contribute to the long term impact of programs designed to reduce HIV risk for AGYW. Prosecution of perpetrators of sexual violence is another area where the national response can enhance specific programs for post-violence care.

The advocacy related to DREAMS implementation has helped shift the policy environment for PrEP accessibility for AGYW. In COP20, all 15 DREAMS countries are planning to implement PrEP for AGYW, but there is still room for improvement. The COVID-19 pandemic revealed the necessity to continue advocating for supportive PrEP policies, such as community distribution, at all levels of governance and implementation.

Where will you implement: *Geographic prioritization*

DREAMS is not meant to be implemented country-wide, but rather in the highest burden areas where large numbers of AGYW are vulnerable to HIV acquisition. Geographic considerations based on current epidemiological data, survey findings, cultural considerations and other routine indicators must be utilized to determine priority areas. When planning a DREAMS program, use a data-based approach and start with the epidemiology. Consider the following:

- Overall HIV burden (i.e., number of PLHIV)
- Total population
- HIV incidence of 15-24 year old females (focus on areas with >1% incidence)
- Disparity in incidence between AGYW 15-24 and adolescent boys and young men (ABYM)
- Other extenuating circumstances and cultural/implementation considerations (e.g. areas with transport corridors, urban hotspots, safety concerns, high rates of adolescent pregnancy, low rates of secondary school completion, etc.)

Additionally, it is important to think about the DREAMS geographical footprint when planning where to begin implementation or expansion. DREAMS is intended to be implemented in every ward or

neighborhood within the selected DREAMS SNUs in most cases. Yet, there is flexibility in geographical footprint if a proper epidemiological-based justification can be provided for prioritizing or excluding specific sub-SNU's (e.g. extremely rural sub-SNUs that have a low population, all HIV concentrated in one sub-SNU).

Who will you enroll: Demographic prioritization:

Beyond geographic prioritization, the DREAMS program aims to reach girls who are at the greatest risk of acquiring HIV. Based on the literature on what factors increase an AGYW's risk for acquiring HIV, a list of enrollment criteria can be found in Table 1, and additional information can be found in Appendix A. These criteria are intended to assure the most HIV-vulnerable girls within the highest burden districts are identified and enrolled in DREAMS.

AGYW (18-24 years old) who sell sex or women who participate in transactional sex, defined as a sexual relationship that is based on an implicit assumption that sex will be exchanged for material support or some other benefit, are at a greater risk of HIV. For AGYW who sell sex, DREAMS programs should work with key population (KP) staff and female sex worker (FSW) programs to ensure that AGYW who have transactional sex and young women sex workers are reached and enrolled in the appropriate program. Factors to consider include: age, type of programming needed to best serve the AGYW, and IP capabilities to handle the special needs of these populations.

Violence is strongly and consistently associated with sex work and transactional sex. It is critical that interventions to decrease HIV risk associated with sex work and transactional sex incorporate comprehensive violence prevention programming.

Overall, DREAMS teams are responsible for assuring that screening and enrollment questions accurately capture HIV vulnerability status related to the enrollment criteria. Table 1 summarizes the enrollment criteria for each of the three DREAMS age bands. To be eligible for DREAMS, an AGYW only needs to meet one of the criteria listed (exceptions to the number of criteria can be requested with a justification sent to the AGYW ISME and SGAC country contact).

Table 1: Enrollment Criteria by Age Band

10-14 Year Old Age Band	15-19 Year Old Age Band	20-24 Year Old Age Band
• Ever had sex • History of pregnancy • Experience of sexual violence (lifetime) • Experience of physical or emotional violence (within the last year) • Alcohol use • Out of school	• Multiple sexual partners (in the last year) • History of pregnancy • STI (diagnosed or treated) • No or irregular condom use • Transactional sex (including staying in a	• Multiple sexual partners (in the last year) • STI (diagnosed or treated) • No or irregular condom use • Transactional sex (including staying in a relationship for material or financial support)

• Orphanhood	relationship for material or financial support) • Experience of sexual violence (lifetime) • Alcohol misuse • Out of school • Orphanhood	• Experience of sexual violence (lifetime) • Alcohol misuse

What will you implement: DREAMS Core Package

DREAMS employs a client-centered approach, for although there are other points of intervention (e.g., families, communities), the AGYW is always at the center. DREAMS requires the implementation of multiple interventions that target different risk factors or behaviors that may lead to HIV acquisition. In order to provide services to target the key vulnerabilities for change, different biomedical, behavioral, and structural interventions are recommended. The DREAMS country team is responsible for selecting the appropriate interventions to create their country-specific Core Package of interventions. Figure 1 details the four main categories of engagement and the group of interventions associated with each category.

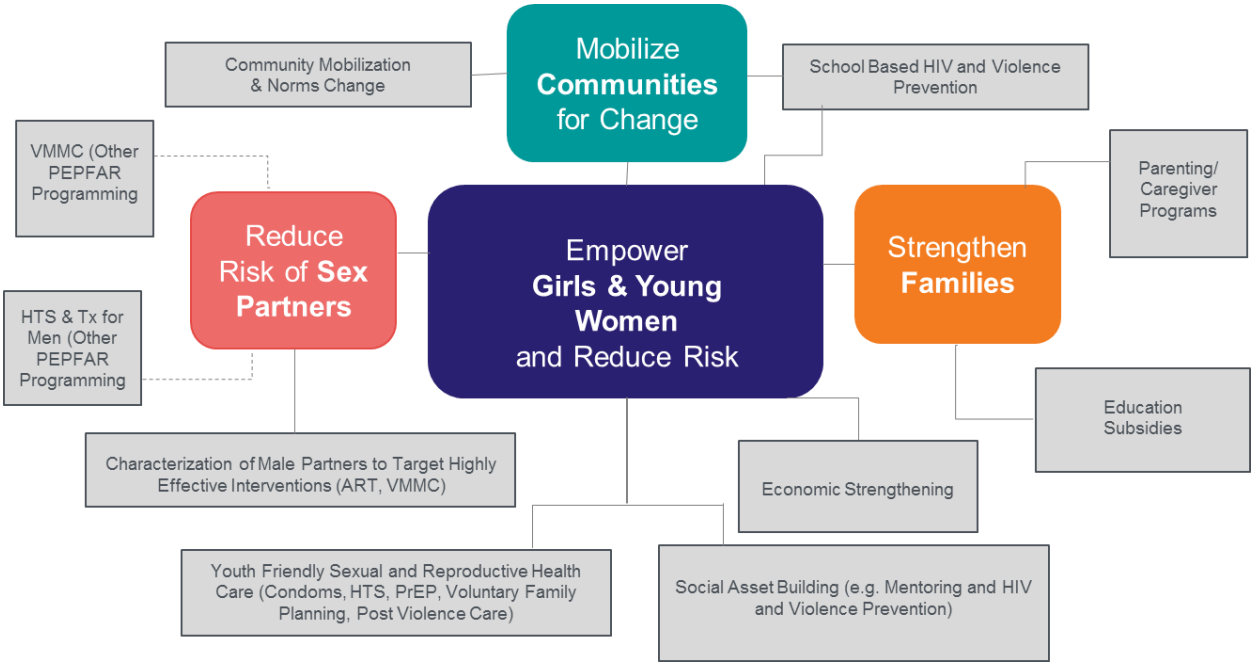


Figure 1: The DREAMS Core Package: DREAMS approach utilizes a theory of behavior change to target different societal, structural and individual factors that lead to an AGYW's increased HIV risk. These risks are targeted through the strategic, layered implementation of evidence-based, culturally sensitive interventions at each level of influence.

This section details each component of the DREAMS core package and its justification for inclusion. Please see Appendix B for details on implementation and relevant resources (i.e. standards, evidence-based curricula, etc.).

1. Empower AGYW and reduce their risk for HIV, unintended pregnancy and violence
    a. Condom Promotion, Demand Creation, Provision and Adherence:
        i. Condoms are highly effective at preventing pregnancy and STIs, including HIV, when used correctly and consistently (8) (9) (10) (11), therefore, it is unethical to withhold condoms when intervening with high-risk populations. Research indicates that pregnancy prevention is a primary motivating factor behind many young women's use of condoms (8) (11) (10). Condom promotion efforts can capitalize on young women's desires to prevent unwanted pregnancy. The promotion and provision of male and female condoms is offered throughout DREAMS programming to AGYW and male sex partners to increase consistent use and availability. DREAMS facilitates a youth-friendly environment and provides education to ensure that AGYW understand the importance of consistent condom use in protecting their sexual and reproductive health and in dual method use for protection from both pregnancy and STIs (8) (9) (10) (11).
    b. Pre-exposure prophylaxis (PrEP) Promotion, Provision and Adherence:
        i. There is extensive evidence that PrEP is a highly effective intervention to reduce HIV acquisition. Initial trials estimated a greater than 90% reduction in HIV for men and women, but additional studies have shown that adherence/continuation, and therefore effectiveness, varies across priority populations (12). Meta-analysis of PrEP use with AGYW shows PrEP reduces risk by 61% given an adherence rate of 75% or more (13). Effectiveness of PrEP is linked to adherence (15) which is dependent upon different behavioral, structural and societal factors (12) (13) (14) (15) (16) (17) (18). Adherence is increased by 40% when social support is available; 38% of that can be attributed to social support from partners (16) (17). PrEP is provided in the context of receiving the full DREAMS core package of services in alignment with WHO normative guidance. Biomedical HIV prevention is an active area of research and advanced development. New ARV-based products such as long-acting injectable ARVs, implants, vaginal rings, and patches are quickly progressing through regulatory approvals.
    c. Linkage to post violence care, including post-exposure prophylaxis (PEP):
        i. Research shows a significant association between intimate partner violence (IPV), a specific form of GBV, and HIV status in women, suggesting women are up to 3x more likely to become HIV positive if they experience IPV (19). Preventing, identifying and responding to violence experienced by AGYW is an effective way to reduce risk for further violence as well as vulnerability to HIV acquisition. PEPFAR-supported sites that are able to do so should offer the WHO recommended minimum package of services for survivors of violence, including first-line support (LIVES), rapid HIV testing, provision of and counseling on PEP, STI screening and presumptive treatment, emergency contraception, and referrals to additional services such as legal support, longer term psychosocial

counseling, child protection and other social welfare services. DREAMS providers, mentors and Ambassadors should be trained in first response to violence, using the LIVES or similar curriculum. (19) (20) (21) (22) (23) (24).

d. HIV testing services (HTS):
    i. This is an essential intervention to increase knowledge of serostatus among AGYW, as well as increase general HIV knowledge. Additionally, an earlier diagnosis for those living with HIV facilitates earlier linkage to care and initiation on lifesaving antiretroviral therapy (ART) (25). HTS is both a potential point of entry for DREAMS enrollment and an ongoing service for DREAMS participants (9) (26). There is some emergent data that HTS may have prevention benefits among youth (26) (27). The importance of linking to appropriate services (i.e. PrEP, PEP, etc.) from the testing platform cannot be underemphasized. DREAMS facilitates strategies, such as mobile vans, self-testing, and testing after-hours and on holidays, to ensure that AGYW and their partners are reached, and appropriately linked, with HTS, HIV prevention services or HIV treatment services at facility and community-based platforms. The acceptance of HTS should never be a condition for enrollment in DREAMS program nor should HIV-infected AGYW be turned away from the program.
e. Expand and improve access to voluntary, comprehensive family planning services:
    i. AGYW in low-income countries experience high rates of early pregnancy which is associated with lower educational attainment and socioeconomic status (28) (29) (30), making AGYW more vulnerable to transactional sex, gender-based violence, and potentially HIV (24) (31) (32). HIV incidence significantly increases during pregnancy and the post-partum period. (33). Additionally, high rates of pregnancy are sometimes due to unmet need for voluntary FP, which increases risks for pregnancy-related morbidity and mortality (34). Sexual violence can lead to unplanned pregnancy. Although PEPFAR does not purchase FP commodities, DREAMS provides counseling and education about the mix of available contraceptive methods as a means to prevent both HIV and pregnancy, with an emphasis on dual method use (35) (36) (37) (38) (39) (40) (41)).
f. Social asset building:
    i. The AGYW at highest risk of HIV often lack strong social networks, including relationships with peers, mentors and adults who can offer emotional support as well as information and material assistance. Interventions that build social capital, both the necessary skills and actual network, have been shown to increase agency and empowerment among AGYW. Although social asset building has not been linked directly to decreases in HIV acquisition, interventions that build social capital have been shown to increase agency and empowerment among AGYW (42) (43) (44). In order to assist AGYW in making important connections, DREAMS promotes the practice of holding small, female mentor-led group meetings in safe, public or pre-determined private spaces on a regular basis. “Safe Spaces” or “Girls Clubs,” work to address AGYW’s multiple vulnerabilities by enabling AGYW to build social networks and linking AGYW to additional DREAMS interventions and services. Multiple DREAMS curricula are

often delivered in these spaces. Literature suggests that social empowerment-interventions should include discussion groups on gender-based violence/intimate partner violence (GBV/IPV) and couples communication (56) (60), mentoring (60) (61), and comprehensive, evidence-based HIV prevention (54) (56) (58) (60) (61) (62) (63) (64). Thus, social asset building is the structure in which curriculum-based interventions are delivered and are critical in the DREAMS layering process.

g. Economic-strengthening:
    i. Economic disparity related to gender inequality is an ongoing and complex driver of HIV. Implementing robust and evidence-based economic strengthening (ES) interventions is a priority for DREAMS in order to decrease AGYW's reliance on transactional sex and strengthen AGYW's self-efficacy and decision-making power in relationships. Stand-alone economic empowerment interventions demonstrate variable effectiveness (50) (51) (52) (52) (53). Combining economic and social empowerment interventions have demonstrated more consistent effects on both behavioral and violence outcomes (54) (55) (56) (57) (58) (59), an approach that is consistent with DREAMS implementation of the primary package. ES experts and the literature recommend two pathways to economic independence – self-employment/entrepreneurship and wage employment. Enhanced economic strengthening is intended for DREAMS participants at highest risk of HIV who would benefit the most from learning marketable skills and finding suitable jobs. Enhanced economic strengthening is offered after basic financial literacy and additional DREAMS interventions have been completed.

2. <u>Strengthen the family</u>
    a. Parenting/caregiver programs:
        i. Having positive relationships with parents, caregivers or other caring adults is a consistent protective factor for AGYW against a variety of negative health and social outcomes (49). DREAMS facilitates parent/caregiver programs that increase caregivers' knowledge, skills and comfort with talking to their children about sexual health, HIV, GBV, violence prevention and response, as well as guides on how to best monitor their children's activities and increase positive parenting practices. Some of these interventions have shown preliminary promise to influence high-risk sexual behavioral patterns among youth (65) (66) (67). Beyond improving relationships between AGYW and parents/caregivers, an informed and educated parent/caregiver can be engaged to help promote other activities within DREAMS.
    b. Educational subsidies and material support for transitioning and completing secondary school:
        i. Female students are especially vulnerable to school dropout and are more likely than boys to never attend school at all (65) (68) (69). Educational subsidies are an effective intervention for keeping girls in school (74) (75) and are correlated with higher rates of HIV testing, and decrease in high-risk sexual behaviors,

likelihood of early marriage (72), school dropout rates and other negative outcomes among female adolescents (70) (71) (72) (73) (74) (75). Additional research suggests a correlation between secondary schooling and HIV negative status, and that additional secondary schooling may be nearly as cost-effective for HIV prevention as PrEP (74) (76).

3. Mobilize communities for change
    a. School-based HIV and violence prevention programs:
        i. The DREAMS Partnership delivers school based HIV and violence prevention in order to provide scientifically accurate information, referrals to health centers for services not provided in school, and to build prevention skills among large numbers of young people in a community. Comprehensive HIV/AIDS and sex education curricula may lower sexual risk behaviors (77) (78) (34). However, a recent review claims that sex education programs alone may not suffice for reducing HIV among AGYW (19). The most effective interventions are often multifaceted and interactive with multiple sessions. Furthermore, sexuality education curricula that address gender and power dynamics are associated with better behavioral outcomes, including significantly lower rates of STIs and unintended pregnancy (79) (80) (81) (82). The DREAMS program does not allow abstinence only HIV/AIDS and sex education programs. Please note that violence prevention programs for the 10-14 year old age band became mandatory in COP19.
    b. Community mobilization/norms change programs:
        i. Community mobilization programming should be widely and strategically implemented, as this provides an essential support framework for HIV prevention programs (83) and serves to engage boys, men, community leaders, and the broader community in addressing and impacting social norms that increase HIV risk for AGYW (84) (85). Community mobilization efforts in related areas, like GBV prevention, have shown a significant impact on norms change, a decrease in violent victimization and perpetration (83) (85) and an increase in empowerment (84). Community mobilization and norms change interventions in DREAMS engage all community members with a focus on men and opinion leaders in community conversations about HIV, gender norms, sexuality, relationships, violence prevention and response, joint decision-making and alcohol use. DREAMS implements curricula with a participatory learning component focused on building skills and a community-level awareness and ownership of HIV risk reduction.

4. Reduce risk of sexual partners of AGYW
    a. Characterizing potential male sexual partners and linkage to other PEPFAR services:
        i. When first planning comprehensive programming for AGYW, it is important to consider reaching male sex partners as an HIV reduction strategy. Biomedical services for men are highly effective in reducing HIV acquisition and reducing HIV transmission to sexual partners (27) (86) (87) (88) (89) (90) (91). VMMC is a

highly effective intervention for reducing the likelihood of HIV acquisition among men and boys as well as protecting their female sex partners (86) (87) (88) (89) (90) (91). ART for men living with HIV is a highly effective intervention to prevent transmission to their sexual partners (27). However, men are reluctant to be tested (90) and linked to care (91) (92). DREAMS teams should use information about the characteristics of male sexual partners of AGYW to engage with other PEPFAR services on targeting men with those characteristics for HTS, VMMC, and ART.

How will you implement: Layering

Layering, or the provision of multiple evidence-based services from the DREAMS core package to each active DREAMS participant, is a core principle of DREAMS as outcome evaluations show that a layered approach is more effective at mitigating HIV risk than a single intervention (5). Additionally, this approach helps to assure that AGYW are surrounded with critical support to keep them safe from HIV and other risks (3) (4).

Each DREAMS country is responsible for designating its own primary, secondary, and contextual packages of services/interventions for each DREAMS AGYW age band (10-14, 15-19, 20-24) based on the country specific context and epidemiological nuances. Emerging evidence suggests that tailoring DREAMS programming around country specific considerations yields stronger results (106). Appendix B, Table 1 has a list of approved curricula for country team consideration. If a country team wants to adapt an intervention or select a different program to meet the goals of the core package, these country or IP-specific curricula require consideration. See Appendix D for more information.

The selection of interventions forms the country-specific DREAMS Layering Table and accompanying DREAMS Intervention Completion Table (Appendix C). All DREAMS countries are required to submit these tables on an annual basis for S/GAC and AGYW ISME approval. Please note, "layering" services does not necessarily mandate that these services must be received concurrently.

The following definitions should guide the development of OU-specific Layering Tables:

- **Primary Services/Interventions**: Interventions that ALL AGYW in an age group should receive if they are DREAMS participants.
- **Secondary Services/Interventions:** Needs-based interventions that are part of the DREAMS core package but may not be received by all AGYW in that age group (i.e. only AGYW who earn an income should participate in a savings group).
- **Contextual Services/Interventions**: Interventions that are part of the DREAMS core package but cannot be linked to an individual AGYW (i.e. community mobilization)
- **Service/Intervention Completion:** This is country-specific criteria for determining the completion of each service/intervention in their DREAMS core package. Service completion definitions should be based on normative guidance and instructions from program developers where available. A service should not count towards an AGYW's DREAMS program completion until it has met the service completion definition.

Only services provided by PEPFAR should be included in the DREAMS Layering Table. However, if PEPFAR implementing partners are making active referrals to a service provided by a non-PEPFAR entity, the active referral may be counted as a DREAMS service. If this is the case, your Layering Table should specify this (e.g. "facilitating access to government education subsidies" instead of just "education subsidies"). Teams may include services/interventions in their layering tables that are paid for with other PEPFAR funding (e.g. supplementary OVC support); please note this in the layering table. To learn more about the curriculum review and approval process, please see Appendix D.

How will you implement: What should not be included in DREAMS:

When implementing DREAMS, it is equally important to understand the data on interventions that are NOT likely to have a significant impact on reducing HIV incidence among females 10-24 years of age so these can be avoided or removed from PEPFAR AGYW programming. Interventions that will NOT likely have a significant impact on reducing HIV incidence or are not appropriate for this comprehensive package are found in Appendix B, Table 2. The activities and interventions listed in this table were selected because evaluations of their effectiveness are either non-existent or showed little-to-no-to-negative impact, or the intervention is not sustainable with PEPFAR funds. Treatment for schistosomiasis may be worth evaluating further but should not be associated with DREAMS at this time. Abstinence-only or sexual risk avoidance education has been extensively studied and has shown to have a negative impact on HIV risk. Therefore, DREAMS programming on HIV and sexual health should be comprehensive, providing abstinence as a method to avoid HIV along with other methods such as condoms. It should not be presented as the only method or the preferred method. These interventions should not be included in a package focused on reducing HIV incidence in AGYW. Additionally, there are activities/interventions that should not be implemented using DREAMS funding because these interventions may be specific priorities for other COP funding. Appendix B, Table 2 identifies these activities/interventions which include the purchasing of ARV drugs for: PMTCT for young mothers, AGYW testing positive in HTC programs, male partners of AGYW testing positive and VMMC. For treatment, these individuals should be referred to PEPFAR-supported or other programs.

Assuring Quality Implementation

The DREAMS core package specifies what evidence-based programs and services should be implemented for each component of the package, but how these interventions are implemented is also critically important. This section will cover the importance of implementing services with fidelity, differential service delivery, training DREAMS implementers and utilizing mentor and tenants of mentorship for impact. Country teams are encouraged to implement each intervention based on normative guidance (e.g., guidelines for clinical interventions), or aligned with the delivery methods used when the intervention was originally developed and evaluated (e.g. consistent with curriculum core principles and implementation guidelines). Interventions delivered as part of DREAMS are a combination of mentor-led, facilitator-led, health-care-worker-led, individual, participatory, small groups and large groups. Therefore, it is essential to fully understand the targeted intervention requirements in order to assess implementation with fidelity. For more information, please see Appendix F.

DREAMS is implemented by facility and community partners, in community safe spaces, in school settings, and at health facilities. A safe space refers to both the physical location and a supportive, non-

judgmental environment. Findings from evaluations of community-based girl groups, also known as safe spaces, provide preliminary, yet promising results, about the positive impact a safe space structure has on AGYW-level outcomes (5) (45) (93) (49). An additional safe space for girls can be schools. Keeping girls in school is a key tenant of the DREAMS program, as school matriculation is a protective factor from a confluence of factors and risk behaviors that may lead to HIV, pregnancy and poor economic and health outcomes (72) (73) (76) (75) (75).

Some interventions may be exclusively available or more convenient at a healthcare facility. In order to reduce the number of incomplete services, DREAMS community partners are to provide active referrals from the community to the facility, mirroring the program implementation for the HIV clinical cascade in COP guidance. Similarly, clinical partners are to provide active referrals from the facility to the community, especially from HTS, ANC, FP, and GBV response service delivery points. Unlike passive referrals where a client might be told about the availability of a relevant service, active referrals are made to a specific staff person at an organization and are tailored to clients' needs. Active referrals are an integral part of PEPFAR programming and are proven to increase people living with HIV (PLHIV) linkage to care (99). Active referrals for routine reproductive health services, not just linkage to HIV care and treatment, are an essential trademark of the DREAMS program. This is to ensure the AGYW receives her intended service, builds relationships with youth friendly nurses and reduces the potential stress of attending the facility.

Additionally, PEPFAR encourages partners, adolescent friendly health service (AFHS) hubs and adolescent friendly health care workers (HCW) to bring clinical services to the community through dynamic and innovative models. Such models may include mobile units, hybrid models and adolescent-friendly provider outreach services. Providing clinical services in community spaces helps normalize the services in the eyes of community members (94), integrates routine health services into an AGYW's life, keeps the service client-centered and reduces stigma around seeking health care services. Integrating routine sexual and reproductive health services into HIV prevention services shows higher acceptance of HIV services. Differential service delivery may increase accessibility of services, as long as confidentiality is ensured and upheld throughout service delivery (94) (95). Note this does not suggest AFHS at facilities should be replaced by community-only modules and that AFHSs should align with relevant in-country standards.

Another way that DREAMS supports quality implementation is through the training of implementers to assure that each curriculum is delivered with fidelity. In addition to training on the content and delivery of specific programs, trainings are offered on how to successfully engage and approach AGYW. Examples include training on how to provide non-judgmental, adolescent-friendly clinical services. Training for teachers is also being supported through collaborations with Ministries of Education and Health to ensure that teachers are comfortable and confident delivering HIV prevention curricula.

DREAMS mentors, hired by DREAMS implementing partners, are a critical aspect of DREAMS implementation and provide ongoing support and individual follow-up with cohorts of DREAMS participants. Mentors often serve as confidants to DREAMS participants, assist them in building positive relationships within their support networks and each other, and provide active linkages to services in the community and facility (49) (95). Results about the role of mentorship in improving reproductive health outcomes for AGYW are preliminary, but promising. One meta-analysis of 19 peer-reviewed articles shows that frequent, long-term, group-based mentorship, as part of a comprehensive

prevention program, directly improves protective factors for AGYW (49). See Appendix F for more information about PEPFAR findings that will inform how DREAMS participants are provided with high-quality, evidenced-informed mentorship to improve the overall impact of DREAMS.

DREAMS is intended to be delivered in person to the AGYW. Yet, a few, very specific situations may arise where individual and group remote support (such as SMS, phone call or WhatsApp dependent on country context) may be necessary. Some of these situations may include movement restrictions due to disease spread, natural disasters, or community/political unrest. Contact should focus on keeping participants engaged with mentors and peers and providing referrals for time-sensitive clinical services (e.g. GBV response, FP, and PrEP). Program delivery should follow the continuum in Figure 2.

Figure 2: Continuum of Virtual DREAMS Content Delivery

Finally, AGYW, government and stakeholder engagement does not start and end in the planning phase, it is a core principle throughout the program cycle. In order to stay informed, coordinated and employ an iterative process, a working group must be formed and continually utilized for program adaptations, routine program management and program standardization. Meeting structures are up to the consideration of country teams, and national and local governing bodies.

Monitoring and Evaluating a DREAMS Program

The DREAMS logic model guides how programs should be planned, implemented, monitored, and evaluated. The model lays out the epidemiological context that puts AGYW at additional risk of HIV infection, the interventions proposed to address these contextual factors, the expected outputs and outcomes of these programs, and the anticipated overall impact of those outcomes in combination.

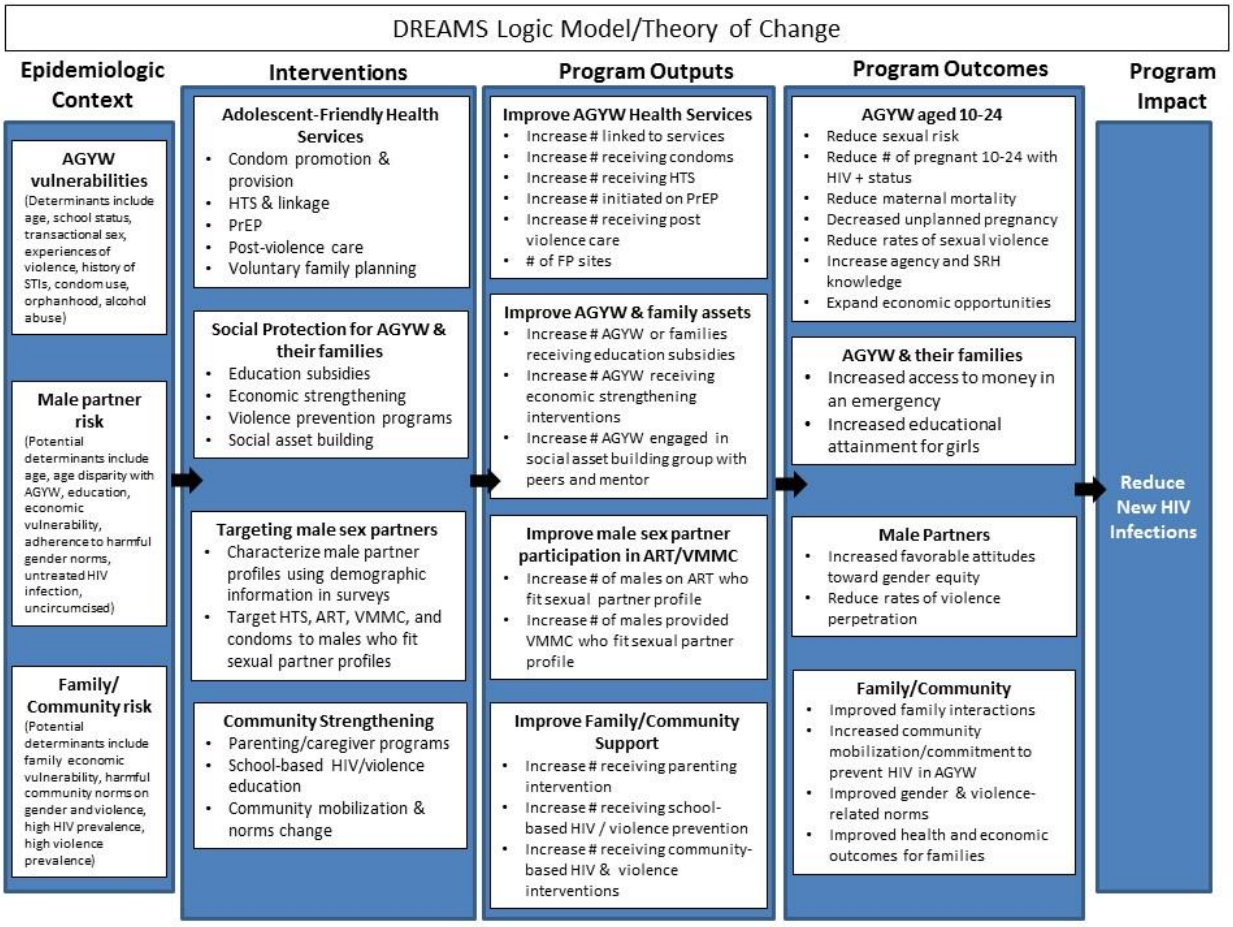


Figure 3: The DREAMS Logic Model

The DREAMS Partnership will use several approaches to measure outputs, outcomes and impact: PEPFAR HIV impact assessment surveys (PHIAs), other available survey or modelling data (DHS, VACS, ANC surveillance, UNAIDS incidence estimates etc.) as they become available, site level data from PMTCT programs, findings from SIMS visits and routine analysis of MER indicators. Impact can also be modeled in all 15 DREAMS countries via modeling of new diagnoses or incidence, based on availability and necessity.

There are several reasons why it is critical to closely monitor the implementation of DREAMS programs:

1. With this novel and multifaceted approach for keeping girls HIV-free, close monitoring of implementation by USG is critical to support real-time course correction based on:
    a. Target population – ensuring that the right target populations (the most HIV-vulnerable AGYW ages 10-24) are being reached in DREAMS SNUs with high HIV burden
    b. Scaling interventions – understanding barriers to scaling interventions to necessary levels and ensuring implementation with fidelity
2. Understanding outcomes: understanding trends in pregnancy, GBV and/or new HIV diagnosis rates among target population based on age-disaggregated data. Programs cannot have impact if they are not effective and implemented with fidelity, do not reach the right populations are of

low quality and do not maintain fidelity to the original program, and do not bring interventions to scale.

3. A key hypothesis of DREAMS is that providing the most HIV-vulnerable AGYW and their communities with a package of services will be more effective at protecting them from HIV than any single intervention. To test this hypothesis, tracking whether AGYW sub-populations within a given DREAMS country are actually receiving the appropriate package of services, provided in the intended fashion, is essential.

PEPFAR programs should be nimble and responsive to data, and DREAMS programming should be adaptable to best meet the needs of AGYW. In order to understand the needs of AGYW DREAMS program should collect program data in a routine and meaningful way and analyze and respond to the results of these data.

Routine Monitoring: Ongoing Governance:

Working groups must be formalized and utilized for routine monitoring, observance and decision making. Each DREAMS country should establish a multi-sectoral advisory committee at the national level, as well as in each region where DREAMS is being implemented. These committees should have membership from the PEPFAR team, national and local government (as appropriate), other donors, the UNAIDS secretariat, UN Family, civil society and, most importantly, AGYW from the specific sub-groups targeted. These AGYW should be trained and supported to gain the skills and confidence necessary to play an active role on these committees.

These committees should have several roles:

- Identify and address relevant policy issues, such as PrEP, age of consent for HIV testing and accessing contraception;
- Identify and coordinate with other relevant initiatives targeting this population;
- Provide advice to PEPFAR and DREAMS implementing partners on the core package as well as on sub-groups to target with interventions;
- Provide ongoing feedback to DREAMS stakeholders (country teams, local government, partners, etc.) and insight on program effectiveness.

Where existing groups play a similar role (for example, in countries where a violence against children (VACS) study has been conducted and a committee formed to take action on its findings or an OVC working group), the DREAMS advisory committee may be subsumed within it, should all parties agree.

Routine Monitoring: Layering Databases: Tracking individual-level interventions for programmatic oversight

In order to routinely collect program data to inform ongoing programmatic improvements, COP18-21 guidance mandates the importance of a client-level layering database to track AGYW's journey through the primary and secondary package at an individual level. This is imperative to track the layering of interventions thoroughly, and to track services an AGYW receives at the facility and the community. Additionally, a client-level database helps the program remain client centered – it places the responsibility of tracking referrals on the implementing partners, and not on the individual AGYW. Ultimately, the AGYW's services are tracked across service delivery sites and provides partners and country offices with relevant data points to help guide and adapt program implementation. If possible, PEPFAR recommends

country teams work within government databases and reporting structures. Best practices include the use of unique IDs, DREAMS passports or ID cards, and DHIS2-based databases, as well as having one M&E partner and one database that is responsible for the coordination of layering data systems across all DREAMS service delivery partners. All partners should have access to their specific data within the system. Find additional information on data monitoring and use here.

Routine Monitoring: AGYW_PREV and DREAMS Program Completion

In FY19 AGYW_PREV, a new DREAMS-specific MER indicator, was rolled out to assess individual level layering progress and district-level reach. AGYW_PREV is a semi-annual indicator and requires USG staff to input results into DATIM. It tracks the number of AGYW who were enrolled in DREAMS and have started at least one DREAMS service/intervention, completed at least one DREAMS service/intervention, completed the primary package, and completed the primary package with additional secondary package services/interventions. AGYW_PREV also assesses how long an AGYW was active in the DREAMS program. From an individual level and for monitoring purposes, an AGYW is considered to have "completed" the DREAMS program when she completes the primary package for her age band and all necessary secondary package interventions. For more information on DREAMS program completion, see Appendix E; for more information on AGYW_PREV, see the most up to date MER guidance here.

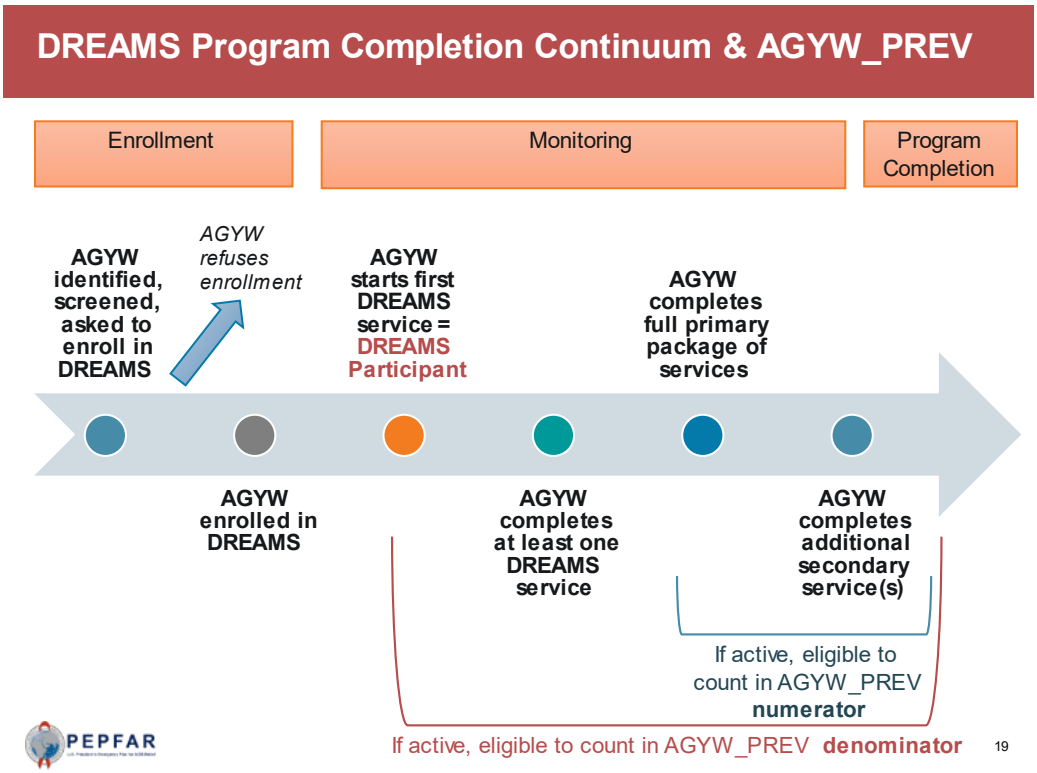


Figure 4: DREAMS Program Completion Continuum

Routine Monitoring: Saturation

In order to determine if enough DREAMS participants have been reached by the primary package and necessary secondary intervention(s) and deem the district saturated, it is first necessary to estimate the

number of vulnerable AGYW within the district, as aligns with the enrollment criteria. A more detailed process in order to enumerate the number of vulnerable AGYW can be found in Appendix E.

Once saturation of at least 75% of vulnerable AGYW in each DREAMS age band is reached, country teams are responsible for adapting their approach to develop a maintenance package. Therefore, DREAMS has a continuous presence, reaches girls who "age-in" to the program and will ultimately assure DREAMS's impact is sustained and emerging vulnerable AGYW are met with necessary services.

Routine Monitoring: Additional MER Indicators

In addition to AGYW_PREV, the following indicators will be reviewed to monitor DREAMS performance and to understand the epidemiological context in each SNU (e.g. if males living with HIV ages 15-35 years are on treatment and virally suppressed). Full indicator definitions, along with additional disaggregation, can be found in the most up to date MER guidance.

Table 2: MER indicators

Indicator	High-level Definition and disaggregates	Reporting Frequency
PrEP_NEW	**Number of new clients receiving PrEP by SEX/AGE**	Q1, Q2, Q3, Q4
PrEP_CURR	**Number of total clients receiving PrEP by SEX/AGE**	Q1, Q2, Q3, Q4
OVC_SERV	**Number of OVC participants receiving services (by AGE/SEX/OVC PROGRAM)**	Q2, Q4
PP_PREV	**Prevention Activity/Service delivery by AGE/SEX**	Q2, Q4
GEND_GBV	**Violence Service type by AGE/SEX** **PEP completion by AGE/SEX**	Q2, Q4
HTS_TST	**HIV Testing service delivery by MODALITY/AGE/SEX/RESULT**	Q1, Q2, Q3, Q4
KP_PREV	**Key population services by TYPE of key population**	Q4
PMTCT_STAT	**Percentage of pregnant women with known HIV status by AGE**	Q1, Q2, Q3, Q4
VMMC_CIRC	**Number of males circumcised by AGE**	Q1, Q2, Q3, Q4
TX_NEW	**Number of new PLHIV receiving ART treatment by SEX/AGE** (review for AGYW and males 15-35 years)	Q1, Q2, Q3, Q4
TX_CURR	**Total number of PLHIV receiving ART treatment by SEX/AGE** (review for AGYW and males 15-35 years)	Q1, Q2, Q3, Q4
TX_PVLS	**Viral load testing coverage and suppression by SEX/AGE**	Q1, Q2, Q3, Q4

Data Monitoring and Use for Performance Improvement, Policy and Impact

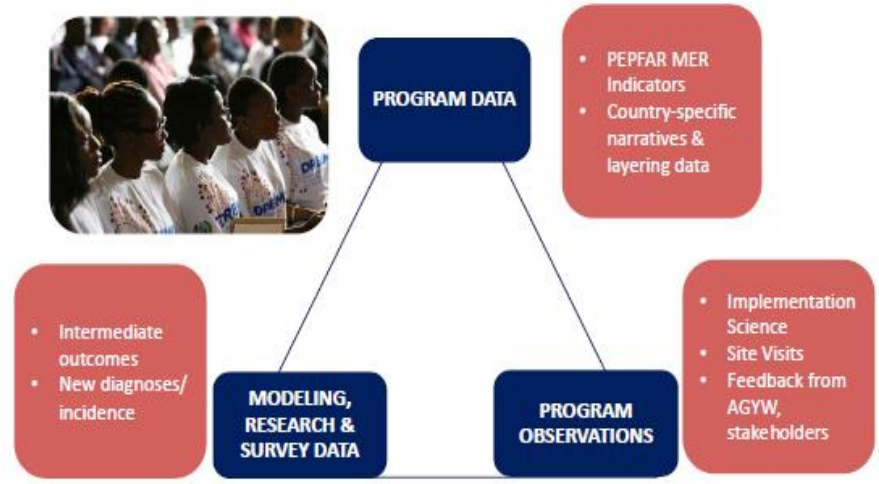
Country-level layering tracking systems will have more comprehensive information than is required for AGYW_PREV reporting. This detailed information should be used along with AGYW_PREV results to make programmatic decisions and to monitor the layering and program completion status for individual AGYW on a regular basis throughout the fiscal year. All DREAMS Implementing Partners within a DREAMS SNU are responsible for regularly reporting and analyzing layering data along with other DREAMS implementers, stakeholders, and service providers.

AGYW_PREV and layering data should be used routinely to answer the questions below:

- How many active DREAMS participants are in the DREAMS program?
    - How many DREAMS participants have become inactive? What is being done to find these AGYW and bring them back into DREAMS? Are there common characteristics of AGYW who become inactive?
- Is layering happening as intended for all AGYW receiving DREAMS services? Are there specific services/interventions that are not reaching AGYW as intended? Are there specific SNUs where layering is stronger or weaker? Are there specific age bands where layering is stronger or weaker?
- How does layering change over the time a girl is enrolled in DREAMS?
    - Have 90% of active DREAMS participants completed at least the primary package after being in DREAMS for 13+ months? If not, are there common reasons for non-completion after a significant time in DREAMS? How can an understanding of these reasons contribute to program improvement?
    - How long is it taking for AGYW (by age band) to complete the primary package? (e.g. we wouldn't expect AGYW in the younger age bands to complete the primary package in <6 months)
- Where are active DREAMS participants along the DREAMS program completion continuum?

Other potential analyses include:

- Trends in DREAMS enrollment by age and SNU
- DREAMS contributions to clinical cascade performance for AGYW and male sex partners of AGYW
- Analysis of unmet need by geography and age to inform targeting, programming, and DREAMS saturation (e.g. VACS, PHIA, IBBS, Spectrum)
- Analyses of VACS data (if available in your OU) to inform your programming. This is especially relevant to primary prevention of sexual violence among 10-14 year olds, Justice for Children activities under the Faith and Community initiative (if relevant), and post-violence care.
- Triangulation of AGYW_PREV, other DREAMS-related MER indicators, and AGYW Prevention SIMS CEEs to assess quality of implementation
- Triangulation of DREAMS MER indicators with financial data to assess distribution of PEPFAR resources in relation to targets and program results
- Assessment of above-site (Table 6) and SID benchmarks related to DREAMS



How will we know if DREAMS is successful?

Informal, iterative and regular monitoring and evaluation is necessary to assure DREAMS is responding to data and providing the appropriate services for the most vulnerable AGYW. Developing a process to triangulate available data from differing sources in a strategic fashion is important to evaluating DREAMS process, outputs, outcomes and impact per the logic model (Figure 3). Triangulation refers to the use of multiple methods or data sources in qualitative or quantitative research to develop a comprehensive understanding of a certain naturally reoccurring phenomena or intentional program (94). As mentioned above, there is no silver bullet data source or indicator to capture the entirety of DREAMS. Using all available sources, such as program data, program observations, custom indicators, and modeling data, help build a comprehensive picture of DREAMS within its context. It is important to note that triangulation does not mean finding complementary data to strengthen an intended argument, but instead allows different data sources to work together to create a holistic and nuanced picture of a program.

Additionally, PEPFAR has worked with implementing partners and research universities to complete a variety of formative assessments of DREAMS outcomes that have helped inform the program at a global and country-specific region. Impact evaluations from the London School of Hygiene and Tropical Medicine (LSHTM) and implementation science from Population Council are in progress and final results will be published in 2021. Preliminary results have already been used to improve the DREAMS program at the district, national, and global level. For example, recent emphases on enhanced economic strengthening and PrEP implementation are based on recommendations and results from various outcome evaluations. S/GAC collaboration is required to determine if/when an outcome evaluation is necessary and the required next steps.

Please reach out to Country Teams and the S/GAC DREAMS team for more information about relevant outcome evaluations or find information at the following links:

- PLOS DREAMS Collection
- London School of Public Health DREAMS Evaluation Work
- Population Council DREAMS Work

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Appendix A: DREAMS Risk and Vulnerability Assessment

Finding and Engaging the Most Vulnerable AGYW. In DREAMS OUs, most AGYW may be vulnerable in some way. However, a systematic and targeted approach to identify the AGYW most vulnerable to HIV acquisition is important for 2 reasons: 1) to appropriately allocate limited resources for the population that most needs DREAMS programming, and 2) to increase the OU's ability to reach saturation (i.e. reaching the majority of the most vulnerable AGYW with at least the primary package of DREAMS services). Using overly broad eligibility criteria will result in utilizing resources for AGYW who are less likely to acquire HIV, as well as targeting an inaccurately high population making it difficult to reach saturation.

In order to reach the AGYW who are most vulnerable to HIV, partners should use particular entry points and eligibility criteria that is based on the scientific literature and consistent across partners and SNUs.

Entry Points for DREAMS

It is essential to identify referral and entry points that target the most-vulnerable AGYW. OUs must make active efforts to identify and engage out-of-school AGYW. OUs should map the community (including schools, clinical partners, governmental and social welfare institutions, and other community organizations or groups), collaborate with other service providers, use this information to identify referral pathways, and engage AGYW who may be difficult to reach. All OUs must collaborate with PMTCT platforms and ANC clinics, as well as HTS, STI and FP, GBV and PrEP settings, to create strong referrals and enroll at-risk AGYW who meet the DREAMS eligibility criteria. In ANC and FP settings, all AGYW who are 10-17 years of age should be screened for DREAMS eligibility. In HTS and STI settings, all AGYW who are 10-24 years-old should be screened for DREAMS eligibility. If OUs need assistance developing a systematic approach to enable referrals and eligibility screening, they should contact their respective AGYW ISME. Facility- and community-based DREAMS implementing partners should develop a joint SOP outlining referral procedures.

Eligibility Screening for DREAMS

Scientific literature identifies the following risk and vulnerability factors for HIV acquisition among AGYW:

- Multiple Sexual Partners
- Sexually Transmitted Infection (STI)
- No or Inconsistent Condom Use
- Transactional Sex
- Experiences of Violence
- Out of School/Never Schooled
- Alcohol Use/Misuse
- Orphanhood

Beginning in COP20, OUs are required to assess the above factors to determine participants' eligibility for DREAMS. These eligibility criteria should be broken down by age group – please see table below. OUs are encouraged to include additional questions designed to build rapport, lessen the stress of sensitive topics, provide a base to lead into more sensitive questions, and identify other risk and vulnerability

factors that can help to target programming, however, these additional questions should ***not*** be used as eligibility criteria.

Required DREAMS Eligibility Criteria by Age Band:

- **Only 1 criterion must be met for eligibility**
- **Specific questions will be needed to assess each factor (i.e. Have you attended school within the past year?)**
- **If you currently have questions for these criteria that are working well, YOU DO NOT need to change them. However, if you have not been using some of these criteria and need questions or would like to improve your questions, see examples below or consult your ISMEs**

10-14 Years:	**15-19 Years:**	**20-24 Years:**
• Ever had sex • History of pregnancy • Experience of sexual violence (lifetime) • Experience of physical or emotional violence (within the last year) • Alcohol Use • Out of School • Orphanhood	• Multiple sexual partners (in the last year) • History of pregnancy • STI (diagnosed or treated) • No or Irregular Condom use • Transactional sex (including staying in a relationship for material or financial support) • Experience of sexual violence (lifetime) • Alcohol Misuse (in the last year) • Out of School • Orphanhood	• Multiple sexual partners (in the last year) • STI (diagnosed or treated) • No or Irregular Condom use • Transactional sex (including staying in a relationship for material or financial support) • Experience of sexual violence (lifetime) • Alcohol Misuse (in the last year)

Examples of additional factors that may be included in a screening/enrollment tool but are *not* to be used as eligibility criteria: (note that this list is not exhaustive)	
All Age Bands	Household status Food Insecurity Romantic partners (including age disparity and partner's HIV status) Knowledge and access to family planning methods Social network (friends and family) Socioeconomic status HIV status Emotional Violence (for 15-24 age bands) Physical Violence (for 15-24 age bands)
20-24 Years	History of pregnancy and number of children Education status

To ensure screenings are administered appropriately, all individuals who provide eligibility screening must be trained in building rapport, how to ask about experiences of violence, the provision of first-line

support in response to disclosure of violence, local mandatory reporting laws, and their partner's SOP to complete active linkages to necessary services (including GBV response). Active linkages to services such as GBV response and HIV care and treatment must be completed when indicated, regardless of an individual's DREAMS eligibility or enrollment status. The AGYW's confidentiality and informed consent must be ensured throughout the screening process. Screening questions should be age appropriate and tailored to elicit candid responses, while allowing an AGYW to easily refuse to answer. OUs may develop a screening tool tailored to their context. Due to the sensitive nature of the certain topics, OUs are encouraged to adopt globally accepted questions when screening for violence. Examples of screening questions are listed below.

Example **eligibility screening questions** for emotional, physical, and sexual violence for **10-14 year olds only**:

- *Emotional Violence* (adapted from VACS Core)
    - In the past 12 months, has a parent, adult caregiver or other adult relative:
        - told you that you were not loved, or did not deserve to be loved?
        - said they wished you had never been born or were dead?
        - ever ridiculed you or put you down, for example said that you were stupid or useless?
- *Physical Violence* (adapted from VACS Core)
    - In the past 12 months, has anyone:
        - punched, kicked, whipped, or beat you with an object?
        - choked, smothered, tried to drown you, or burned you intentionally?
        - used or threatened you with a knife, gun, or other weapon?
- *Sexual Violence* (adapted from VACS Core)
    - In your lifetime, has anyone ever touched you in a sexual way without you wanting to? Touching in a sexual way without permission includes fondling, pinching, grabbing, or touching you on or around your sexual body parts.
    - Has anyone ever made you have sex, through physical force, harassment, threats, or tricks?

Example screening question for transactional sex:

- Have you ever had sex with someone because you expected that they would provide you with gifts or favors, help you to pay for things, or help you in other ways? (Adapted from VACS Core; Tanzania DREAMS)

Example screening questions for alcohol misuse for **15-24 year olds only**:

- During the past three months, has your use of alcohol led to health, social, legal or financial problems? (Adapted from WHO ASSIST)
- Do you ever forget things you did while using alcohol? (CRAFFT)

If OUs would like to request exceptions to the required eligibility criteria described in this section, they should work with their respective AGYW ISMEs to submit a justification and exception request.

Appendix B: The Core Package of Interventions – Rationale, Curriculum and Putting it all Together

Table 1: The core package of interventions for DREAMS

For more information on curriculum specific processes, please see Appendix D. For more details about the curricula listed below please see the DREAMS Curricula Bootcamp Master List.

Empower Girls & Young Women and Reduce their Risk				
Intervention	**Target Groups**	**Outcomes**	**Considerations for Implementation**	**Intervention Resources/ Curriculum (if relevant)**
Condom promotion and provision (female and male)	Young women and adolescent girls and their male sexual partners	Reduced transmission and acquisition of HIV	-Address national laws, policies, guidelines, community/social perceptions and norms, and gender norms and inequities that may prevent AGYW from accessing and using condoms (e.g. provider bias). -Address local key barriers to male and female condom access and utilization to inform programming. -Assess differential condom delivery locations, i.e. schools and safe spaces. -Consider young women's interest in preventing pregnancy. Align with existing USG-funded ASRH and FP initiatives, as well as other donor and national FP initiatives, if such programs exist in country (e.g. Family Planning 2020, USAID Office of Population and Reproductive Health). -Improve demand creation by researching how to make condoms appealing to young people. -Ensure messages about dual protection are part of condom education and counseling.	-Programmatic Considerations for Condoms as a Structural Level Intervention: http://www.cdc.gov/hiv/prevention/programs/condoms/ -AIDSTAR-One: Behavioral Interventions: Comprehensive Condom Use Programs: http://www.aidstar-one.com/focus_areas/prevention/pkb/behavioral_interventions/condom_use -UNFPA: Condom Programming for HIV Prevention: an Operations Manual for Programme Managers: http://www.unfpa.org/sites/default/files/pub-pdf/condom_prog2.pdf -Family Planning a Global Handbook for Providers: https://apps.who.int/iris/bitstream/handle/10665/260156/9780999203705-eng.pdf;jsessionid=BA6254F3E8161A5F524178E3DC3DCDA5?sequence=1

HTS	AGYW and their male sexual partners* (*see Table 2 for more info)	Earlier diagnosis of HIV infection Linkage to appropriate, high impact services	-Address national laws, policies, guidelines, or community/social perceptions and norms that may prevent AGYW from accessing and accepting HTS (e.g. age of consent). -Align with existing HTS initiatives and local guidelines, including index testing and partner notification following PEPFAR's safe and ethical index testing guidance. -All HTS services offered to AGYW should be adolescent-friendly (e.g. inviting spaces and adolescent-friendly hours). -Provide high-quality testing that observes all the 5 C's (confidentiality, informed consent, correct results, counseling, and connection to care). -Integrate HTS services into other community and facility services and screen all AGYW accessing HTS services for DREAMS eligibility. DREAMS programs should not condition enrollment in the program on acceptance of HTS, nor should AGYW living with HIV be turned away from the program.	-WHO HTC Consolidated Guidelines: http://www.who.int/hiv/pub/guidelines/arv2013/clinical/testingintro/en/ -Adolescent-specific guidelines (section 5.1.4.4):http://www.who.int/hiv/pub/guidelines/arv2013/clinical/en/ -AIDSTAR-One: HIV Testing and Counseling: http://www.aidstar-one.com/focus_areas/hiv_testing_and_counseling -PEPFAR Safe and Ethical Index Testing Guidance: https://www.pepfarsolutions.org/index -YouthPower Considerations for Index Testing and Partner Notification for Adolescent Girls and Young Women: https://www.youthpower.org/agyw-index-testing-partner-notification
PrEP	AGYW age 15-24* (*depends on country policies)	Reduce acquisition of HIV	-Address any policy or regulatory issues in country that create barriers to effective PrEP implementation for AGYW. -Conduct education and demand creation with community leaders and parents/caregivers. -Ensure linkages with PrEP services being accessed outside of facilities in pharmacies, community health workers, social franchises, etc. Screen all AGYW accessing PrEP services for DREAMS eligibility.	-PrEP best practices, research and clinical guidelines: http://www.cdc.gov/hiv/prevention/research/prep/ -PrEP Watch: http://www.prepwatch.org/home -WHO implementation tool for PrEP of HIV Infection: module 12 adolescents and young adults:

			-Use PrEP information and education to assist AGYW in identifying seasons of risk during which they should be using PrEP. -PrEP should be prioritized for young women at the greatest risk of HIV acquisition, including those who are pregnant or breastfeeding or who may be having transactional sex. -AGYW who seek out PrEP and are determined to use it, whether or not they disclose their reasons for doing so, may indeed be at substantial risk, and should receive PrEP services. -All PrEP offered to AGYW should be adolescent friendly (eg nonjudgmental staff and adolescent friendly hours). -Align with existing USG-funded ASRH and Reproductive Health as well as other donor and national FP initiatives, initiatives (e.g. Family Planning 2020, USAID Office of Population and Reproductive Health). -Differentiated service delivery models such as community based delivery can be utilized. - New ARV-based products such as long-acting injectable ARVs, implants, vaginal rings, and patches are quickly progressing through regulatory approvals and should be considered once approved.	https://apps.who.int/iris/handle/10665/273172
Expand & improve access to voluntary, comprehensive FP services	AGYW	Reduce unmet needs for FP and increase education around	-Address national laws, policies, guidelines, or community/social perceptions and norms that may prevent AGYW from accessing FP services (e.g. provider bias). -Align with existing USG-funded ASRH and FP initiatives, as well as other donor and national FP initiatives, if such	-Contraception for women at High Risk of HIV: https://www.usaid.gov/sites/default/files/documents/Contraception_for_women_at_high_risk_of_hiv-technical_brief_FINAL.pdf

		available methods	programs exist in country (e.g. Family Planning 2020, USAID Office of Population and Reproductive Health). -Ensure and monitor linkages with FP services being accessed outside of facilities in pharmacies, community health workers, social franchises, safe spaces, schools, etc. -Screen all AGYW accessing FP services for DREAMS eligibility. -Service providers should be practicing youth friendly service delivery and providing accurate and unbiased information for all FP services offered to AGYW. -All linkages to FP for DREAMS AGYW should be active linkages, not passive referrals. -A hybrid-model with access to adolescent facilities and services offered at safe space girls clubs and facilities may provide optimal access and should be considered. -Ensure provider- and client-facing FP tools and IEC materials are available. -A full range of contraceptive methods should be presented including LARCs, and dual protection counselling (i.e., using condoms to protect against HIV/STI and pregnancy) should be stressed. - PEPFAR does not pay for FP commodities, except for condoms and lubricants, so teams should coordinate with USAID family planning, as well as other donors, to ensure DREAMS recipients have access to comprehensive voluntary family planning options.	-WHO: Programming strategies for Post-Partum Family Planning: http://apps.who.int/iris/bitstream/10665/93680/1/9789241506496_eng.pdf -Actions for improved clinical and prevention services and choices: preventing HIV and other sexually transmitted infections among women and girls using contraceptive services in contexts with high HIV incidence: https://www.unaids.org/en/resources/documents/2020/preventing-hiv-sti-among-women-girls-using-contraceptive-services -FP/HIV Integration Quality Assurance Tool: https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/tagged_fp-hiv_monitoring_tool-paper_version_1.2.pdf -FP/HIV Services Integration Toolkit: https://toolkits.knowledgesuccess.org/toolkits/fphivintegration

Post Violence Care	AGYW at risk for GBV, especially IPV and sexual violence against children	Identify and respond to AGYW experiencing violence	-Identify cases of violence among AGYW during participation in DREAMS (both community and clinical activities) and provide an appropriate and timely response. -Provide age-appropriate post-violence clinical care services per the minimum package defined in the GEND_GBV MER indicator. -Train service providers in age-appropriate violence case identification, first-line support, and post-violence care (151). -Work to expand/enhance government guidelines and practices for high quality post GBV care. -Develop or strengthen standardized, two-way referral systems so AGYW seeking post GBV care are linked to DREAMS. - Based on the coverage of government and other donors, identify gaps in the coverage of comprehensive post GBV care that needs to be covered by DREAMS (e.g. could be a specific component of the minimum package, or a proportion of the target population that is not covered).	-WHO's Caring for Women Affected by Violence Curriculum: https://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/ -Trauma focused counseling: https://www.nctsn.org/sites/default/files/interventions/tfcbt_training_guidelines.pdf -The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs: https://cdn.ymaws.com/www.forensicnurses.org/resource/resmgr/Education/PEPFAR_Clinical_Mngt_of_Chil.pdf -Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines: http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/ -Responding to children and adolescents who have been sexually abused: WHO Clinical Guidelines: https://www.who.int/reproductivehealth/publications/violence/clinical-response-csa/en/
Social asset building	AGYW	Increase in social capital; Reduce social	-Use female mentor-led safe spaces or girls' clubs as a platform to support the development of peer networks for AGYW and implementation of the DREAMS core package	-From Research, To Program Design, To Implementation Programming For Rural Girls In Ethiopia: A Toolkit For Practitioners,

		isolation; Increase agency and empowerment among AGYW	both directly or through active linkages to clinical and/or community-based services. -Social assets are cultivated through regular, small-group meetings in safe, public spaces where participants receive social support, information, and developmentally appropriate evidence-based curricula and services (and/or links to services such as health care). -The curricula delivered in safe spaces often include economic strengthening, violence prevention, and comprehensive HIV prevention. -Sometimes FP, condoms, PrEP, and HTS are made available in safe spaces—if not available on site, active referrals must be made to those services. -To support AGYW engagement and retention in DREAMS programming, childcare may be provided for DREAMS participants with children while they attend safe spaces and other DREAMS programming. -Led by female mentors who can serve as role models and advocates on behalf of assigned mentees—see detailed guidance on mentors in Appendix F.	Population Council 201: https://toolkits.knowledgesuccess.org/toolkits/very-young-adolescent-sexual-and-reproductive-health-clearinghouse/research-program-design -Girl-Centered Program Design: A Toolkit to Develop, Strengthen & Expand Adolescent Girls Programs; Population Council 2011: https://www.popcouncil.org/research/girl-centered-program-design-a-toolkit-to-develop-strengthen-and-expand-ado -Youth Power Action Key Soft Skills for Cross Sectoral Youth Outcomes: https://www.youthpower.org/sites/default/files/YouthPower/resources/Key%20Soft%20Skills%20for%20Cross-Sectoral%20Youth%20Outcomes_YouthPower%20Action.pdf -For more information and resources to enhance mentoring in DREAMS, please see Appendix F -Other evidence-based interventions that are reviewed and approved by OGAC and ISMEs
Enhanced Economic Strengthening	AGYW	Increase in financial knowledge and actual bridge to	-To educate and support AGYW (out of school in older age bands (15-24 year olds), consistent with local labor laws) on both self-employment/entrepreneurship and wage employment pathways, the following 5 components should	-Profiting from Parity: Unlocking the Potential of Women's Business in Africa: https://openknowledge.worldbank.org/handle/10986/31421

		employment capital	be implemented as part of a comprehensive economic strengthening program: - Market assessment to explore opportunities that can build resilient and economically empowered communities, guide skill development and training, and identify opportunities for program linkages related to labor, with a focus on growing industries and traditionally male-dominated sectors; - Gender-specific training to develop financial literacy, marketable skills, and an entrepreneurial mindset (i.e. coping strategies for resilience to setbacks); - Start-up support (post-training): i.e. starter packs or other support for self-employment and/or access to paid internships/jobs for wage employment; - Savings groups (if/when AGYW have access to income); and - Ongoing coaching/mentoring and facilitating access to, and acceptance in, social and business networks. -IPs should consider older DREAMS participants for positions such as community health workers, community led monitoring, PHIA data collectors, etc. For more information on the intended process please see Figure 1.	-YouthPower: Employment Programming Considerations for Adolescent Girls and Young Women in DREAMS Contexts: https://www.youthpower.org/resources/youthpower-webinar-resourcesemployment-programming-considerations-adolescent-girls-and-young-women-dreams-contexts -YouthPower: Key Approaches to Labor Market Assessment: https://www.youthpower.org/key-approaches-labor-market-assessment-interactive-guide Approved Models (resources/TA available from developers): -ELA developed by BRAC: https://www.bracinternational.nl/en/what-we-do/empowerment-livelihood-adolescents-ela -Siyakha developed by Bantwana: https://bantwana.org/project/siyakha-girls-pilot-under-the-accelerating-strategies-for-practical-innovation-and-research-in-economic-strengthening-aspires -WINGS+ developed by AVSI: https://www.poverty-action.org/study/enterprises-ultra-poor-women-after-war-wings-program-northern-uganda

				-Vusha Girls developed by ACWICT: https://www.acwict.org/initiative/vusha-girls-employability-program -STEP (developed by Leuphana University): https://step-training.com -PI Training (developed by Leuphana University): https://pi-training.org -Other evidence-based interventions that are reviewed and approved by OGAC and ISMEs

Mobilize the Community for change				
Intervention	**Target Groups**	**Outcomes**	**Considerations for Implementation**	**Additional resources and approved curriculum (if relevant)**
School-based HIV and violence prevention	Children and adolescents in schools and communities	Increase knowledge, skills, agency; Reduce number of sexual partners, unprotected sex; Increase male and female condom use; Delay sexual debut; Reduce violence	-Assess current landscape of comprehensive violence and HIV/AIDS prevention education in schools, communities, facilities and faith-based organizations. -Work with the education sector and appropriate ministries to provide accurate, evidence-based, and developmentally appropriate comprehensive HIV/AIDS prevention education in schools.	-UNESCO, International Technical Guidance on Sexuality Education: An Evidence-Informed Approach, 2018: https://www.who.int/publications/m/item/9789231002595 -UNESCO Sexuality Education review and Assessment tool (SERAT) 3.0, 2020: https://cse-learning-platform-unesco.org/digital-library/sexuality-

		victimization and perpetration	-If school-based violence prevention is ongoing, assure curriculum is evidence-based. -HIV/AIDS prevention should be offered to AGYW and their male classmates. -DREAMS does not support abstinence only HIV/AIDS preventions interventions. See Table 2 for more information. If comprehensive curricula are not able to be delivered in school settings per government policy, DREAMS funds should NOT be used to fund implementation of curricula that do not meet DREAMS standards. DREAMS funds should instead be directed to policy change.	education-review-and-assessment-tool-serat-30 -IMPower (violence prevention): https://www.nomeansnoworldwide.org/approach ; http://pediatrics.aappublications.org/content/133/5/e1226.full.pdf+html -Other evidence-based interventions that are reviewed and approved by OGAC and ISMEs
Community mobilization and norms change	Community leaders; AGYW and their broader communities	Reduce violence; Change harmful gender norms; Increase community commitment to reducing HIV and GBV among AGYW	-Implement evidence-based programs to build community cohesion, commitment and collective action for preventing HIV and violence among AGYW, as well as interventions that focus on changing harmful community/social norms that can contribute to HIV and violence risk either directly or indirectly (i.e. norms around judgement and stigma to SRH/HIV services, norms around child marriage, norms around GBV). -Prioritize implementation with male and female community leaders, faith-based and traditional leaders, and decision makers. -CMNC curricula/programs are often time intensive. Implementation should follow the	- SASA!: http://raisingvoices.org/sasa/ -Coaching Boys into Men: https://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men/

			guidelines from the evidence base, developer, or program data upon which approval was granted. - Ensure linkages to clinical platforms such as HTS and post GBV care.	

Strengthen the Families				
Intervention	**Target Groups**	**Outcomes**	**Considerations for Implementation**	**Approved curriculum (if relevant)**
Parenting/ Caregiver Programs	Caregivers of vulnerable adolescent girls	Reduce AGYW's risk and vulnerability; Violence prevention; Improvement in parental relationship and emotional support	-Implement parenting programs with demonstrated effects on adolescent HIV risk behaviors and on protection from sexual violence. -Ensure that these programs educate parents/caregivers on and support uptake of high impact DREAMS interventions (e.g., PrEP, condoms). - Provision of a parenting program for caregivers of 10-14 year old AGYW is mandatory. While beneficial to caregivers of all adolescent girls, this intervention is not mandatory for AGYW ages 15-17 years. Parenting/caregiver programs should NOT be offered to parents/caregivers of 18-24 year olds. - Parenting programs may be offered to parents of AGYW and AGYW who are parents/caregivers. Parenting programming for AGYW who are parents is primarily intended to improve services for and retain AGYW aged 20-24 years. The parenting program should be developmentally appropriate, focused on	-Families Matter! Program: https://drive.google.com/file/d/168YEKRVBHeVpmoCd3ffmebWsg-d1RJJn/view -Sinovuyo Teen and WHO Parenting for Lifelong Health Programmes: https://www.who.int/teams/social-determinants-of-health/parenting-for-lifelong-health/programme-manuals

			parenting skills tailored to the developmental age of the child.	
Education Subsidies/ Support	AGYW and their parents/ guardians (note: subsidies may be provided to schools in form of bursar)	Increase school attainment, both transitioning to and finishing secondary school; reduce vulnerability to HIV and early, unintended pregnancy	-Engage caregivers on the long-term benefit of girls completing secondary school; problem solve around cultural and logistical issues that prohibit school attendance. -Ensure there are not direct or indirect financial barriers to girls attending secondary school -i.e. if education subsidies are covered by the host country government or other funders, assess if there is a need to provide financial assistance for books, uniforms etc. -Ensure girls and their families are aware of and can access programs that provide funds for school – whether these programs are through PEPFAR or country government schemes. -Ensure government programs and schemes are sufficient to provide school for every school-age girl, and provide additional assistance if gaps arise. -Consider other forms of education support such as early warning drop out programs and tutoring. - Ensure AGYW and their families identified for school subsidy support through DREAMS have a plan for assistance that outlines in advance any specific responsibilities, including any co-payments required throughout the duration. - If secondary school completion is high among DREAMS target population (e.g. 80% or more of	

			vulnerable AGYW complete secondary school in your setting), OUs can opt-out of this component. - Identify and coordinate with any government benefits or other donors funding education initiatives to avoid duplication.	

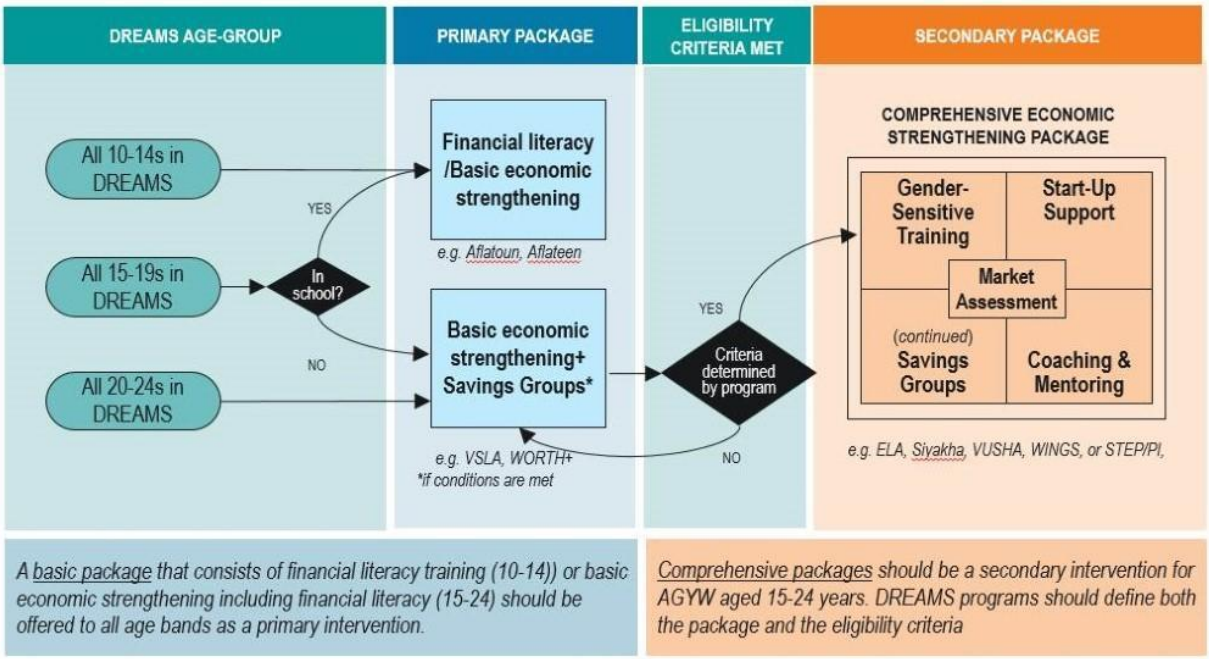
Decrease Risk **in Sex Partners of AGYW**				
Intervention	**Target Groups**	**Outcomes**	**Considerations for Implementation**	**Approved curriculum (if relevant)**
Characterization of male partners to target highly effective interventions (ART, VMMC)	Sexual partners of AGYW	Better targeting of HIV prevention, care and treatment to males who are the potential sex partners of AGYW	-Use data and findings from existing surveys, including CMSP work by Genesis to inform program and assess AGYW risk. -Leverage routine services that provide information to treatment, VMMC, male and female condom promotion and HTC programs so they can increase focus on males most likely to be the sources of infection for AGYW in the community.	-MENSTAR: https://menstarcoalition.org/ -Genesis reports on characterizing male partners in DREAMS: https://pepfar.sharepoint.com/sites/DREAMS/SitePages/Home.aspx

Table 2: Interventions NOT to be implemented with DREAMS funds

Intervention	Reason
Treatment for Schistosomiasis	There is no evidence at this point that treatment for *Schistosomiasis* prevents HIV infection.
Abstinence-only or peer led sexual education	Both of these types of sex education interventions have little to no evidence of efficacy and have been shown (in some cases) to have negative effects on young people's sexual behaviors.
Packages limited to HTC; behavior change counseling; and condom promotion and provision	Several high-quality studies (CAPRISA 008, VOICE, FEMPREP) offered counseling, HTC and condoms as their standard of care in the control arm and still saw high incidence rates in this population.
Unconditional and Conditional cash transfers for STI reduction, knowledge of HIV status or safe sex practices	While a number of studies show positive impacts from conditional cash transfers, this is not a sustainable intervention for use of PEFAR funds. Additionally, there are often government aid programs available for DREAMS staff to link DREAMS AGYW.
Credit-based approaches to economic strengthening (standalone, not in combination with social empowerment approaches)	Lower-quality studies demonstrate inconsistent outcomes, including instances of adverse effects.
Income-based approaches to economic strengthening (standalone, not in combination with social empowerment approaches)	Lower-quality studies demonstrate inconsistent outcomes, including instances of adverse effects.
Stand- alone youth centers (this does not refer to adolescent friendly health centers)	Numerous studies have shown that youth centers do not decrease HIV risk
ART for PMTCT for young mothers	DREAMS funds should be used to encourage the most vulnerable pregnant females 15-24 to attend ANC and be tested for HIV. However, treatment or prophylaxis for those girls or young women found positive should be funded through existing PMTCT programs and not the DREAMS initiative.
HIV Care and Treatment for girls and young women	DREAMS funds should be used to test vulnerable girls and young women for HIV. Those identified in HTC programs as HIV positive should be actively linked to care and support. However, DREAMS funds should not be used to fund ART for these patients; those

	funds should come from existing PEPFAR programs or other sources.
HIV Care and Treatment for male sexual partners of AGYW	DREAMS funds may be used to identify and test the partners of vulnerable girls and young women for HIV. Those identified in HTC programs as HIV positive should be actively linked to care and support. However, DREAMS funds should not be used to fund ART for these patients; those funds should come from existing PEPFAR programs or other sources.
VMMC for male sexual partners of AGYW	DREAMS funds may be used to identify and test the partners of vulnerable girls and young women for HIV. Those identified in HTC programs as HIV negative should be actively linked to HIV prevention programs, including VMMC. However, DREAMS funds should not be used to fund VMMC service delivery for these men; those funds should come from existing PEPFAR programs or other sources.
Emergency contraception purchases	DREAMS funds should not be used to purchase emergency contraception (EC) in the case of sexual violence. EC as part of post violence care should be funded through an alternate source. Current programs are funded by USAID (non-PEPFAR funds), UNFPA, or other bilaterals. DREAMS funding can be used for all other aspects of post violence care (i.e., lab testing, STI treatment, counseling, referrals, case management, etc.) DREAMS funding can also provide FP education, including awareness of EC as part of post violence care
Contraceptive commodity purchases	DREAMS funds should not be used to purchase contraceptive commodities (with the exception of male and female condoms). Contraceptive commodities are often funded by USAID (non-PEPFAR funds), UNFPA, or other bilaterals. DREAMS funding can be used for all other aspects of FP services (i.e., outreach services, training service providers, etc.)

Figure 1: Enhanced Economic Strengthening Graphic



Appendix C: DREAMS Layering Completion Table Instructions, Example and Template

DREAMS Layering Table

The DREAMS Layering Table (Table 1) summarizes the package of DREAMS services/interventions that are delivered to DREAMS participants in a particular country by age group. DREAMS Layering Tables are to be updated annually as an interagency effort. Please note the following definitions when completing this table:

- Primary services/interventions: Interventions that **ALL AGYW** in an age group should receive if they are DREAMS participants.
- Secondary services/interventions: Needs-based interventions that are part of the DREAMS core package, but will not be received by all AGYW in that age group (e.g. only AGYW who earn an income should participate in a savings group).
- Contextual services/interventions: Interventions that are part of the DREAMS core package, but cannot be linked to an individual AGYW (i.e. community mobilization and norms change).
- Service/Intervention Completion: This is country-specific criteria for determining the completion of each service/intervention in their DREAMS core package. Service completion definitions should be based on normative guidance and instructions from program developers where available. A service should not count towards an AGYW's DREAMS program completion until it has met the service completion definition.

Considerations for Economic Strengthening:

- All 10-14 AGYW should receive financial literacy as part of the primary package. This can be covered by an entire financial literacy curriculum or financial literacy sessions integrated within another curriculum. 10-14 year olds should not receive savings group interventions.
- All 15-19 AGYW should receive basic economic strengthening including financial literacy as part of their primary package. Savings groups should be offered in the secondary package (only if AGYW are earning an income). A subset of 15-19 AGYW should receive a comprehensive package as a bridge to wage employment or self-employment as part of their secondary package. DREAMS programs should clearly define the criteria to determine which AGYW receive either the basic or comprehensive package of economic strengthening services (e.g., those who are out of school, etc.).
- All AGYW 20-24 years should receive basic economic strengthening that includes financial literacy as a part of their primary package. A subset of these AGYW should receive a comprehensive package as a bridge to wage employment or self-employment as part of their secondary package. DREAMS programs should clearly define the criteria to determine which AGYW receive either the basic or comprehensive package of economic strengthening services (e.g., those who are relying on transactional sex as their income). Savings groups should be offered in the secondary package (only if AGYW are earning an income).

Considerations for Clinical Services:

- Teams should consider separating out information/education, screening, and actual receipt of clinical services such as HTS, PrEP, post-violence care, and FP. For example, screening for HTS or PrEP could be in the primary package for all age bands whereas actual receipt of HTS or PrEP would be in the secondary package as not all AGYW may be expected to need this service.

- Similarly, information about FP options may be in the primary package but receipt of FP services would be in the secondary package.

DREAMS Intervention Completion Table

The DREAMS Intervention Completion Table (Table 2) defines "completion" for services in your DREAMS core package. ***Each service/intervention represented in your DREAMS Layering Table should appear in the DREAMS Intervention Completion Table.***

Considerations for completion definitions:

- Completion definitions should be based on normative guidance, instructions from program developers and/or program evaluations when available.
- It is expected that completion for curriculum-based interventions be no lower than 80%, with an ideal completion definition in the 90-100% range. Implementing partners should provide makeup sessions to ensure that completion of curricula is as close to 100% as possible for DREAMS participants. Even if an AGYW has this service counted as complete due to % attainment, she should still be encouraged to finish and/or make up sessions to complete the entire curriculum.
- Evidence-based curricula should be delivered as they were evaluated (e.g. number, length, and frequency of sessions).
- Parenting curricula should include completion definitions for both AGYW and parents/caregivers.

Table 1. DREAMS Layering Table Example

		10-14	15-19	20-24	Notes
INDIVIDUAL	**Primary Interventions**	• Social Asset Building • School or Community-based HIV & violence prevention • Parenting/Caregiver Programming • Financial Literacy	• Condoms • HTS • School or Community-based HIV & violence prevention • Financial Literacy • Social asset building	• Condoms • HTS • Community-based HIV & violence prevention • Financial literacy • Bridge to employment • Social asset building	• In school receive school-based HIV education; out of school, participate in community based education
	Secondary Interventions	• Education subsidies • Condoms • HTS • Contraceptive Mix • Post-violence care	• Education subsidies • PrEP • Contraceptive Mix • Post-violence care • Bridge to employment • Parenting/Caregiver Programming	• PrEP • Contraceptive Mix • Post-violence care	• Contraceptive Mix includes all aspects (e.g. increase availability, outreach, training, alignment with other initiatives, provision, etc.)
CONTEXTUAL	**Contextual Level Interventions**	• Community Mobilization & Norms Change • Reducing risk of sex partners (link to HTS, VMMC, Treatment)			

Table 2: DREAMS Intervention Completion Table

Core Package Category	Specific Service/Intervention	Definition of Completion	Total Time to Complete Intervention	Source Used (if applicable)
Parenting/Caregiver Programming	*Specify curricula/um*	*Ex: AGYW attended 15 of 16 sessions*	*Ex: Weekly meeting over 16 weeks*	*Ex: Specific curricula manual/guidance*
Social Asset Building				
Community Mobilization & Norms Change				
HIV & Violence Prevention				
Economic Strengthening				

Appendix D: DREAMS Curriculum Review Process and Checklist

DREAMS Curricula Review and Approval Processes

Evidence-based interventions (EBIs) are a foundational element of the DREAMS core package to facilitate sustainable social and behavioral change in individuals and communities. In general, an evidence-based curriculum is one that has a well-articulated theory of change, is shown to be effective at reaching its objectives through rigorous evaluation and has been peer reviewed. In order to ensure all interventions are of high quality, DREAMS curricula must be thoroughly reviewed by HQ ISMEs and approved by S/GAC prior to implementation. There are three DREAMS curricula approval classifications:

1. Global Curricula: EBIs that can be used in all OUs. Global curricula are reviewed by an interagency ISME team and approved by S/GAC. Curricula can become globally approved after review and approval as outlined in the global curriculum review process. These interventions should be delivered as they were evaluated (e.g. number, length, and frequency of sessions). Appendix B Table 1, includes a list of globally approved curricula for DREAMS implementation, and teams are encouraged to use one of these evidence-based curricula when feasible.

   If your OU requires substantial adaptation of a globally approved curriculum (e.g., changes beyond locally relevant names, terms, and situational context), please work with your ISME team to seek approval and navigate the adaptation process.

2. Country-Specific Curricula: curricula approved for implementation in an individual country due to context-specific needs. For instance, in-school HIV and violence prevention programming may be limited to nationally approved Ministry of Education curricula, or IP-specific curricula may be the best fit for the implementation environment. For example, the curricula could be currently implemented, meet criteria/standards of the S/GAC checklist, and program metrics show strong results (e.g., retention and completion, demonstrated knowledge).

   Country-specific curricula are not pre-approved for use by other OUs. There are circumstances when a country team may desire to use a curriculum approved for another OU. In this case, each OU must submit individual approval requests to implement the curriculum in their respective OUs as outlined in the country specific curriculum review process.

3. Agency-Specific Curricula: curricula approved for use by a specific agency across OUs. For example, Peace Corps' (PC) Grassroot Soccer SKILLZ curricula was developed for PC's implementation model globally and is distinct from Grassroot Soccer's suite of curricula. In this case, PC SKILLZ curricula are approved, however the broad suite of GRS curricula are not reviewed or globally approved. The agency-specific review and approval process can be found on the DREAMS SharePoint site.

A continuously updated list of global, country-specific, and agency-specific approved curricula can be found on the DREAMS SharePoint site.

Appendix E: DREAMS Program Completion and Saturation

Introduction

As DREAMS becomes standard practice within PEPFAR for HIV prevention among adolescent girls and young women (AGYW) in 15 countries, questions have surfaced around the responsibility of the program to DREAMS girls as they complete interventions and age out of their age bands or DREAMS. For example, should AGYW enrolled in DREAMS eventually "graduate" from the DREAMS program and if so when and how? What is the definition of "saturation" in DREAMS districts? If saturation is reached in a district, what should "maintenance" look like?

To address these complicated questions, we gathered a group of DREAMS and OVC subject matter experts in 2018 to discuss the possible scenarios DREAMS participants could face and how PEPFAR teams can best support them in staying healthy and safe. We also gathered input from country teams that were already considering these issues (Uganda, South Africa, Tanzania, and Kenya). After initial efforts to operationalize the saturation portion of this document, we further refined the document and added process considerations in November 2019.

This document covers two main topics – program completion and saturation. Program completion addresses when DREAMS as a package of comprehensive interventions can be considered complete at the individual level. Saturation addresses how a country team can document that DREAMS has saturated at the SNU level (75% of vulnerable AGYW have completed the appropriate package of interventions) among all relevant age groups of AGYW. While DREAMS is still a new program, as it evolves, we want to see DREAMS implemented in more SNUs to maximize the benefit of the program and ensure all of the most vulnerable AGYW have been reached. To reach that goal, we need to assess progress in current SNUs to determine when to redirect resources to new SNUs while continuing to meet the needs of vulnerable AGYW in the original SNUs.

DREAMS Program Completion

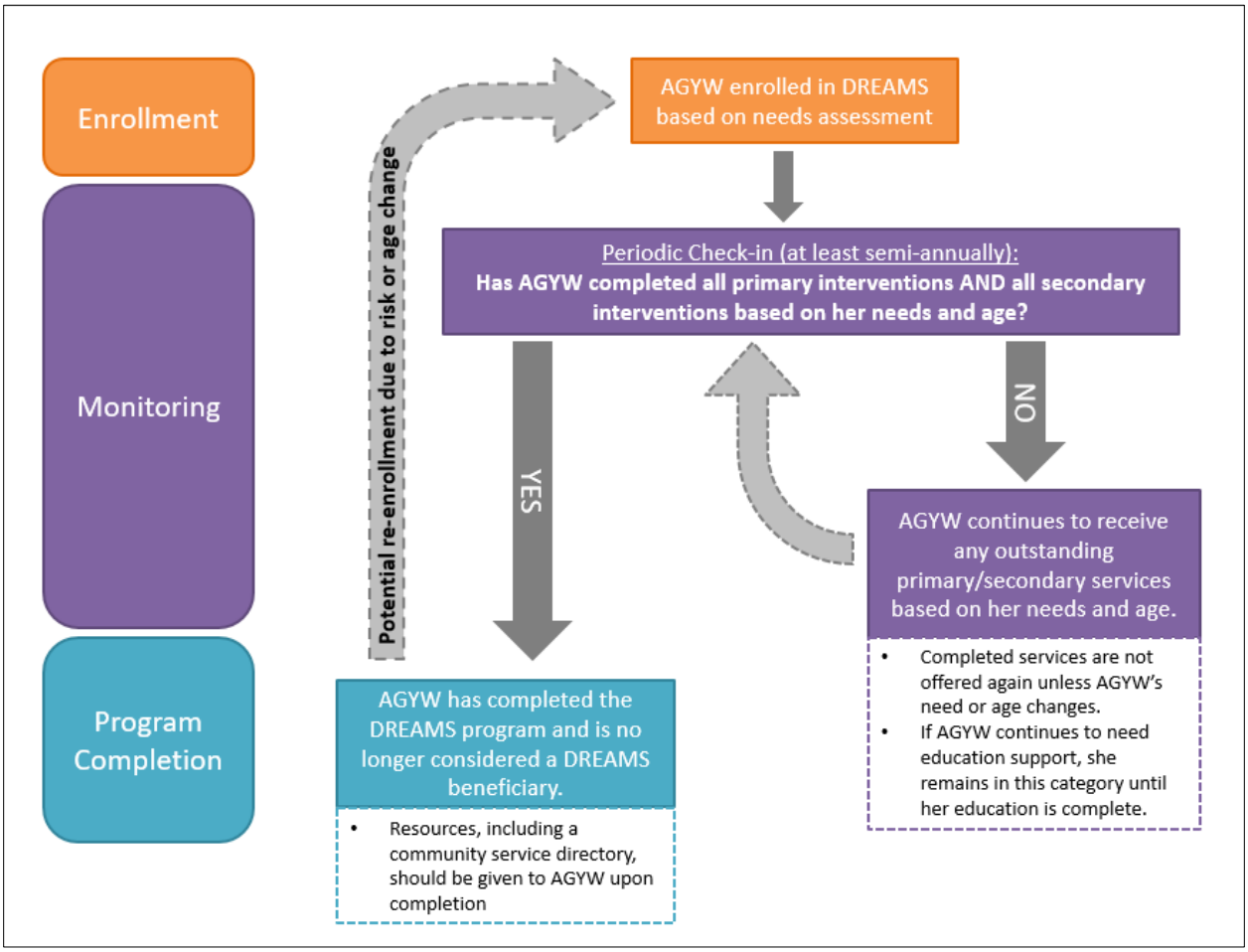
DREAMS program completion is defined as when an individual AGYW has completed all primary and relevant secondary core package interventions based on her unique needs, HIV risk, and age. The DREAMS theory of change posits that the receipt of layered, evidence-based interventions will reduce an AGYW's risk and prevent HIV acquisition. By ensuring that she receives all of the programs or services in the core package of interventions that she needs based on her age and risk, we believe DREAMS will improve outcomes in AGYW's lives. Thus, we consider "graduation" from DREAMS to mean completion of all appropriate programs and services for an individual AGYW which should then lead to improved agency and decreased vulnerability and HIV risk.

Program completion is therefore output-oriented, and is not dependent on achievement of individual outcomes such as educational attainment or skills-based assessments. We will continue to gauge DREAMS progress at the population level through changes in new diagnoses and/or incidence and rely on evidence of program completion as sufficient to assume success at the individual level.

All DREAMS countries should follow the general DREAMS Program Completion Continuum (figure 1), which includes three distinct phases -- enrollment, monitoring and program completion. Countries may adapt this continuum to their country-specific implementation of DREAMS in regards to: (1) make up of primary and secondary packages for each age group, (2) frequency of periodic check-ins, though these

must occur at least every 6 months, and (3) the resources and follow-up provided to AGYW upon DREAMS program completion.

Figure 1: DREAMS Program Completion Continuum



Enrollment: An AGYW begins the DREAMS Program Completion Continuum at enrollment into the DREAMS program. Country-specific eligibility criteria, vulnerability assessments, and/or enrollment screening should be used to enroll AGYW into DREAMS (please refer to Appendix A). These tools should be used to identify AGYW who are most vulnerable to HIV acquisition in that setting. **AGYW are only considered DREAMS participants after they have been enrolled in DREAMS and have started or completed at least one DREAMS service or intervention.**

Monitoring: The majority of an AGYW's time in DREAMS is spent in the monitoring and active participation phase. During this period, DREAMS partners must ensure that the AGYW completes all primary and secondary services and interventions based on her needs, HIV risk, and age group. Implementing partner staff (e.g. mentors, program managers, etc.) should be reviewing layering data at least quarterly to ensure that layering is happening and AGYW are receiving the services they need a timely manner. In line with AGYW_PREV, implementing partners must report each AGYW's layering status at least semi-annually to determine if she has completed all primary and relevant secondary services and interventions, or if she is still in the process of completing interventions. Completion of each service and intervention in an OU's core package should be defined in their DREAMS Service Completion Table which accompanies the DREAMS Layering Table. The AGYW remains in the monitoring phase while completing any DREAMS

services or interventions and should continue to receive these services based on her needs and age. Once an AGYW has completed a service or intervention in its entirety, she should no longer be provided that service unless her needs change and that service is again needed.

The monitoring phase aligns with the AGYW_PREV MER indicator for which countries are required to track and report whether or not AGYW complete primary and secondary services and interventions. There are 13 MER indicators related to DREAMS programming that OU's are required to review on a quarterly, semi-annual and annual basis per MER v2.5 guidance. The most efficient way to review a DREAMS recipient's layering status is to review her data in the country's layering tracking system that follows which interventions or services she has received and completed.

The monitoring phase aligns with the new AGYW_PREV MER indicator for which countries will have to track and report whether or not AGYW are completing primary and secondary interventions.

Considerations

- Reaching completion of certain interventions may require particular AGYW to remain in the monitoring phase for a longer period of time, even if they have completed all other DREAMS services and interventions. For example, if an AGYW is receiving education support based on economic need, she will remain in the monitoring phase until she no longer needs that support. While this is allowable, this must be balanced with the fact that DREAMS is not intended to support individual AGYW from the time they are 10 until age 24. Additionally, an AGYW who is still accessing PrEP should remain active past PrEP uptake, at least through the first 6 months of PrEP use or discontinuation.
- While DREAMS is not intended to support individual AGYW from the time they are 10 until age 24, it is expected that some active participants may age up into the next DREAMS age band while in the program (e.g. an AGYW enrolled at age 14 turning 15 while still in the monitoring phase). In this case, the AGYW that has aged up should complete all primary and relevant secondary services for her new age band. She does not need to re-complete any duplicative services or interventions that are in both her old and new age band.

Program Completion: Program completion is the phase in which a DREAMS participant has finished all primary and secondary interventions and services relevant to her age group and needs. Once an AGYW reaches this phase, she has completed the DREAMS program and is no longer considered a current or active DREAMS participant. Monitoring of AGYW is not required after they have reached program completion, however, she should be given information before she formally leaves DREAMS regarding local services that she may need in the future and how to reconnect with DREAMS if she believes her risk level changes. It is important for implementing partners to manage this transition and AGYW's expectations about participation in DREAMS once they have reached program completion.

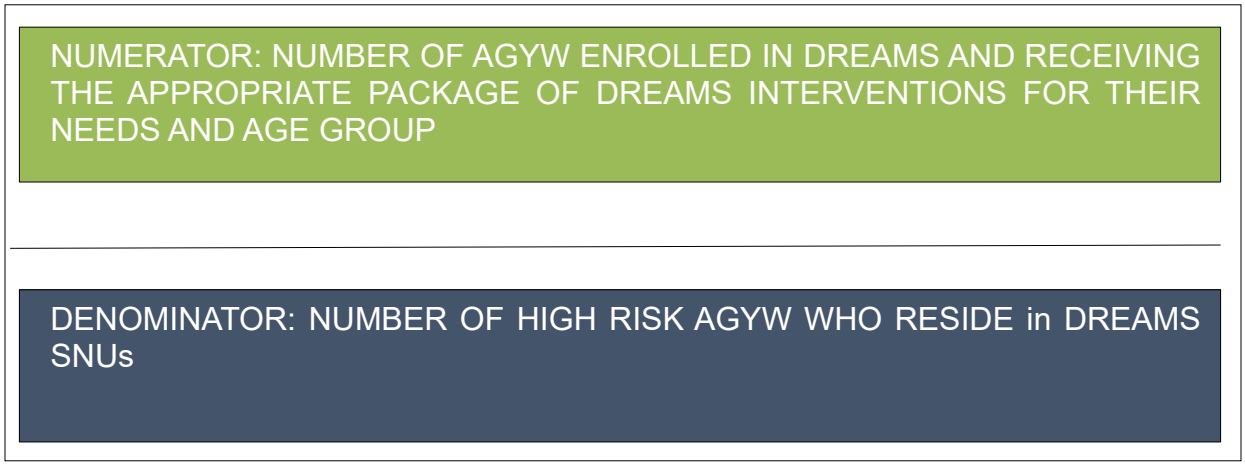
Reenrollment: Potential reenrollment can occur when a life event or circumstances elevates the risk and vulnerability of a former DREAMS participant. For example, if a girl graduates from DREAMS at 12 years old, and she later comes to the attention of DREAMS as a sexually active, at-risk 15 year old, she can be reenrolled in DREAMS and should then receive any programs or services for that new age group that were not previously completed to meet her needs (e.g. contraceptive method mix, condoms, PrEP). If an AGYW is reenrolled, the program completion continuum (Figure 1) begins again. Depending on the OU's layering system, OU's may decide whether to track a reenrolled AGYW as a new participant (i.e. using a new unique identifier) or as the same participant with additional needs (i.e. using AGYW's original unique identifier).

Saturation

Before determining if saturation has been achieved in a DREAMS SNU, the country should first consider the broader context of epidemic control. If 95-95-95 has been achieved for all sub-populations, including AGYW, in the SNU, then PEPFAR's investment in DREAMS should be phased out. This should be done on the same scale and timeline as the rest of the PEPFAR portfolio. In SNUs where 95-95-95 has not yet been achieved, DREAMS teams should consider the issue of saturation in preparation for each new COP. There is no time limit to achieving saturation, aside from reaching epidemic control, given that districts vary by size and funding.

Saturation in DREAMS is achieved when 75% or higher of vulnerable AGYW in a DREAMS SNU have completed the primary and secondary DREAMS interventions relevant to her needs and age group. In order for an SNU to be classified as saturated, this 75% or higher achievement must be reached for each of the three age categories targeted in DREAMS by each OU (10-14, 15-19 and 20-24). Saturation is calculated for each age group by using the formula in Figure 2.

Figure 2. Saturation Numerator and Denominator



Saturation Assessment and Calculation Process:

While each DREAMS OU may have different available data and steps for calculating saturation within DREAMS SNUs and age bands, this section provides general guidance on how to approach and consider the process. Please see PEPFAR Share Point for supplementary resources to guide OUs through this assessment and calculation process, including examples of each step described below.

I. Determine population estimates by age band and SNU; this may include several different size estimates from different sources if applicable. Analyze HIV vulnerability and risk data by age band and SNU.
II. Calculate the saturation denominator(s) by age band/SNU using the population estimate and vulnerability and risk estimates.
III. Estimate the numerator of AGYW who have reached DREAMS program completion based on individual needs or using AGYW_PREV numerator disaggregate as a proxy.
IV. Calculate saturation by dividing the numerator by the denominator, possibly obtaining a range of potential saturation estimates, by SNU and age band.

Documenting data sources and assumptions for each component of the saturation assessment and calculation process is critical for both understanding the potential programmatic implications and presenting estimates in support of potential geographic expansion.

Step 1. Determine the population size for each of the age groups in the DREAMS SNU. This should be done using some type of representative data set like the most recent census at the PSNU level

- Possible resources to obtain size estimates:
  - Datapack submitted population size estimates
  - Census 5-year Age/Sex population estimates
  - ICPI spreadsheet with census, world pop, and landscape data
- Considerations:
  - DREAMS aims to reach HIV-negative AGYW to keep them negative. While HIV status and testing should not be a requirement for enrollment, for program planning purposes the theoretical population of who should be in DREAMS would not include HIV+ AGYW.
  - Datapack estimates should build on host country consensus on population sizes and Spectrum, and would provide the most consistent estimates across other PEPFAR data.
  - If no official host government estimate exists, use at least two sources. If the sources differ by more than 10%, a range in population size estimate should be used.
  - Account for growth in population, considering effects of the youth bulge, if estimates are older and do not account for population growth (the census estimates have been adjusted to project population growth).

Step 2. HIV vulnerability and risk criteria will be **OU specific** and must emphasize vulnerability and risk to HIV acquisition, rather than general vulnerability such as poverty and should **align with DREAMS enrollment criteria** (e.g. GBV, secondary school enrollment, contraceptive use, transactional sex).

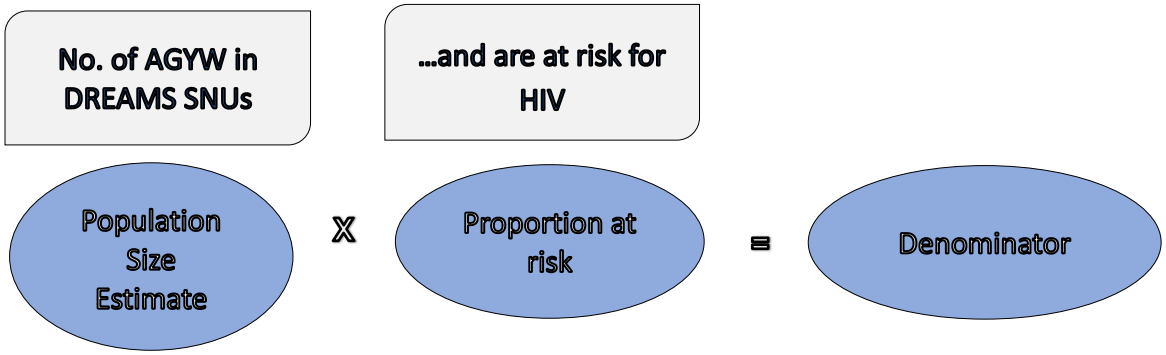
- Possible data sources:
  - Girl Roster (if already completed in the OU)
  - Data from risk assessment tools/screening and enrollment forms
  - Layering systems or other monitoring tools, where data on those who were screened and not enrolled and included
  - Survey data, including VACS, DHS, PHIA
  - Scientific literature on HIV risk in OU context
- Considerations:
  - Data may not be available at the DREAMS SNU level
  - Data sources may not exactly match DREAMS enrollment criteria or age bands. If this information is not already being collected, encourage DREAMS IPs to collect data on their screening and enrollment cascade to better understand profile of DREAMS participants.
  - Many AGYW may have multiple, overlapping vulnerabilities or risks. Most data sources do not provide information on this overlap. Therefore, consider calculating a 95% confidence interval for the vulnerability or risk estimate and use the upper limit for a conservative estimate or prioritize particular data points/criteria. In most cases, using the highest estimate for vulnerability or risk would be appropriate.

- If feasible/useful, estimate vulnerability using two data sources or approaches to obtain comparisons and again get a range. This is especially pertinent if using multiple data sources where there are overlapping categories of vulnerabilities

Step 3. Calculate the saturation denominator(s) by age band/SNU using the population estimate and the vulnerability/risk estimates

- Considerations:
  - Figure 3 demonstrates the data points from Step 1 and 2 that can be used to calculate the saturation denominator.
  - Using multiple data sources for your population size estimate and proportion at risk will yield a range of estimates for your denominator.

Figure 3. Inputs for DREAMS Saturation Denominator



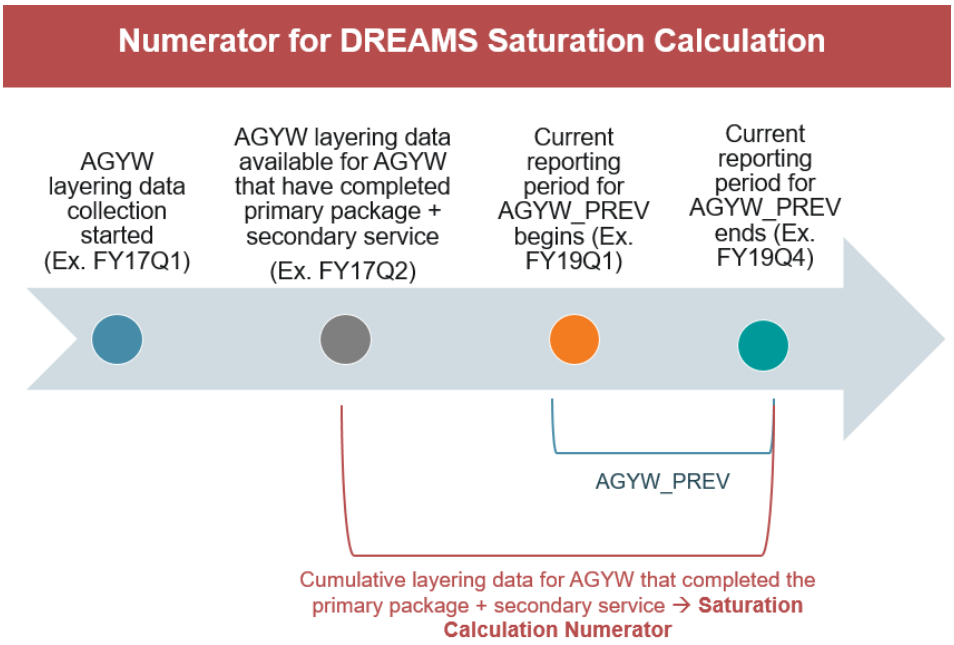
Step 4. Estimate the numerator of AGYW who have reached DREAMS program completion based on individual needs or using AGYW_PREV numerator disaggregate as a proxy.

Numerator Options: Use the option below that provides the most robust estimate of AGYW that completed the appropriate package of DREAMS services or interventions for their needs and age group.

- *Option 1: Use DREAMS program completion data*
  - This is the preferred option where data is available.
  - DREAMS program completion data requires monitoring of not just AGYW_PREV, but an individual AGYW's needs for different components of the secondary package of services at different time points.
  - Data may be available in layering system, case files, or other program records.
- *Option 2: Use number of AGYW who completed the primary package and an additional secondary service as a proxy for program completion (i.e. AGYW_PREV numerator disaggregate)*
  - Use this option if program completion data is not available, as described in Option 1.
  - Use AGYW_PREV numerator disaggregate: Number of AGYW that have fully completed the primary package of services/interventions and at least one secondary service/intervention

- **Cumulative Data:** Ideally, saturation should be calculated using cumulative data on AGYW program completion from the beginning of DREAMS; however, this may not be possible in many countries. Potential scenarios include:
    - If OU began DREAMS layering data collection prior to FY19, calculate saturation using cumulative data from the start of data collection in each DREAMS SNU.
    - Cumulative data will cover a different time period than the AGYW_PREV reporting period. See Figure 4 below.
    - If OU began DREAMS layering data collection in FY19 when AGYW_PREV reporting began, calculate saturation for FY19 only. Beginning in FY20 and for future years, calculate saturation cumulatively.

Figure 4: Cumulative Saturation Numerator Scenario



Step 5: Calculate saturation by dividing the numerator by the denominator, possibly obtaining a range of potential saturation estimates, by SNU and age band. (If you have multiple estimates for the denominator or numerator you will also have a range of estimates for your final saturation calculation.)

Data Use: Saturation Data: *What do you do with your saturation calculation results?*

- **Plan for expansion and present data at COP**

  As part of COP planning, some countries may consider broadening geographic coverage beyond the current DREAMS SNUs to other prioritized SNUs. Saturation in DREAMS is achieved when 75% or higher of vulnerable AGYW in a DREAMS SNU have completed the appropriate package of DREAMS interventions for their age group. In order for an SNU to be classified as saturated, this 75% or higher achievement must be reached for each of the three age categories targeted in DREAMS by each OU (i.e., ages 10-14, 15-19, and 20-24); however, teams may propose expansion in COP21 if at least one age band is saturated in a current DREAMS SNU. In instances where the saturation estimates included a range of different numbers, teams should consider the pros and cons of each method and data inputs to assess whether or not they can support a case that they

reached the 75% benchmark. Saturation does not have to be reached across all DREAMS SNUs or age bands to propose geographic expansion; saturation can be reached SNU by SNU.

Saturation is not the sole criteria for DREAMS geographic expansion. Consideration of DREAMS geographic expansion should be made by each country team in consultation with their Chair, PEFPAR Program Manager, AGYW ISMEs, and the OGAC DREAMS team. Please refer to COP guidance for more information.

- **Knowledge and Program Planning**
  All DREAMS countries should analyze DREAMS saturation on an annual basis to inform programming and planning processes. It is important that countries clearly document their data sources, decisions, process, and any data caveats used to generate their saturation calculation data. Where saturation estimates do not reach the 75% benchmark, countries should examine their data and program implementation to determine programming and targeting adjustments for the next year.

  Examples of analyses using AGYW_PREV and program data to inform and respond to saturation estimates include:
  - Which services are the most difficult to deliver and/or complete by age band?
  - Review proportion of AGYW_PREV to assess among those who have completed at least the primary package, what proportion have completed primary + secondary. If this shows that the majority have received only primary or only secondary, is there evidence that the AGYW enrolled are the most vulnerable or that the package is being delivered appropriately?

Maintenance

As DREAMS SNUs reach saturation, country teams should develop and implement maintenance plans. The goal of DREAMS maintenance is to maintain saturation levels across all DREAMS age bands to sustain DREAMS contributions to prevention and epidemic control. When developing maintenance plans, country teams should follow the below guiding principles:

- Reach and maintain saturation levels (defined as at least 75%) by age band and SNU
  - Phased approach: When one or more age band in a DREAMS SNU is saturated, but at least one age-band is still in process
  - Full saturation: When all age bands have been saturated
- Maintain active and visible DREAMS presence in all current SNUs
- Maintain the core package of interventions by age group, targeting smaller numbers of AGYW
- Account for epidemic control within country and/or SNU
- It is not expected that AGYW are active in the DREAMS program from age 10 to 24 years. An AGYW should exit DREAMS once she has reached program completion, however she can reenroll in the future based on new or recurring vulnerability/risk.

In order to maintain saturation in each DREAMS SNU, country teams should appropriately target to reach the most vulnerable AGYW, including those who “age-in” to DREAMS and “age-up” between DREAMS age bands in maintenance SNUs. In the event of a phased approach to saturation, country teams should target for maintenance for the appropriate age bands. Data sources used to estimate saturation (e.g., census,

population size estimates, etc.) should be used to estimate how many AGYW will age up and age into DREAMS to inform targets set in maintenance districts.

Some cost savings in maintenance districts compared with full implementation is needed to consider geographic expansion. Targets will likely be reduced as saturation has been reached which should result in cost savings; however, it may be more costly to reach those AGYW who have yet to complete the DREAMS package because they may be among the hardest to reach. Country teams may decide to continue or expand contextual interventions in maintenance SNUs to sustain community-level changes. Country teams should continue to leverage host government, private sector, and other programs for components of the core package based on AGYW's needs and overall post-epidemic control planning.

Appendix F: DREAMS Technical Considerations and Guidance on Mentoring

Introduction

A preliminary step in improving the mentoring aspect of DREAMS was for PEPFAR to assess existing DREAMS mentoring activities in all fifteen DREAMS OUs. In order to accomplish this, OGAC collaborated with Genesis Analytics to create a survey that OGAC disseminated to DREAMS OUs in FY20 to begin gathering this information. Country teams were asked to submit program information on how mentors were currently recruited, trained and provided ongoing support in DREAMS. An additional assessment of existing mentoring activities in DREAMS began in FY20 as part of a Bill and Melinda Gates Foundation (BMGF) funded project. The purpose of the project is to assess mentoring in AGYW prevention programming broadly due to the limited understanding of how mentoring is currently implemented and availability of guidance on recruiting, training and supervising mentors. Both of these exercises, combined with feedback from DREAMS AGYW, observations during DREAMS monitoring visits and inputs from the AGYW Prevention COOP, formulated the basis of mentoring guidance for DREAMS.

DREAMS Mentoring Survey

A total of 37 unique respondents equivalent to DREAMS IPs completed the survey, which represented roughly 33% of the total number of the 111 partners implementing DREAMS at the time of the survey being administered.[1,2,3] Of the 37 completed surveys, over 60% were multiple survey submissions from the same DREAMS OU.[4] The data provided interesting insights into how some partners are developing mentoring cadre for DREAMS, however, it is important to note that the survey was limited in providing a comprehensive understanding of mentoring in DREAMS overall. The results from the mentoring survey can be accessed here. Respondents also provided some additional qualitative information along with supporting documentation (e.g., SOPs, job descriptions, etc.) to assist in further unpacking their activities around DREAMS mentoring.

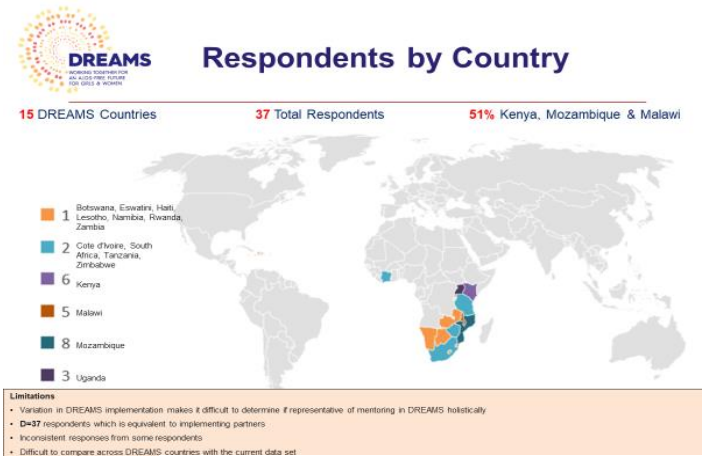


Figure 1: Mentor Survey, PEPFAR

[1] *At the time of the survey, the total number of DREAMS IPs was calculated by country and includes seven IPs that are only implementing DREAMS in COP19/FY20 (i.e., not continuing in COP20) and instances where the same IP is counted multiple times due to implementing DREAMS in more than one country.*

[2] *Based on the completed surveys received, respondents are defined as implementing partners.*

[3] *The total number of implementing partners responsible for developing mentoring cadre in DREAMS is unknown at this time.*

[4] *OUs with >1 respondent included Cote d'Ivoire, Kenya, Malawi, Mozambique, South Africa, Tanzania, Uganda and Zimbabwe.*

Gates Funded Mentor Project

Genesis Analytics was selected by BMGF to complete a project on mentoring and collaborated with OGAC and the AGYW Prevention COOP mentoring subgroup for technical input and guidance on engaging with the DREAMS program. Genesis started with a literature review followed by an environmental scan of mentoring in five OUs with both PEPFAR and Global Fund AGYW prevention programming, which was combined with results from the OGAC-led survey conducted across all fifteen DREAMS OUs.[5] For the five OUs, Genesis conducted deep-dives with ten DREAMS implementing partners (two per OU), PEPFAR team members, and mentors and mentees in select DREAMS OUs. Two interagency HQ DREAMS leads were also interviewed. The aim of the environmental scan was to understand and document the best practices that exist in AGYW mentorship in prevention programming by reviewing the mentoring components of both PEPFAR and Global Fund programs based on the objectives outlined in the *Figure 2*. Genesis completed the field work for the mentor project in April 2021 and provided recommendations that can be accessed here along with some that have been incorporated throughout this guidance.

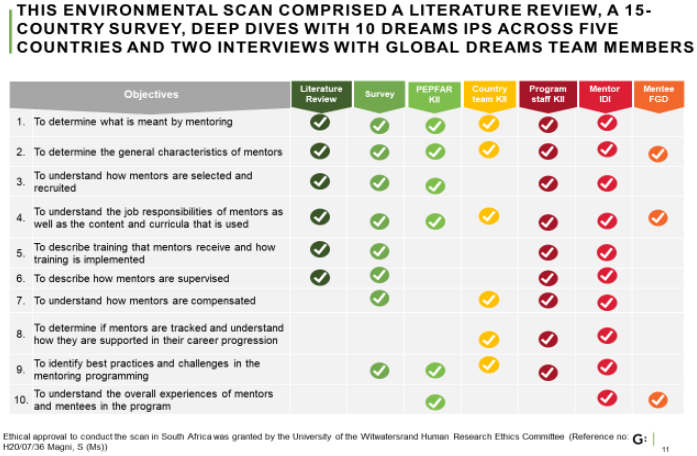


Figure 2: Objectives of Environmental Scan for Mentor Project, Genesis Analytics

Preliminary Findings and Key Considerations

The survey and landscaping analysis both revealed many interesting details regarding how mentoring is implemented in DREAMS OUs, although it is important to note that both possessed inherent limitations to providing a comprehensive representation of mentoring in DREAMS overall. Additionally, OGAC and the AGYW Prevention COOP mentoring subgroup are still reviewing these findings and Genesis is still completing data collection and analysis that may have future programmatic implications for DREAMS. However, there are some key considerations based on the preliminary findings that have been highlighted in the COP 21 Guidance and as part of the DREAMS Guidance refresh.

Universal Understanding of Mentoring

A revelation that occurred during the environmental scan is the fact that there was no universally accepted definition of mentoring, although experience and trust are two consistent elements across definitions. Though mentoring is commonly used in a variety of settings, in HIV prevention programming the mentoring component is often used to build protective assets (i.e., safe means of

[5] *Mozambique, Namibia, South Africa, Tanzania and Zambia*

earning income, safe meeting place to develop peer network).[6] For DREAMS, mentoring aims to build protective assets, and the definition of a DREAMS mentor is wider than social asset building and extends to supporting participants' access to most if not all the DREAMS Core Package, similar to how layering is considered an indispensable tenet of DREAMS. Genesis found that relatively few interviewees across the five deep-dive OUs were able to articulate how mentoring supported DREAMS in achieving its goals. They also found that although different terms to describe mentors are used, the description of the role mentors play is relatively consistent across countries.

OGAC and the AGYW Prevention COOP mentoring subgroup are further unpacking what this means for DREAMS moving forward and plan to assess how teams and partners can be best supported in improving the understanding of mentoring in DREAMS for all relevant stakeholders.

Recruitment, Selection and Onboarding

The survey showed that all 37 respondents reported using mentors in their DREAMS program, with the majority confirming that they deployed standardized tools and processes to recruit and select prospective mentors from within and outside of DREAMS. Respondents reported that mentors were predominantly female, ranging from 18-40 years of age with the majority being reported as older or the same age as their mentees. Almost all respondents reported that DREAMS mentors came from the same community as their mentees and had to meet standard education, language and literacy requirements.

Genesis' findings were overall consistent with what was reported in the survey regarding the composition of mentors, with some inconsistencies in the age range of mentors within and across the five deep-dive OUs. Pairing of mentors with mentees based on age was mentioned in both the survey and environmental scan, but it is unclear how this takes place when mentors were reported as being much older than their mentees during the environmental scan. There was also an expressed passion for helping AGYW and improving their futures as an important driver for why AGYW became mentors. Interviewees in one OU emphasized that being a role model was more important than being relatable to mentees, which highlighted an existing tension between representation and role modelling. They also found that outside of the standardized job description, job recruitment requirements and processes varied within and across the deep-dive OUs. However, there were consistencies in job advertisement development and dissemination and internal and external recruitment sources. Selection committees comprised of partner staff are common, but there were inconsistencies in the selection tools being used. Some respondents also reported that mentors are required to undergo background and/or reference checks during the selection process.

> ***Recommendation***
>
> DREAMS programs should develop or enhance standardized recruitment and selection processes that strike a balance between selecting mentors as role-models and relatable to their assigned mentees and communities. DREAMS programs should consider "hiring for attitude and motivation and training for skill" to support the selection of individuals possessing key characteristics for being strong mentors, even if they initially lack the required technical knowledge. DREAMS programs should also remain mindful of how they are pairing mentors to mentees in relation to age, while ensuring that mentees feel comfortable and trusting of the

[6] *Population Council. 2016. Building Girls' Protective Assets: A Collection of Tools for Program Design. New York: Population Council.*

mentors. DREAMS mentors should not be assigned cohorts where the mentor is younger or the same age as the mentees.

Orientation and Training

Most of the respondents reported having an SRH knowledge requirement and verification process generally consisting of a training/workshop followed by a written or oral exam or knowledge check. In some cases, respondents reported requiring this knowledge at the time of selection. Most respondents also reported that initial and refresher trainings were provided to mentors, which varied in frequency and content of training. There appeared to be consistent core training reported by all respondents (i.e., Basics of HIV, SRH, and some limited training on group facilitation, etc.), however, other relevant trainings (e.g., first-line support training like LIVES, communication, problem-solving) were less consistent or not reported.

Genesis found that representatives from all ten partners interviewed in the deep-dive OUs reported providing training to mentors, and that interviewed mentors reported finding both the initial and refresher trainings useful. Interviewed mentors reported receiving both formal and informal training conducted by either the mentor's assigned DREAMS partner or another DREAMS partner. Respondents also reported that mentors receive training on both the OU selected evidence-based curricula being delivered in safe spaces and some limited soft skills such as facilitation, and that training needs are often assessed through ongoing supervision of mentors. Genesis found that interviewees consistently expressed how good "soft" skills, such as being able to build rapport with AGYW, seemed more important than having technical knowledge alone.

Recommendation

DREAMS programs should provide a standardized package of training for DREAMS mentors across the OU. This package should include training on both technical and soft skills, the specific curricula delivered in DREAMS programming for that OU, and an overall orientation to the DREAMS program and how DREAMS mentors support DREAMS in achieving its goals. Mentors should receive first-line support training (i.e., LIVES) to support their capacity to respond effectively and responsibly to disclosures of violence, especially considering that mentees tend to confide in their mentors about sensitive and often challenging situations. DREAMS programs should also prioritize on-the-job training throughout a mentor's time in DREAMS in addition to annual formal refresher trainings. Sensitization training for mentors on inherent bias, beliefs and value systems and how this can support or challenge their ability to perform their roles in a manner truly supportive of mentees should also be considered.

Roles and Responsibilities

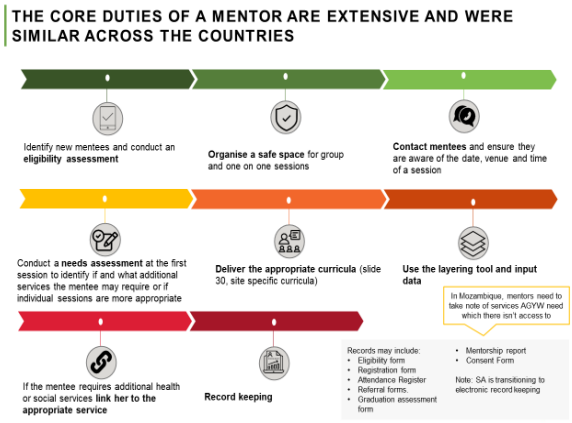
All survey respondents reported on the varied and extensive roles and responsibilities of mentors in their programs. Respondents reported substantial commitments of time and effort by mentors to provide intensive support to mentees both in and outside of safe spaces, which included individual and group interactions. Most respondents reported that mentors mostly led cohorts of mentees alone or in pairs, with the number of mentees per session ranging from as little as five with the highest reported being thirty. The number of cohorts assigned to mentees was not captured in the survey, but nearly 70% of respondents reported that mentors consistently engaged with the same cohorts of mentees.

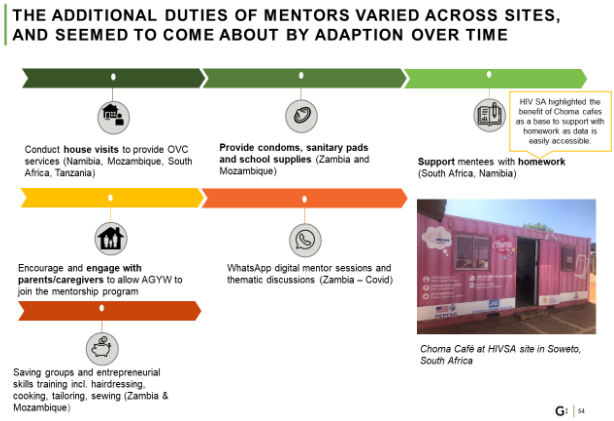
Genesis also found that mentor responsibilities are wide-ranging, and that "core" responsibilities were similar across countries. Group facilitation was a key task for mentors across all ten partners, with variation in curricula delivered by mentors, number of assigned cohorts and mentors in each cohort.

Recordkeeping and M&E were consistently mentioned by interviewees. Some interviewed mentors also shared that they undertook additional tasks as needed, such as home visits and supporting mentees with homework.

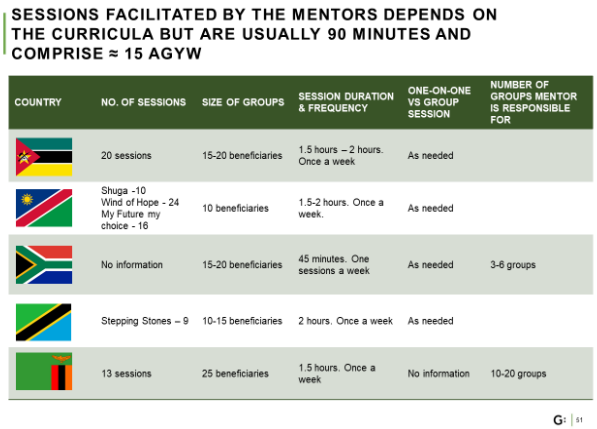
Recommendation

DREAMS programs should develop or enhance standard mentor job descriptions that outline the "core" and "additional" responsibilities. The job description and recruitment materials should explicitly outline the wide-ranging duties and responsibilities for mentors, including group composition and routine time commitments and expectations for engagement with mentees both in a group setting and individually. Resources are available in the table below to support these efforts.





Figures 3 & 4: Core vs. Additional DREAMS Mentor Duties, Genesis Analytics



COUNTRY	NO. OF SESSIONS	SIZE OF GROUPS	SESSION DURATION & FREQUENCY	ONE-ON-ONE VS GROUP SESSION	NUMBER OF GROUPS MENTOR IS RESPONSIBLE FOR
	20 sessions	15-20 beneficiaries	1.5 hours – 2 hours. Once a week	As needed	
	Shuga -10 Wind of Hope - 24 My Future my choice - 16	10 beneficiaries	1.5-2 hours. Once a week.	As needed	
	No information	15-20 beneficiaries	45 minutes. One sessions a week	As needed	3-6 groups
	Stepping Stones – 9	10-15 beneficiaries	2 hours. Once a week	As needed	
	13 sessions	25 beneficiaries	1.5 hours. Once a week	No information	10-20 groups

Figures 5: Cohort and Session Details, Genesis Analytics

Supervision

Supervision is defined as support for mentors to perform duties and deliver programming with fidelity through ongoing engagement, monitoring and/or evaluation. All survey respondents confirmed that some form of supervision is provided to mentors along with most having standard supervision SOPs. Supervision varied in frequency, with nearly 60% reporting that mentors received supervision on a weekly basis.

Genesis found that all interviewed partners and mentors from the deep-dive OUs reported providing and receiving some form of supervision, respectively. The composition of supervisors differs by OUs, and some interviewees reported that senior DREAMS mentors are promoted into mentor supervisor roles. Most supervisors manage an average of ten mentors, with one OU having an average of thirty mentors per supervisor. It was reported that supervision was formal and used various tools to support the process.

Recommendation

DREAMS programs should consider formalizing a feedback mechanism for DREAMS AGYW to mentors and mentor supervisors, and it may be useful to provide supportive supervision[7] training for mentor supervisors. Supervision guidelines should not only focus on data collection and reporting but should also include quality of delivery to better support mentor supervisors and mentors. DREAMS programs should provide mentors with knowledge-sharing opportunities, including peer-to-peer and peer-to-technical staff. Mentors should be capacitated to navigate the inherent challenges of their role through supplementary assistance such as psychosocial support. Not just for the purpose of supporting mentees, but for the mentor as well. For example, mentees often place a great deal of trust in their mentors and disclose highly sensitive information such as GBV. This information can be difficult to manage and even triggering based on a mentor's own lived experiences. Along with referral resources and other tools needed for mentors to support mentees, mentors also need support as well.

Compensation

More than half of the respondents reported that compensation was provided in the form of a subsidy/stipend, with a much smaller percentage providing additional forms of compensation (i.e., transport, airtime, etc.). Respondents from Mozambique reported offering performance-based awards for mentors. Few respondents reported offering salaries/wages for mentors.

Genesis found that most of the interviewed DREAMS partners reported that they consider their DREAMS mentors as staff as opposed to volunteers. Where mentors are classified as staff, it was reported that they receive a salary, and volunteers receive a stipend or allowance that is a "country-specific amount". Some respondents reported that mentors also receive a "commission" or "bonus" in addition to their salaries. Additional types of compensation such as transport were also reported, but to a lesser degree. Several interviewees from DREAMS partners expressed the critical need to better support mentors through improved compensation, but also other areas such as training and supervision. Genesis' review of the literature suggested that mentors perform better and are retained longer when they are compensated in accordance with the level of effort required for their roles.

Recommendations

All DREAMS mentors should have access to a mobile phone to perform their duties.[8] DREAMS programs should provide travel support and data/airtime bundles as a standard provision for mentors to effectively carry out their tasks and responsibilities. DREAMS programs should

[7] *Supportive supervision is a process of helping staff to continuously improve their work performance with a focus on using supervisory visits as an opportunity to improve knowledge and skills of staff, in addition to monitoring performance and deliverables.*

[8] *DREAMS mentors should either already own or be equipped with a mobile phone to carry out their mentoring duties. If already owned, then DREAMS programs should supply airtime/data to support their duties. If a mentor does not own a phone, then DREAMS programs should supply a mobile device in addition to airtime/data.*

assess a clearly defined level of effort and time commitment by mentors and match compensation to similar professional opportunities in a mentor's assigned community. Mentors should receive sufficient remuneration and resources that are reflective of the intensive work they perform.

Retention, Tracking and Career Progression

Respondents reported that the average mentor stay in the DREAMS program primarily ranged from 1-2 or 2+ years, however, additional questions in the survey revealed that some of those same respondents reported challenges with mentor retention overall. Challenges to retention were predominantly based on the pursuit of career progression, advanced or return to education and life events such as marriage. Less than half of respondents reported that they provided career transition support, with much of this support being in the form of recommendation letters. Most respondents did not support defined career paths for mentors, although, 70% reported routinely hiring mentors in DREAMS. Over half reported providing economic empowerment to mentors with the majority of this being in the form of entrepreneurship. Other economic empowerment provision for mentors, such as job readiness, was reported as being provided to a much lesser degree.

Genesis found that interviewed mentors consistently expressed a desire for career progression within DREAMS and did not wish to leave the program. Interviewed mentors reported that they left DREAMS either because they reached the "upper age limit" or they were no longer able to participate due to reasons such as marriage or their spouses not permitting them to do so. Mentors reported being provided with some career support, but it appeared to be informal and "relationship based". There was an acknowledgement that the program benefits the mentors as well as the mentees, but that a longer-term plan for mentors needed to be guided by PEPFAR. A review of the literature suggests that mentors often view career progression as more valuable than money alone, although, compensation was still considered important.

Recommendations

There was a clear gap in existing support for career progression and transition for DREAMS mentors, which was also highlighted in the survey as a barrier to mentor retention in DREAMS. DREAMS countries should document a clear career progression plan for mentors and consider providing them with additional trainings (e.g., training as lay counsellors) to support their career progression. DREAMS programs should support mentors in developing curriculum vitae (CVs) and linking to other employment, when possible, and mentors should be provided a reference letter as they transition out of DREAMS. DREAMS programs may even consider whether there are opportunities to affix accreditation to some of the trainings received by mentors in DREAMS to also support career progression.

Conclusion

There are some robust but varied mentoring activities being implemented in DREAMS, however, it is not entirely clear to what degree given variations in reporting within and across DREAMS OUs. It is also understood that some DREAMS programs may already have many of these processes and tools in place. Therefore, this guidance should be used to supplement or enhance existing mentoring activities in your DREAMS programming. Please work with your AGYW prevention ISMEs if you require additional technical support for the mentoring component of your DREAMS programming, and please reference the table below for specific tools and resources that may be used to support mentoring in your DREAMS program. You may also access a collection of best practices shared by respondents for the survey and preliminary Genesis recommendations from the environmental scan.

IMPROVING MENTORING IN DREAMS			
OBJECTIVE/GOAL	**CONSIDERATIONS FOR IMPLEMENTATION**	**TOOLS & RESOURCES**	
		SUGGESTED TOOLS & PRACTICES TO HAVE IN PLACE	**POTENTIAL RESOURCES**
RECRUITMENT & SELECTION, ONBOARDING To seek out and hire strong candidates to support mentoring in DREAMS	**Recruitment:** - Mentors should be slightly older than the mentees in their cohort(s) - Create an ideal mentor to mentee ratio that allows for mentors to create a strong connection with individual AGYW and a supportive group environment (e.g., each mentor assigned 4 cohorts of 15 AGYW)[9] - Most optimal ways to reach prospective candidates **Selection:** - Basic education/literacy requirements - HIV and sexual and reproductive health knowledge or capacity to develop knowledge - Prospective candidates representative of assigned community - Focus on interpersonal skills during selection since technical knowledge can be gained during training - Background checks, consistent with agency and national policies, must be performed prior to onboarding **Onboarding:** - Formal process for informing mentor of selection and next steps	● Recruitment strategy (e.g., radio announcements, posters, advertisements, etc.) ● Job Description ● Interview strategy (interview questions and score sheets, etc.) ● Standardized scoring and selection criteria ● Offer letter ● Onboarding SOP ● Background screening/reference checks	● The Population Council Mentoring Toolkit ● Chapter 1 ● YouthPower Action Adolescent Girls and Young Women (AGYW) Mentoring Program Toolkit

[9] *Provided as an example ONLY. AGYW Prevention COOP mentoring subgroup further exploring what this means for DREAMS given its scale and what the emerging literature defines as an optimal mentor to mentee ratio.*

ORIENTATION & TRAINING To ensure that mentors are adequately oriented, on-boarded, trained and supported	**Orientation** • Duties and responsibilities • HIV impact on AGYW in OU/globally • Organizational details • DREAMS and PEPFAR **Training** • Training plan (e.g., initial/refresher trainings, specific EBIs used for DREAMS in OU, program-specific duties) • Examples of knowledge development content to standardize for a mentor training plan: - DREAMS - First-line support training (i.e., LIVES) - SRH - Social Asset Building/safe spaces - EBIs used in DREAMS for OU - Facilitation and community engagement - Soft skills[10] - GBV prevention/response - Supporting active linkages to services - Recruiting and enrolling AGYW - Tracking and reporting • Coaching/Support (e.g., Peer support, post training evaluation, mentor feedback)	● Standardized orientation packet ● Training plan/schedule (e.g., initial/refresher trainings, specific EBIs used for DREAMS in OU, program-specific duties) ● Pre/Post training mentor evaluation and feedback SOP	● The Population Council Mentoring Toolkit - Chapter 2 ● YouthPower Action Adolescent Girls and Young Women (AGYW) Mentoring Program Toolkit ● Peace Corps – Youth Mentoring workbook ● Peace Corps – Community mapping resources ● Peace Corps/USAID – Life Skills and Leadership manual ● Youth Power Action Key Soft Skills for Cross Sectoral Youth Outcomes
JOB RESPONSIBILITIES To clearly define roles and responsibilities for mentors	Clearly defined mentor responsibilities - Specific responsibilities and expectations for mentors (e.g., primary duties in which all mentors should carry out, number of assigned mentees/cohorts) - Auxiliary duties that mentors are permitted to perform as needed but are not required - Responsibilities related to planning and coordinating	● Standardized mentor position description and packet ● Standardized job aids/tools to perform duties ● SOPs/resource lists (e.g., referral trees, forms, community resource guide) ● Standard reporting forms	● The Population Council Mentoring Toolkit - Chapters 1 & 3

[10] *Soft Skills: Positive self-concept, Self-control, higher order thinking skills, social skills, effective communication, empathy, and goal-oriented.*

	sessions, mentoring AGYW (group or individually), monitoring and reporting, and active linkages and referrals to community and clinical services		
SUPERVISION To support and empower mentors to perform duties and deliver programming with fidelity through ongoing engagement, monitoring and/or evaluation	Identified supervisors and clearly defined roles and expectations of interactions with mentors Type (qualitative/ quantitative, formal, informal) and frequency of supervision for mentors Provision of routine feedback on mentor performance Opportunities for mentors to communicate feedback to supervisors and request additional support as needed Determination of needs for refresher/additional training Clear understanding of mentor attrition rates	• Supervision SOP • Standardized performance monitoring tools (e.g., performance appraisals, trackers, supervision checklist) • Mentor feedback forms (e.g., mentor survey forms) • Mentor training tracker • DREAMS AGYW feedback tool on mentor performance • Training/performance certificates • Provision of psychosocial support for mentors, as needed	• The Population Council Mentoring Toolkit: - Chapter 4 • YouthPower Action Adolescent Girls and Young Women (AGYW) Mentoring Program Toolkit - Supportive Supervision and Annex 8
COMPENSATION To promote accountability of mentors and ensure that mentors are provided compensation and resources representative of their LOE, and to ensure that mentors are recognized for and are aware of the value of their contributions to the success of DREAMS	Provision of support for mentors to accomplish defined responsibilities and tasks (e.g., providing mentors with a data plan to facilitate virtual mentoring during COVID and transport to support active linkages of mentees to services) Clearly defined employment or contract status (e.g., volunteer, stipend only, wage employee) with duties and responsibilities aligned with compensation structure and clearly presented in the mentor service contract Compensation is reflective of LOE and competitive with other professional opportunities in the community performing similar duties Accessible compensation platforms (e.g., bank accounts, mobile	• Mentor service contract with detailed compensation information • Standardized compensation SOP and tools (e.g., timesheets, session reports, travel forms, call log) • Standardized SOP for recognition and other incentives (e.g., career progression support, performance-based awards)	• The Population Council Mentoring Toolkit: Chapter 4 (Monitoring and Evaluation) • Youth Power Action AGYW Mentoring Program Toolkit - Supportive Supervision AND Annex 8

	transfers) for transferring wages to mentors Prerequisites and documentation for mentors to receive compensation (e.g., documentation mentors must submit to initiate receipt of payment or travel stipend) Mentor recognition and potential for performance-based rewards		
RETENTION, TRACKING AND CAREER PROGRESSION To support clearly defined professional growth and retention of mentors during time in and transition out of DREAMS	Support for career progression to enter workforce Clearly defined career progression and pathways for mentors within DREAMS or as they decide to transition out of DREAMS Additional trainings and potential certifications to better capacitate mentors in achieving their professional goals Routinized tracking of mentor attrition rates and contributing factors	● Development of job seeking materials (i.e., CV, letter of recommendation) ● DREAMS mentoring completion certification ● Career guidance and link to new employment opportunities ● Provision of additional trainings to elevate mentor skillset and increase competitiveness in the job market ● Mentor feedback mechanism	● The Population Council Mentoring Toolkit: - Chapter 2

You may also find additional resources shared by survey respondents in supporting documentation and best practices.