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IMPLEMENTATION BRIEF

Reaching Adolescent Girls and Young Women most in need of HIV and Sexual and Reproductive Health and Rights Services in Eastern and Southern Africa

December 2025

THE GLOBAL FUND

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Acronyms

AGYW	adolescent girls and young women
ART	antiretroviral therapy
DHS	demographic and health survey
ESA	Eastern and Southern Africa
GBV	gender-based violence
HTS	HIV testing services
MICS	multiple indicator cluster survey
PHIA	population-based HIV impact assessment
PrEP	pre-exposure prophylaxis
SHIPP	sub-national HIV estimates in priority populations
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
TWG	technical working group
VACS	violence against children survey

1. Background

Ending AIDS by 2030 and assuring sexual and reproductive health and rights (SRHR) for all requires reaching people with the highest risk and vulnerability with HIV prevention and sexual and reproductive health (SRH) services. The insights and recommendations presented in this brief draw on a regional Think Tank convened by UNICEF ESARO which brought together over 50 experts, youth representatives, government actors and implementing partners to define practical, context-appropriate approaches for reaching adolescent girls and young women (AGYW).

Over the past decade, AGYW aged 15-24 living in Eastern and Southern Africa (ESA) have benefitted from an overall decline in new HIV infections, fewer unmet family planning needs, and greater access to adolescent-responsive HIV and SRH services.[1] Despite these gains, many AGYW in ESA remain at substantial risk of poor HIV and SRH outcomes. AGYW continue to shoulder an unacceptably high burden of HIV infection compared to their male peers and the general population. In 2024, an estimated 140,000 AGYW acquired HIV, accounting for one-quarter of all new infections in the ESA region. This rate is three times higher than that of their male peers.[2] Of the 55,000 new HIV infections among children (0-14 years) in 2024 in ESA, nearly one-third were among mothers who acquired HIV during pregnancy or the breastfeeding period. The adolescent pregnancy rate in the region, 92 births per 1,000 girls, is twice the global average.[3] Several countries report that an estimated 20% of girls experience pregnancy before 20 years of age.[4] These figures highlight the urgent need for services that are responsive to AGYW's realities.

The vulnerabilities AGYW face are complex and interconnected at the individual, interpersonal, community, and structural levels and include limited access to health services and education, poverty, gender inequality, and exposure to violence. These structural and social drivers increase the risk of HIV, early and unintended pregnancy, and other negative SRH outcomes.[5] Risk is particularly elevated among AGYW who are pregnant or breastfeeding, living with HIV, part of key populations, or living in high-risk settings such as mining areas, farming communities, and high-mobility corridors.[6,7,8]

Risk among AGYW is not static; it is multidimensional and shifts over time.[9,10] While taking risks is a normal and necessary part of adolescent development, many "first-time" experiences—such as first sexual relationship, first pregnancy, or first time leaving home—are inherently high-risk due to power imbalances, limited knowledge, and lack of support.[11,12,13] Brain development during adolescence also plays a role—impulsivity and reward-seeking are high, while self-regulation and planning are still developing. This leads to lower risk perception and greater vulnerability to harm.[14]

These risks intensify during key life transitions—starting or leaving school, entering relationships, migrating for work—and are shaped by broader contextual factors such as conflict, displacement, or poverty.[15] Recognizing when and where risks emerge, and how they evolve, is essential to delivering services at the right time, to the right individuals, in the right way.

Defining risk and vulnerability

These definitions of risk and vulnerability explain how social, behavioural and contextual factors shape AGYW's HIV and SRHR outcomes.

What do we mean by risk?

A **risk environment** is a situation or context involving increased exposure to danger.

A **risk behaviour** involves actions that increase exposure to a threat or something potentially harmful.

A **risk factor** is an attribute, characteristic or exposure that increases the likelihood of an individual experiencing a negative outcome either immediately or in the future.

What do we mean by vulnerability?

Inherent conditions, including biological, that an individual is exposed to and are often created through factors out of the individual's control.

Societal factors that may adversely affect an individual's ability to exert control over their health and well-being.

Vulnerability can increase health-related risks and risk behaviours. For example, being in a violent relationship may lead to being unable to negotiate sex with a condom which, in turn, may lead to HIV infection.

Given the diversity of risk profiles and limited resources, it is not feasible to provide all services to all AGYW, everywhere. Programmes must prioritize identifying and reaching those most at risk - not just those who are easiest to reach. This requires more intentional targeting through layered strategies such as using geographic data, platform-specific entry, and individual-level risk assessments. Strengthening referral systems and ensuring service integration is also key to addressing the multiple and overlapping vulnerabilities faced by AGYW,[16,17,18] including those in humanitarian settings.[19] These considerations are increasingly urgent in the context of tightening national and donor budgets and the rapid expansion of new biomedical HIV prevention options. For example, the availability of both oral and long-acting PrEP reinforces the need for programmes to use targeting approaches to prioritise AGYW with the greatest HIV risk, while ensuring that PrEP is delivered as one component of a broader, integrated SRHR and HIV prevention package.

Developing the brief and co-creating with AGYW

UNICEF Eastern and Southern Africa Regional Office convened a regional Think Tank *"Targeting HIV and SRHR Programmes to Better Meet the Needs of Adolescent Girls and Young Women in Eastern and Southern Africa."* This multi-stakeholder forum brought together over 50 experts and thought leaders from across the region- including representatives from government ministries, non-governmental organisations, civil society, youth networks, academic institutions, research bodies, and implementing partners.

The Think Tank served as a platform for cross-sectoral dialogue, exchange of experience, and joint reflection on how to enhance the reach, relevance, and impact of AGYW-focused programmes through better targeting. Its objectives were to:

- Share evidence, lessons learned, and insights from research, programmes, and models to inform approaches to targeting;
- Improve understanding of how geographical risk-targeting can influence programme quality;
- Identify the programme architecture required to enable effective geographical and individual targeting;
- Improve understanding of how data can be a valuable tool to inform programme targeting at both geographical and individual levels; and
- Develop key considerations to improve the effective delivery of AGYW programmes in ESA.

This implementation brief draws on the discussions, evidence, and collective expertise shared during the Think Tank. It aims to support country-level stakeholders in translating those insights into practical, context-appropriate AGYW programme strategies and evidence-informed targeting approaches across the ESA region. The brief includes case examples from across the region, outlines practical implementation considerations, and emphasizes the importance of referral systems and service linkages to ensure continuity of care. It concludes with guidance on how data can be used to inform and adapt targeting approaches for sustained impact.

AGYW participated in the Think Tank, sharing their lived experiences, priorities, and recommendations for more effective and empowering programming. Their voices helped shape this brief and are reflected in the following guiding principles:

- **Targeting must reflect diversity:** Programmes should be designed to meet the varied and evolving needs of AGYW across different settings and circumstances.
- **Equity should not be compromised:** Targeted approaches must not reinforce existing inequalities or exclude those with less visible vulnerabilities.
- **Language matters:** Framing should promote equity, inclusion, and the resilience and strength of AGYW—supporting them to claim their agency and advocate for their rights.
- **Community engagement is key:** Involving key influencers- such as parents, caregivers, and community leaders- can build supportive environments and strengthen the effectiveness of AGYW programming.

2. Approaches to targeting HIV and sexual and reproductive health and rights services for AGYW

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Effective programming for HIV and SRHR for AGYW requires smart, strategic targeting. Targeting refers to designing and delivering services or interventions for a group of people based on a set of shared characteristics linked to people's location, needs, desires, experiences, risk and vulnerabilities. Four key approaches to support programme targeting can be layered and adapted based on local contexts (see Figure 1).

What is Targeting?

Targeting is the process of determining how to aim programmes and sharpen interventions to accelerate progress in addressing risk and vulnerability and improving outcomes among AGYW. This involves segmenting the population by geography, intervention, and risk.

Figure 1. Targeting Approaches for AGYW

Geographical	Risk factors + sub-population	Programmatic / Platform-based	Individual-level screening tools
Purpose: High-level planning to maximize resource use	**Purpose:** Which groups of AGYW at greatest need of HIV prevention	**Purpose:** Where do we find AGYW in greatest need? What platforms can we leverage?	**Purpose:** To establish AGYW eligibility; need for additional support and referral

- **Geographical targeting** is used for high-level planning to identify populations based on variation in location-related characteristics, such as high prevalence or incidence of HIV and other sexually transmitted infections, areas of seasonal work, poverty rates, areas of food insecurity, proximity to industry or transit routes, areas impacted by climate events and conflict, and similar factors.

- **Risk pathways and subgroup populations targeting** identifies which groups of AGYW are in greatest need of HIV prevention and SRH services and why—highlighting key pathways through which risk accumulates and which structural or contextual risks and individual behaviours should be addressed through interventions. Groups at higher risk may include adolescents or young women who are pregnant and breastfeeding, who are engaged in transactional sexual relationships, have multiple sexual partnerships and/or are exposed to violence.

- **Programme or platform-based targeting** focuses on platforms and programming models where known groups of AGYW at high risk of HIV are found - for example, antenatal and postnatal clinics, violence prevention services and post-violence care, and vocational training programmes for young mothers. These platforms offer opportunities for additional screening and layered services, such as HIV prevention and social protection.

- **Individual targeting** focuses on unique individual characteristics, such as demographics (e.g., sex, age), behaviour (e.g., multiple sexual partners), attitudes (e.g., distrust of health workers), and occupation (e.g., in school/out of school, employed/unemployed).

2.1 Geographical Targeting

How do we prioritize programmes and allocate resources for AGYW by sub-national region?

Geographical targeting is used for high-level planning and resource allocation. It enables implementers to identify sub-national areas where AGYW are more likely to experience high HIV incidence, limited access to services, or increased vulnerability due to location-specific factors. UNAIDS recommends that HIV-related investments for AGYW be tailored by geography to respond to the sub-national HIV incidence rates to maximise programmatic and cost effectiveness.

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Modelling tools such as UNAIDS' sub-national HIV estimates in priority populations (SHIPP) tool can aid national HIV programmes in estimating resource needs and sharpening programming at sub-national levels to better reach AGYW with the greatest need for HIV and SRH services.[20,21,22,23] Numerous countries have used the SHIPP tool to consider sub-national HIV incidence data disaggregated by age, sex, location and risk groups. The SHIPP tool provides HIV incidence for four categories of AGYW: no sexual activity, cohabitation/single partner, non-regular sexual partner(s), and being part of a key population.[24] While there are not comparative tools for SRH outcomes, HIV and SRH among AGYW share many of the same risk drivers and it is likely that targeting tools for AGYW most in need of HIV services will also include AGYW who need SRH services.

The SHIPP tool allows for several types of geographical variation and analyses, for example, using the 2023 July updated SHIPP tool estimates to:

- Identify regions at highest and lowest HIV incidence and match them to individual-level interventions (see the following example from Kenya on using SHIPP to target HIV prevention programmes, as well as *"Decision-making AID for Investments into HIV Prevention Programmes for AGYW,"* UNAIDS 2023).

- Map differences in HIV incidence by 5-year age groups (15-19, 20-24, etc.) for both AGYW and their male sexual partners for each region. For example, in Lesotho, HIV incidence increases from moderate among AGYW aged 15-19 years to high among AGYW aged 20-24 years, while in Eswatini HIV incidence is high among AGYW in both age groups (15-19, 20-24 years).

- Calculate the HIV cases estimated to occur in each of the four SHIPP groups by age and country/region. For example, in Mozambique, 55% of all HIV infections among AGYW occur among AGYW in cohabiting/single partner relationships, a group which comprises over half of all AGYW. In Lesotho, on the other hand, 8% of new HIV cases are estimated among AGYW who are members of key populations, a group which account for 1% of the population.

Population-based surveys and studies across multiple sectors can provide geographic data while increasing understanding of risk and vulnerability. Age and sex-disaggregated data from Demographic Health Surveys (DHS), Violence Against Children Surveys (VACS), Population-Based HIV Impact Assessments (PHIA), and Multiple Indicator Cluster Surveys (MICS) will contribute to understanding risk at sub-national levels. These and other national household surveys can be complemented by local knowledge on workplaces (e.g., mines, farms) and transport and migration routes where AGYW may be at higher risk.

Sources of Data

DHS are nationally representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition. https://dhsprogram.com/

MICS are designed to collect statistically sound, internationally comparable estimates of about 130 indicators to assess the situation of children, women and men in the areas of health, education and child protection. https://mics.unicef.org/

The **PHIA** consists of HIV-focused, cross-sectional, household-based, nationally representative surveys of adults and adolescents aged 15 years and older. Some surveys also include children aged 0-14 years. To date, PHIA surveys have been completed in 15 countries. https://phia.icap.columbia.edu/

VACS are nationally representative household surveys among children and young people aged 13 to 24. VACS measures how much and how often sexual, physical, and emotional violence occurs.

HIV programme data - including routine service statistics, uptake of PrEP and other prevention commodities, and facility- or community-level client profiles- are essential to complement estimates and modelling tools. Many countries report that relying solely on estimates can lead to over- or under-estimation of high-risk groups and projected commodity needs. Triangulating modelling outputs with programme data helps ensure more accurate planning, targeting, and resource allocation.

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Implementation considerations

- Integrating geographic mapping with programming will help determine strategic priorities and focus resources and efforts to achieve a maximum return on investments.
- The SHIPP tool is a valuable resource to inform geographic targeting and understanding about how many AGYW are at high risk at sub-national level, and differences by age and sexual activity. When using the SHIPP tool, implementers should carefully review data quality and robustness and consider additional risk factors and existing programmes or platforms.
- Effective geographic targeting requires triangulation of different data sources, including estimates of population numbers provided by the SHIPP tool, population level data for epidemic trends, supplemented by data on SRH outcomes (pregnancies, violence, etc.), data on risk pathways or need, and data from different platforms such as early warning systems for school dropout.
- Local data systems and community led processes, including those led by AGYW, are vital for the identification and confirmation of high-risk geographies, local risk factors, and common risk pathways associated with HIV and SRH outcomes for AGYW.

Kenya: Using SHIPP to target HIV prevention programmes and prioritize resources

In Kenya, 32% of adult new adult HIV infections occur among AGYW.[25] Kenya adopted epidemic appraisal to optimize its HIV response to achieve national prevention targets. The appraisal process asked which counties and populations should be prioritized for HIV prevention. HIV prevalence and incidence were analysed to identify high burden counties for geographic prioritization. Population size and HIV prevalence were analyzed to define epidemic typology and prioritize populations for prevention interventions. Routine programme monitoring data were used to assess programme coverage. Using the SHIPP tool, the government identified counties where different types of epidemics- concentrated, generalized, mixed- were occurring and then aligned the programme response with the HIV epidemic typology (see Figure 2). The SHIPP tool was then used to assess allocation of funding resources, leading to advocacy for reallocation of existing resources and increased funding for areas not receiving sufficient resources.

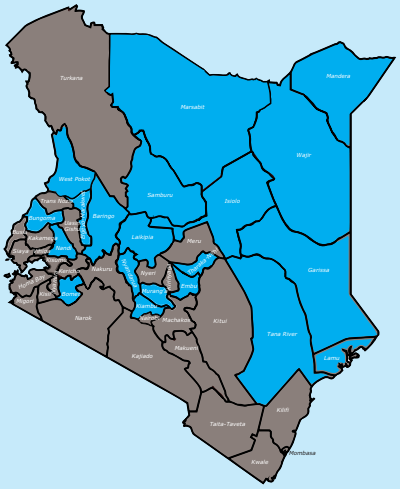
Implementers noted that SHIPP is a useful tool but cannot be used in isolation. Drawing on additional data sources was important to gain a full understanding of the dynamics of the HIV epidemic. Also, while the SHIPP tool provides estimates of AGYW at risk, it does not identify where and who they are and the most effective programmes for them. It is also important to provide training on using the tool and interpreting the results together with different stakeholders.

Drawing on the lessons learned, Kenya is developing a vulnerability assessment tool for use in priority counties to identify AGYW who are most at risk. Kenya is also committed to learn from implementation data how best to target programming for AGYW at risk. The data generated from the SHIPP tool will continue to be used to assess resource needs, monitor progress, and advocate for a focus on priority populations.

Figure 2: Kenya: HIV epidemic typology leading the HIV response

EPIDEMIC TYPOLOGY

Concentrated Epidemics



Epidemic in 22 counties

- Scale up effective and focused HIV prevention to reduce transmission in the high-risk networks.
- Focus on high coverage of pregnant women for HIV testing and ART for those who are living with HIV.
- Scale up and saturate coverage of key populations.
- Ensure that people living with HIV are virally suppressed.

Generalizing Epidemics

Epidemic in 4 counties

- Focus on changing sexual behaviour patterns in the general population. The focus should be on reducing multiple and concurrent partnerships.
- Scale up and maintain high coverage of pregnant women for HIV testing and ART for those who are living with HIV.
- Scale up and saturate coverage of key populations.
- Ensure that people living with HIV are virally suppressed.
- Scale up coverage of adolescent girls and young women.
- Increase proportion of boys and men who are circumcised.
- Identify the vulnerable populations and saturate coverage of these sub-poplulations.

Mixed Epidemics

Epidemic in 21 counties

- Focus on high risk networks and other populations at risk in the general populations.
- Scale up and maintain high coverage of pregnant women for HIV testing and ART for those who are living with HIV.
- Scale up and saturate coverage of key populations.
- Ensure that people living with HIV are virally suppressed.
- Scale up coverage of adolescent girls and young boys and men (specifically in traditionally non circumcising counties).

South Africa: Using Focused Data for Impact

South Africa's National Department of Health has embedded microplanning within the National Strategic Plan for HIV, Tuberculosis and Sexually Transmitted Infections to strengthen programme targeting for groups at risk of HIV, including AGYW. The Focus for Impact approach uses detailed data to identify populations most at risk and living in areas most affected by HIV.[26] While comprehensive prevention, care and treatment is provided nationally, this approach promotes intensified concentrated efforts in regions identified as having a high burden of HIV and tuberculosis. It guides implementers through four key questions to shape a targeted, high-impact response:

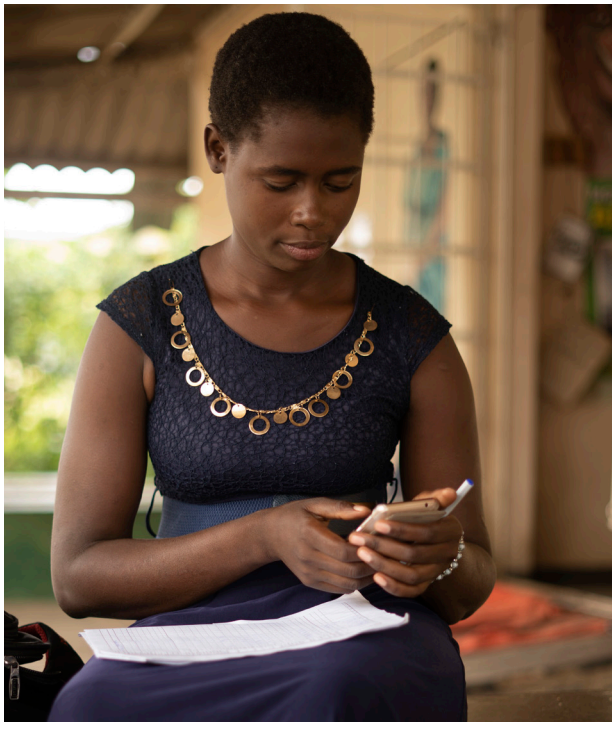
- **Where** are the high burden areas?
- **Why** is this a high burden area?
- **Who** is at risk in this high burden area?
- **What** are we going to do to reduce the burden in this area?

Focusing strategically at provincial, district and ward level has helped the government and implementing partners intensify service delivery and better address the social and structural factors that increase vulnerability to HIV infection. This strategy ensures saturation of high-impact prevention and treatment services and stronger multi-sectoral efforts to tackle the social and structural factors that increase AGYW's vulnerability to HIV infection.

2.2 Understanding Risk Pathways

Which groups of AGYW are in greatest need of HIV prevention and SRH services and why?

Understanding risk and vulnerability is essential to effectively target services so that programming can address drivers of risk and vulnerability associated with poor HIV and SRH outcomes. An array of factors intertwines to contribute to risk and vulnerability, health behaviour, and health outcomes in adolescence (see Figure 3). Importantly, risk pathways are not static; AGYW experience various levels and types of risk and vulnerability throughout adolescence and into young adulthood.



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Evidence highlights several key risk pathways heightening AGYW's vulnerability to HIV. Early and unintended pregnancies often signal the onset of unprotected sex and a decrease in school attendance.[27] Reduced schooling limits access to critical information, social support, and health services. Living in poverty or experiencing food insecurity can drive AGYW towards transactional sex. This not only complicates their access to healthcare but also diminishes their ability to negotiate safer sex practices. In addition, AGYW who experience sexual or physical violence are at increased risk of HIV, not only from immediate exposure but also due to the long-term impacts of trauma and disempowerment.

Pregnant and breastfeeding women are at greater risk of HIV exposure and acquisition[28], especially adolescent mothers living in high HIV burden settings.[29] Adolescent mothers may experience profound developmental, social and economic changes, including stigma, violence, reduced educational and job opportunities and inadequate social support – all of which may contribute to HIV risk.[30]

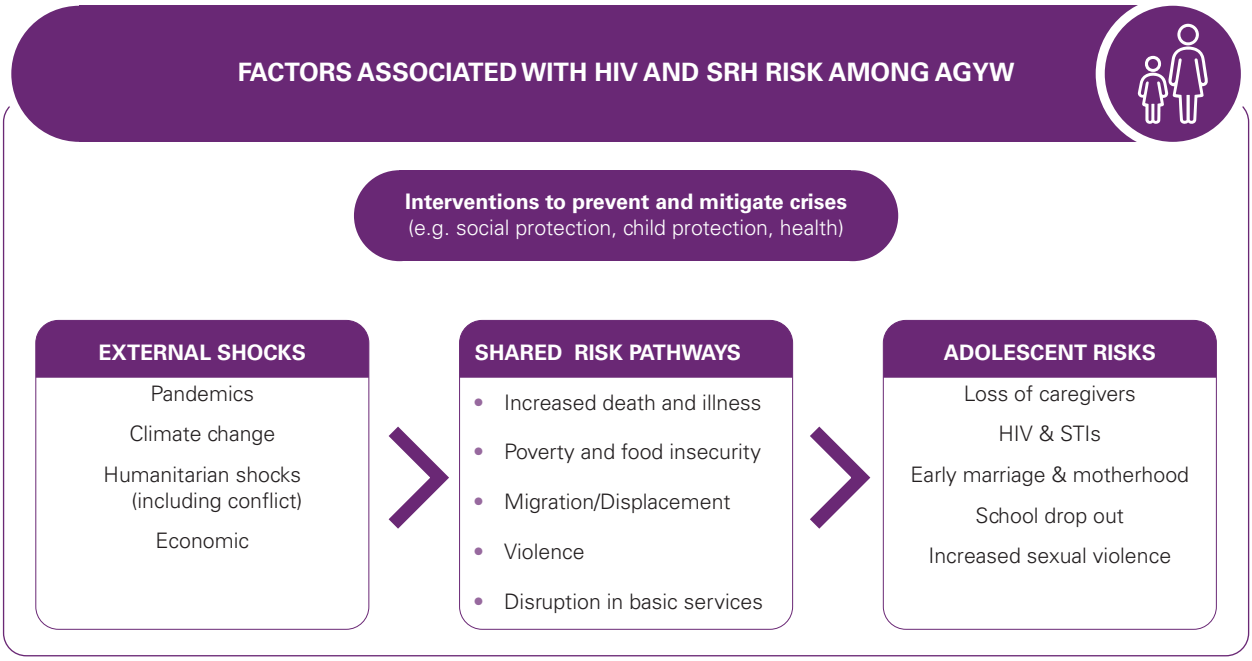
While this brief focuses on targeting approaches for AGYW, strengthening HIV prevention efforts with their male sexual partners is recognised as a critical component of reducing AGYW's HIV risk. Several countries are exploring how to identify and engage male partners—particularly partners who are older, in high-mobility occupations, or in areas with heightened sexual network activity.

Risk pathways cannot be considered in isolation. These interconnected pathways necessitate targeted, multisectoral responses and a strong understanding of the vulnerabilities affecting AGYW at sub-national levels. A better understanding of risk pathways can provide information on AGYW sub-populations with different needs and vulnerabilities and why they experience specific HIV and SRH outcomes. It can also provide insights on the causal mechanisms that should be addressed by packages of HIV and SRH interventions designed for each group. Combining geographical risk data with insights into individual risk pathways helps identify where AGYW at highest risk are located, thus strengthening effective delivery of services.

Community-led approaches, such as geo-spatial and community systems data, hotspot mapping and microplanning, also effectively contribute to understanding AGYW risk and vulnerability. For example, scanning relevant changes to industry activity, construction sites, food security[31] and areas impacted by climate change[32] may contribute to understanding the likely changes in HIV and SRH risk for AGYW. Data collection and risk analysis can be integrated with existing local routine monitoring systems led by government or community organisations to enable early detection of increased risk. Location and social mapping have been used effectively to identify AGYW at risk of formal or informal sex work.[33] Where community-led monitoring initiatives already exist, they can offer valuable insight into service quality, user experience, and accountability—helping programmes adapt targeting approaches based on real-time feedback from AGYW and their communities.

It is also important to recognise that some AGYW may have undeclared or hidden risks due to socio-cultural taboos, stigma, or fear of disclosure, and that legal and policy barriers - such as restrictive age-of-consent requirements for SRH and HIV services - may further limit their ability to access prevention and care.

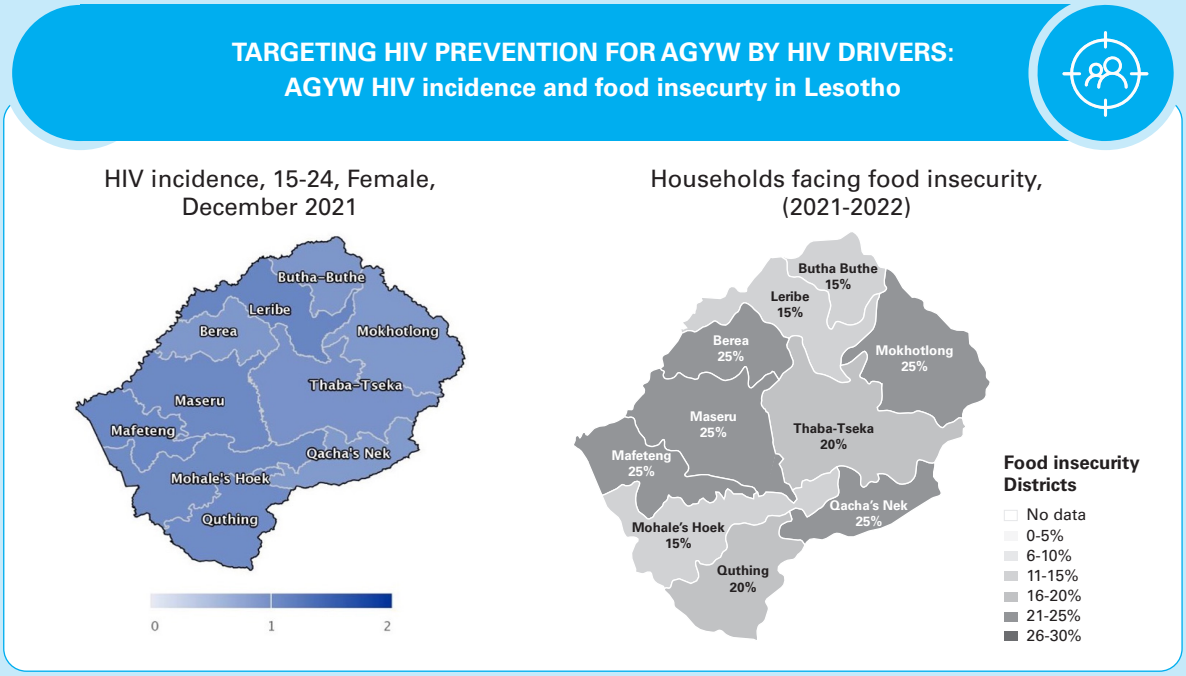
Figure 3: Factors associated with HIV risk and poor SRH outcomes among AGYW



Lesotho: Food insecurity and HIV risk

Analyses of the Lesotho PHIA combined with satellite drought data found strong associations between drought, transactional sex and HIV prevalence. To respond to this risk pathway, food insecurity data layered with HIV incidence data provides an opportunity to link AGYW who may be experiencing hunger – and who are therefore at higher risk of negative HIV and SRH outcomes - with economic and livelihoods support or social protection programmes. HIV prevention added to existing livelihoods and social protection programmes can reach AGYW at greatest need. For example, AGYW HIV prevention packages can be delivered alongside food support during a drought for HIV-affected families and vulnerable households where AGYW live.

Figure 4: Targeting HIV prevention for AGYW by HIV drivers in Lesotho



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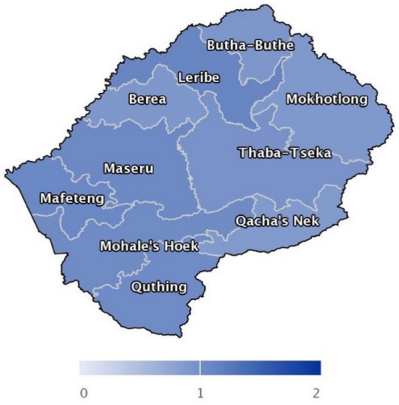
Lesotho: Heightened activity in sexual networks

In Lesotho, differential risk pathways significantly impact the vulnerability of AGYW to HIV, despite consistent high HIV incidence across districts. Notably, areas near trucking routes, mining sites, and large infrastructure projects experience heightened activity in sexual networks, exposing AGYW to increased risk behaviors due to the transient male populations and economic opportunities present. Local stakeholders and AGYW have highlighted how these environments contribute to vulnerabilities, further intensified by limited educational resources and healthcare services. To effectively address these challenges, integrating local knowledge of sexual networks, industry, and migration routes with tools like the SHIPP is crucial. This approach would facilitate tailored interventions that reflect the specific needs and contexts of high-risk regions and would enhance HIV prevention efforts for AGYW in Lesotho.

Figure 5. Combined strategies to target HIV prevention for AGYW in Lesotho

HIV PREVENTION IN THE "WORKPLACE":
Infrastructure, migration/ mobility corridors, trucking routes

HIV incidence, 15-24, Female, December 2021



Screen AGYW in communities along migration/ mobility corridors, new infrastructure projects, and/ or trucking routes

Programming for male sexual partners of AGYW in these areas (index testing)

Implementation Considerations

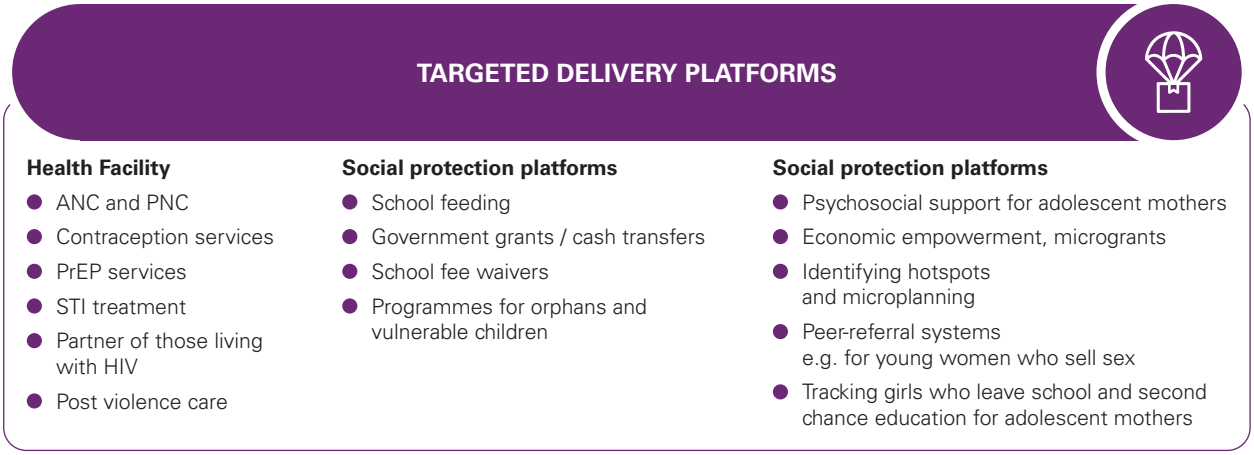
- Understanding and integrating multiple risk pathways will strengthen the delivery of comprehensive services to target groups.
- Microplanning and community mapping of risk by community level workers can support identification of AGYW at highest risk at the local level.
- Community mapping of interventions and programmes can enable the identification of AGYW who are at highest risk.
- Community-led mechanisms and knowledge systems, including those associated with local knowledge such as chiefs, elders and local committees, are often responsible for identifying household recipients of social assistance, information that can be used to identify AGYW at high risk.
- Considering changes in the natural and physical environment, for example natural disasters, new industry and migration influx, and areas with high food insecurity can effectively contribute to identifying risk pathways.

2.3 Programme Targeting

On which platforms do we find AGYW in greatest need?

AGYW who are at greatest need often remain outside the reach of routine service delivery structures and are less likely to seek services independently. Once the characteristics of AGYW sub-groups at high risk are understood, their risk factors and any nuances associated with national or sub-national geography, programme and other sector-specific platforms that commonly serve these groups can then be used to efficiently target service delivery. These platforms provide opportunities for individual assessments and the application of screening tools to enhance identification and support. However, these approaches may risk further stigmatizing or inadvertently marginalizing these groups. The goal should be to create supportive environments that encourage AGYW to engage with these services voluntarily.

Figure 6: Targeted delivery platforms



Health facilities are vital access points. Beyond HIV-specific services, facilities offering ante- and post-natal care, contraceptive services, and STI treatments can effectively identify AGYW at high risk of negative HIV and SRH outcomes. At the **community** level, young mentor mother programmes,[34] economic empowerment activities, and peer referral systems can assist with identifying and supporting AGYW in need of further risk assessment and related services.

Evidence indicates that AGYW who are survivors of violence are also at risk of negative HIV and SRH outcomes.[35,36] Programmes offering **post-violence care** to AGYW can be effective platforms for assessing additional individual risk and referring clients to other services.

A growing body of evidence shows that **staying in school** protects AGYW from HIV by reducing early pregnancy, limiting exposure to age-disparate and transactional relationships, and preserving access to supportive networks—factors that are known to heighten HIV vulnerability when disrupted.[27,28] There are also opportunities to reach AGYW who may be at higher risk, such as adolescent young mothers and AGYW who are not in school. Return to school programmes, second chance education, and out-of-school vocational training are likely to include AGYW who may need additional risk assessment and services. AGYW enrolled in tertiary education institutions may need HIV prevention services delivered *in situ* to maximise access.

Social protection measures that reduce household economic stress have been shown to lower key HIV risk pathways, including food insecurity and transactional sex, underscoring their importance in helping AGYW remain HIV-negative.[31,32,37] Social protection platforms that address poverty often target households which include AGYW who will benefit from referral to HIV and SRH interventions.[38]

Programmes for **key populations**, for example AGYW involved in commercial or informal sex work, are also opportunities to link AGYW with appropriate HIV, SRH and other services, including violence prevention and social protection.[39,40] AGYW in transactional relationships are at increased risk as their relationships are often characterised by unequal power dynamics. In these sexual relationships where the exchange of money or goods is implicit, AGYW may not self-identify as sex workers and share some emotional intimacy with their partner(s).[41]

Implementation considerations

- Clinical platforms offering antenatal care, post-natal care, contraceptive and SRH services and pre-exposure prophylaxis (PrEP) are opportunities to integrate individual risk assessments that support access to comprehensive services for AGYW who are having unprotected sex.
- Programme platforms providing post-violence care offer opportunities to identify AGYW experiencing situations of high vulnerability that may contribute to negative HIV and SRH outcomes.
- Education platforms, such as second chance education, return to school for adolescent and young mothers, and out -of school vocational training offer opportunities to identify AGYW with multiple needs through targeted implementation of individual risk assessment.
- The integration of individual risk assessment across social protection platforms is an opportunity to identify AGYW at highest risk of negative HIV and SRH outcomes.
- Integration of individual risk assessment for AGYW within female sex work programmes will effectively enable targeted programming for AGYW who sell sex.

Tanzania: Cash Plus – Identifying adolescents in households with multiple vulnerabilities

Tanzania's social protection programme provides cash grants to the poorest households that are most often labour-constrained and with a high dependency ratio. Recognizing that adolescents living in these households face high HIV and SRH-associated risks, Cash Plus builds on income support by focusing on adolescents living in those households. Adolescents are provided with livelihood skill development, HIV and SRH education, linkages to existing HIV, SRH and violence prevention services, and small grants to support safe economic activities. The package is provided in two phases: a three-month education programme, followed by a nine-month mentorship during which adolescents are supported by community-based mentors and peer educators to apply their knowledge and skills.

A mid-line evaluation[42] found that Cash Plus has contributed to increased knowledge on some aspects of HIV risk, reproductive health and contraception, greater participation in economic activities, and likelihood to seek contraceptive services. Although there was no impact on adolescents' experience of violence or sexual exploitation, there were positive changes in gender-equitable attitudes among males, including attitudes towards violence. There were also no significant changes in seeking HIV testing, school enrolment, or in risky sexual behaviours.

On-going analysis is helping to shape interventions for adolescents in cash grant households in an effort to contribute to their safe transition to adulthood.

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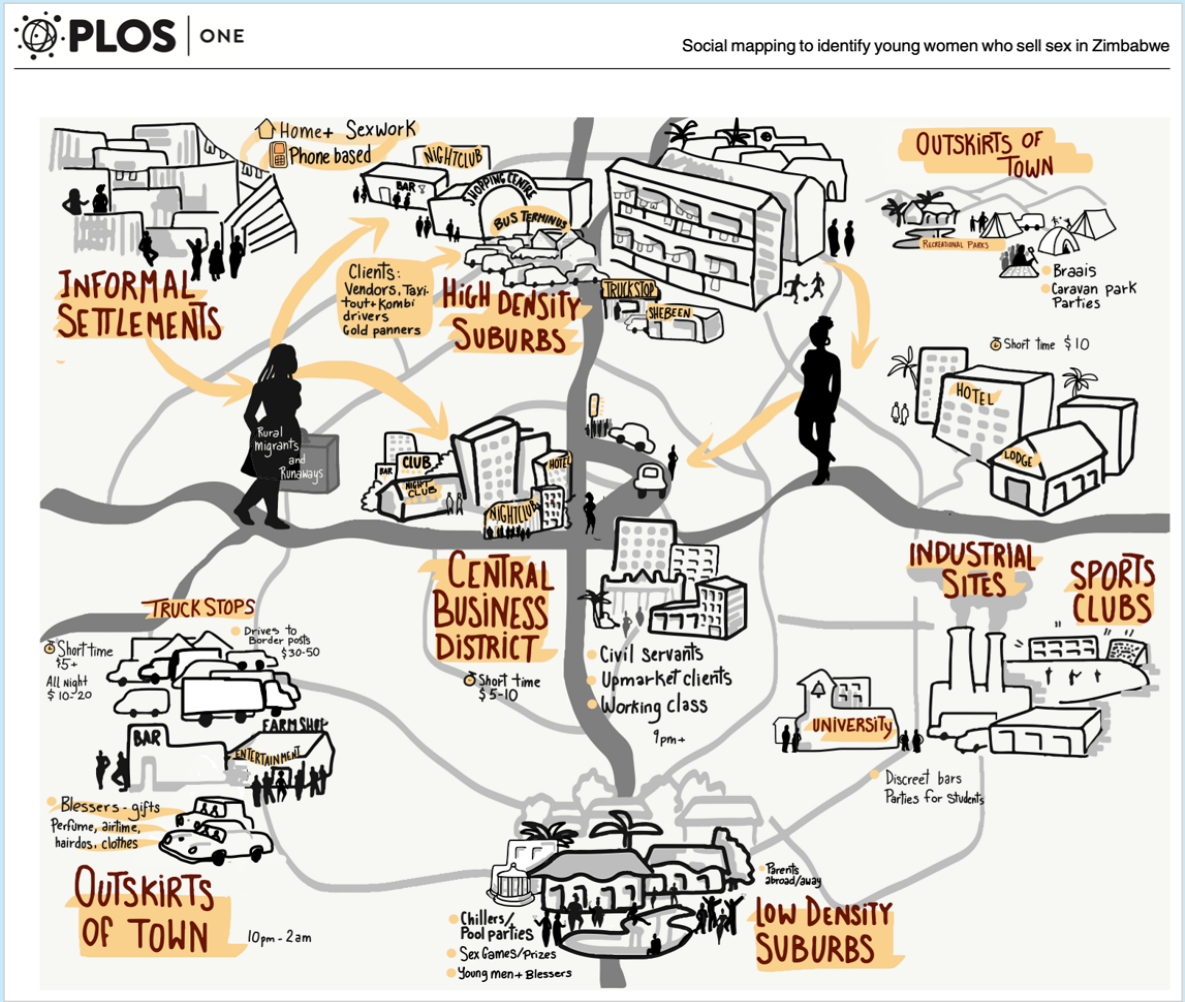
Zimbabwe: Using community platforms to reach AGYW who sell sex

Not all AGYW who sell sex identify as sex workers and are therefore often missed by existing progammes that specifically target sex workers. Young women who sell sex informally or formally are also less likely to access sexual health and HIV prevention services, including using condoms or pre- and post-exposure prophylaxis, than older female sex workers. In Zimbabwe, the Centre for Sexual Health and HIV & AIDS Research addressed the difficulty in finding AGYW engaging in sex work by combining community mapping (see Figure 7) with clinical service delivery while iteratively using strategic information to address community and clinical programme gaps. Since the national programme primarily focuses on formal sex workers, the specific strategies used - social mapping and peer microplanning - helped identify and reach younger women who do not self-identify as sex workers and would not ordinarily access sex worker services.

HIV and SRH services for female sex workers are delivered through thirteen fixed site clinics co-located with public sector facilities in 10 provinces across the country, over 100 mobile outreach facilities, and 5 drop-in centres within high population volume sites. The clinics and drop-in centres are "one-stop shops" that provide comprehensive HIV and SRH services, including condoms and lubricants, STI screening and management, family planning, HIV testing, post-exposure prophylaxis and pre-exposure prophylaxis, antiretroviral treatment, and support for survivors of gender-based violence. AGYW who sell sex are recruited by peers who conduct microplanning to identify and map hotspots and conduct outreach to other young sex workers. Through peer microplanners in the community, screening questionnaires assess risk according to six factors: age, duration in sex work, condom use, number of clients per week, drug and alcohol use, and exposure to violence, with each AGYW being tracked according to their risk level. AGYW are then referred to additional services according to their individual needs.

Figure 7. Social mapping in Zimbabwe

Social mapping aimed to identify young women who exchange sex for money or other resources (YWSS) whether or not they identify as sex workers. The process captured various dimensions of the local risk environment: geographic locations where young women sell sex; the social context in which sex is exchanged (with whom, why, under what circumstances); and the YWSS social networks that can help reach YWSS with prevention services. Mapping included talking with adult sex workers, direct observations, group discussions and informal interviews.



An illustration showing the geographic and sociodemographic data compiled at each site during social mapping.
https://doi.org/10.1371/journal.pone.0194301.g001

Namibia: Targeting AGYW in need of services

Led by the Ministry of Health and Social Services, in collaboration with the Ministry of Education, Innovation, Youth, Sports, Arts and Culture and implementing partners, Namibia has successfully developed a sustainable process to identify AGYW most at risk or in need and to link them to HIV and SRH services using geographic, risk and programme targeting. Programme data are gathered from a variety of sources and used to identify sub-national areas to target. Sources of data include the Namibia PHIA, the DHS, the Education Management Information System, national student health surveys, the District Health Information System 2, UNAIDS Spectrum estimates, and health facilities' ante-natal care records. These sources inform tailored interventions across regions, based on an understanding of risk and vulnerability (see Figure 8). For example, the results effectively targeted young mothers enrolled in return-to-school programmes who were in need of HIV and SRH services.

Figure 8. Tailoring services for AGYW with high HIV and SRH risk in Namibia

<table>
<tr><th colspan="4">Package of Services for High Risk AGYW</th></tr>
<tr><th></th><th>10-14 year olds</th><th>15-19 year olds</th><th>20-24 year olds</th></tr>
<tr><td rowspan="3">Primary Interventions</td><td colspan="3">• In-school HIV/GBV prevention: Window of Hope (except 20-24)
• Risk assessment of HIV and referral for those in neeed of HTS
• SRH risk assessment and referrals as appropriate
• GBV screening and referrals with appropriate intervention
• Social asset building</td></tr>
<tr><td rowspan="2"></td><td colspan="2">• Condom promotion and provision
• Financial literacy (Aflayouth)</td></tr>
<tr><td>• HIV/GBV prevention education: SHUGA</td></tr>
<tr><td rowspan="2">Secondary Interventions</td><td colspan="3">• Post-violence care
• Provision of HTS (Direct or through referral)
• Provision of SRH services (Direct or through referral)
• Parenting program: Family Matter!
• Economic strengthening for families
• Education support
• Impower: GBV prevention for the girl</td></tr>
<tr><td>• Condom promotion and provision</td><td colspan="2">• PrEP as appropriate
• Economic strengthening for the AGYW
• Entrepreneurship and/or employability
• Education support - bridge to tertiary or employment</td></tr>
</table>

2.4 Individual targeting

How do we effectively screen AGYW for risk and vulnerability?

Depending on the geographic location and risk factors, a comprehensive package of services may be available to most AGYW. In other circumstances, implementers may conduct individual screening to assess for heightened risk and vulnerability.

Programmes are increasingly using individual assessments to align services with the specific needs of AGYW, ensuring that they are responsive and evolve with fluctuating risk profiles of AGYW.[43] As noted in Section 2.3, integrating individual risk assessments into existing programme platforms can enhance acceptability and sustainability of the assessment process, ensuring these efforts do not overly burden communities or clinical cadres' existing workloads.

Assessment tools, including self-assessment options, when implemented correctly and feasibly can be transformational in enabling AGYW to appreciate their risk and needs while improving their agency and self-care. For example, the Population Council's Girl Roster, which has been used in more than 35 countries, including in the ESA region, identifies household level risk factors among AGYW.[44]

Others include Eswatini's vulnerability assessment questionnaires (see below) and Malawi, Uganda and Zimbabwe's national risk and vulnerability assessment tools. These processes have been integrated into AGYW programmes supported by Global Fund investments, helping to inform more targeted and responsive service delivery.[45]

Eswatini: Identifying AGYW in need of HIV and SRH services through assessments and referrals

Eswatini has made significant progress in reducing new HIV infections. Nonetheless, incidence among AGYW remains nearly seven times higher than that of adolescent boys and young men. Also, according to the VACS (2022) 25.5% of females aged 13-24 experienced violence in their lifetime, with 1 in 12 having experienced sexual violence.

Implementing partners used an individual vulnerability and risk assessment process to assess and identify AGYW for enrollment in high impact HIV prevention services. Community cadres (Life Mentors and Home Visitors) identified AGYW through door-to-door visits, referrals from community leaders and peers, and schools participating in an educational support programme. Tools included a vulnerability assessment tailored by age band and use of a self-administered questionnaire for sensitive questions. Vulnerability criteria included history of sexual activity and pregnancy, experience of violence, status of school enrollment, orphanhood, and alcohol and substance abuse.

AGYW identified as high-risk participated in 12 risk awareness sessions and one-on-one meetings with the community cadre, including setting goals for accessing basic services. The community cadre also referred AGYW to further services, such as HIV testing, STI screening, violence prevention and response, and vocational training. The vulnerability assessment was repeated every six-months to monitor any changes.

The programme saw an increase in community referrals and collaboration with schools to identify out-of-school AGYW. Following participation in the programme, there was increased use by AGYW of family planning services, PrEP initiation, and HIV testing and treatment. However, health facilities were less likely to refer AGYW to additional services, regardless of the need or risk.

It is essential that risk assessment approaches remain adaptive, person-centred, and sensitive to context, rather than relying solely on broad or static risk profiles. Risk questionnaires may be completed by service providers, peers or the client, either in person or virtually. It is vital that self-administered assessments are combined with appropriate referral and/or programming that address any issues that may emerge.

Effective risk assessment tools include questions that focus on known risk factors and are aligned with interventions that are available at a local level. Questions about family structure, for example parental and caregiver relationships and caring responsibilities, can provide insight into individual HIV and SRH risk associated with household vulnerability, including orphanhood, food security or low household income.

An awareness of the use of language and the approaches taken to individual risk assessment require careful consideration. Approaches to reach the 'most vulnerable' or 'highest risk' AGYW with interventions supporting improved HIV and SRH outcomes may have the unintended consequence of increasing stigma. Ethical principles that prioritize confidentiality, data protection and 'do no harm' are vital[46] to avoid stigmatising AGYW who present with risk factors.

These assessments also empower AGYW to understand their own risks, fostering agency and enabling appropriate support. Without these assessments, it becomes challenging to provide AGYW with suitable referrals to necessary services, which ultimately aids in improving their HIV and SRH outcomes through well-coordinated local interventions.

South Africa: Assessing AGYW risk and needs at health facilities and in schools

In South Africa, AGYW receive a vulnerability and risk assessment through gender-based violence platforms, including services at primary health care facilities, community outreach, school peer counsellors, domestic violence courts, and other organisations that provide gender-based violence services. The assessment tool collects data on demographics and risk behaviour that exposes the participant to HIV risk, violence, and or alcohol and drug abuse. In addition to receiving a minimum package of post-violence care services, participants are offered referrals for other health services, legal support, and child and social protection. To further expand reach, self-assessments are offered at "Safe Spaces" within schools. Using a gamified approach, AGYW assess their own vulnerability and risks and are given an opportunity for one-on-one coaching. Both approaches have proven successful in identifying AGYW who are at increased risk of HIV infection, poor mental health, and violence, and either providing or referring them to services.

Implementation considerations

- Approaches to individual risk assessment that consider implementation feasibility and scalability are likely to be most successful.
- Individual risk assessment questions will be most effective when matched with known risk drivers and vulnerability factors present in areas where programmes operate.
- Knowing the availability of interventions at the local level is vital to address individual risk and vulnerability factors identified through individual risk assessment.
- Assuring confidentiality throughout assessment processes and in record keeping, as well as alignment of consent to the assessment with national laws and policies, is key to the integrity of the individual risk assessment process.
- Innovative mechanisms, such as app-based risk assessment, can effectively complement or replace face-to-face assessments in technologically competent and resourced AGYW communities.
- Capacity strengthening of community and peer cadres is needed to ensure effective administration of individual risk assessment and reduced stigma.
- Communication strategies that help AGYW understand their risk of poor HIV and SRHR outcomes and why that understanding is important will support the effective uptake of assessment mechanisms.

3. Referral Systems: How do we ensure AGYW in greatest need receive comprehensive services effectively?

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AGYW facing multiple and intersecting vulnerabilities often require a broad package of services that no single programme or provider can deliver. As outlined in the previous section on targeting, the diverse and dynamic risk pathways of AGYW—whether related to early pregnancy, being out of school, experiencing violence, or engaging in transactional sex—highlight the need for multisectoral responses. For example, given the high co-occurrence of HIV risk, SRHR needs and experiences of GBV among AGYW, programmes increasingly require more integrated approaches across these domains. While integration remains a long-term goal, current efforts can focus on strengthening coordinated service delivery and referrals, ensuring AGYW are linked to the full range of services they need.

Referral systems are the practical bridge between targeted identification and comprehensive service delivery, ensuring AGYW are connected to the full range of care and support they need—across health, protection, education, and social services.

Effective targeting helps identify who needs services and where they are, while referral systems make it possible to act on this information, linking AGYW to appropriate interventions. Without strong referral systems, even the best targeting strategies risk falling short. Gaps in service delivery can lead to missed opportunities for HIV prevention, treatment, and support—ultimately undermining both programme impact and AGYW's health and wellbeing.

Designing and implementing a referral system

Referrals occur when an individual is directed to an appropriate facility, programme, or service provider to address the individual's relevant needs. National referral systems define the responsibilities and actions of multiple stakeholders at national and sub-national levels. Referrals can be initiated through various channels, such as individual risk assessments administered by health workers, social welfare officers or school officials, or through formal relationships with community health workers, peer supporters, and other community members.

Referral mechanisms, including referral feedback loops that monitor the referral process, can be electronic or paper-based. Unique identifiers for individual clients can support case-based management of needs and prevent the duplication of data when aggregated. Completed referrals are then monitored and their effectiveness evaluated based on collected data.

Referral monitoring systems can also inform the broader programme. For example, metrics that track a cascade of need, service availability, referrals and completed referrals generate data that can be fed upwards to a national data system (such as DHIS2). The data can then be reviewed by coordinating mechanisms such as AGYW technical working groups (TWG) and the information used to improve programme targeting and resource allocation based on service availability and use at the local level.

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Components of an Effective Referral System

- Policies highlight confidentiality for everyone and consent policies for minors.
- Procedures state who should make a referral, when a referral should be made, what steps are involved in making a referral, the tools that are used, and how to follow up a referral.
- Referral staff are trained in making and following up referrals.
- Referral directories provide updated information on available services.
- Monitoring systems determine what referral data will be collected and how it will be analysed and used.
- Client feedback mechanisms help monitor whether services were effective and can identify areas of improvement.

Zimbabwe: Linking young mothers to comprehensive services

Young mothers are at high risk of HIV and other sexually transmitted infections, rapid repeat pregnancy, violence, and mental health conditions. In Zimbabwe, peer counselors from Zvandiri[47] administer risk assessments to young women attending antenatal and postnatal care clinics. Based on the results, these young women are then linked to additional services, such as pre-exposure prophylaxis, cash transfers, economic strengthening activities, violence prevention and response, and second chance education. The peer counselors offer to accompany clients to help them access these additional services. Since inception, the programme has seen a steady increase in the number of young mothers accessing multiple, layered services.

Implementation considerations

- Understanding the up-to-date availability of services at local level is key to enabling the delivery of comprehensive services for AGYW. Sub-national service directories that are regularly updated and include available services and eligibility criteria are a vital tool to coordinate implementation of locally relevant referrals.
- The most effective referral systems adopt adolescent-friendly principles, ensure confidentiality, and enable access to services that are tailored to the needs of AGYW.
- Trusted, trained peer supporters and community health workers are well-positioned to support service uptake by accompanying AGYW, especially those at high risk, to referred services.
- Strengthening the capacity of community-based organisations to support effective individual risk assessment and referral to services can enable AGYW at high risk to access comprehensive services.
- Monitoring systems that collect data on each step of the referral cascade will support accountability and ensure that AGYW are receiving the services they need.
- Client feedback mechanisms built into service delivery and referral systems can improve the quality, acceptability and effectiveness of services.

Coordinating referral systems

Coordinating referral systems at sub-national and national level supports targeting, referral, and equitable access to services for AGYW at high risk. Effective coordination platforms sit at national level and then cascade down to local levels with complementary structures. For example, multi-sectoral TWGs for AGYW programming can be highly effective coordination mechanisms when appropriately structured and organised to ensure representation by relevant ministries, donors, civil society organisations and AGYW-led groups. TWGs with defined roles and responsibilities, regular meeting schedules and defined accountabilities can effectively monitor referral systems, facilitate information sharing, and review multisectoral data on trends, best practices and challenges for improving comprehensive service delivery to AGYW most in need. Financial data can also be reviewed and triangulated with programme data to facilitate targeting resources at the local level. In the context of funding constraints and new biomedical HIV prevention options, it is increasingly important that programmes target and layer interventions more intentionally to ensure resources reach AGYW with the highest need.

Implementation considerations

- Multi-level coordination is required for effective implementation of referral systems that encompass comprehensive services for AGYW.
- Embedding coordination responsibilities associated with the management of referral systems in existing multi-level coordination platforms will improve their acceptance, effectiveness, and sustainability.
- Existing leadership and coordination structures can support multi-sectoral collaboration, shared ownership, and effective management of the comprehensive service package for AGYW—helping to align efforts across health, education, and social services.
- Functioning AGYW TWGs at national and sub-national levels can enable the effective implementation of referral systems.
- Representation in AGYW TWGs from different sectors, including health, education, community and social development, supports multisectoral collaboration to ensure reaching AGYW at highest risk with comprehensive services.
- When community-led, multi-sectoral coordination on AGYW and HIV and SRH programming is in place, data on referrals and linkage can be routinely reviewed and used to inform programme targeting and improvement.

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Malawi: A multisectoral referral system for AGYW

In 2018, Malawi launched a national AGYW strategy with a multisectoral governance structure to improve access to services across sectors. The strategy established national and sub-national coordination mechanisms, implementation modalities and an AGYW national core team that includes representatives from the health, education, youth, gender, and social protection sectors.

The strategy formalizes the use of a standardized comprehensive assessment of individual risk and vulnerability, including knowledge of HIV, sex with multiple partners, transactional sex, condomless sex, a current or recent STI, uptake of SRH services, economic insecurity, school attendance, experiences of violence, and alcohol and drug use. AGYW at high risk are identified through community models, such as peer-led programmes and youth structures, health facilities and schools.

The referral process has been supported by:

- The development of sub-national AGYW services directories that are maintained by sub-national coordination structures.
- The introduction of individual risk and vulnerability assessments undertaken by the government and civil society across sectors.
- The use of embedded unique identification codes, aimed at preventing duplication and enhancing client-centred outcome tracking and comprehensive referral processes and, where feasible, with client escorts.
- The referral system is underpinned by a comprehensive monitoring and evaluation system tracking a cascade of indicators corresponding to the different steps in the process.

As a result of these combined efforts, uptake of services increased in Malawi. From October 2024 to June 2025, 2,602 AGYW have been screened using the risk and vulnerability assessment tool in community settings across three districts. Seventy-nine per cent of the AGYW screened were referred to health, education, social welfare and child protection services. The majority (90%) were referred for health services (1,167) and education services (500). Health services included HIV testing, condom access, family planning, and mental health counselling, while education services included readmission, bursary for school uniforms, and writing materials. Over 50% (947) of AGYW accessed multiple services. In addition, collaboration and coordination across community (community health workers, community police, social welfare officers, child protection officers) and clinical sectors (clinicians, nurses, laboratory technologists) have improved and strengthened.

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4. Using data to better plan, implement and monitor programmes that target AGYW

Data collection and analysis can inform how to deliver comprehensive services to those AGYW who are at highest risk. Targeting is informed by data on geographic areas (national surveys, surveillance and modelling data), risk pathways, programme platforms, individual assessments, and referrals. Systems and processes that regularly capture and capitalise on data from multiple sources (client profiles, type of service delivered and accessed, referrals made and completed, and HIV risk and vulnerability outcomes) can determine targeting and referral effectiveness, and inform adaptations and tailoring of targeting approaches. These data will also contribute to supporting resource allocation based on estimated need and actual numbers of service users. However, too many indicators for data capturing, where metrics do not directly refer to an intervention, may result in over-collection of data that has no programme value and could create data-fatigue in practitioners, especially large systems of monitoring individual-level risks among all AGYW.

Digital tools used by well-trained health practitioners are a great enabler of data collection and analysis and may help improve the quality of the data. Locally appropriate and relevant tools can enable prompt collection of data that can be shared quickly through relevant systems and structures. This process enables immediate review of data and supports agile programme alignment based on data insights.

Implementers need to have relevant and sufficient capacity to ensure quality data collection and analysis, including age and sex disaggregation. Where individual data are collected, unique identifiers within paper-based or digital systems can improve data quality, leading to enhanced programme effectiveness. Further, where data review and appraisal are integrated into routine processes, programmes are consequently able to respond more effectively to risk fluctuation in adolescence.[48]

Coordinating bodies, such as multisectoral TWGs, are instrumental in facilitating data analysis and use to ensure that resources are allocated to enable precise implementation and targeted programming for AGYW at high risk. These actions can enable systemic improvements that facilitate improvement in HIV and SRH outcomes for AGYW at high risk and those who are exposed to systemic vulnerabilities.

Implementation considerations

- Regular data collection and real-time review is required to identify trends and inform effective programme targeting.
- Routine data collection and analysis from multiple sources, including triangulating data, is valuable to inform targeting strategies and programme improvements.
- Age and sex disaggregated risk data that is collected and made available for analysis on a regular basis can be instrumental in directing improvements in geographic, risk and programme targeting.
- Where guidelines and policies are in place, simplified standard operating procedures and job aids will support effective data management related to linkages and referrals.
- Documentation of unit costs, budgets and resource needs for multisectoral coordination of linkages and referrals can be used to effectively inform future budgeting and planning.
- Digital tools are a valuable resource to improve the quality of referral and linkage data gathered at programme level.
- Unique identifiers, if used across platforms and sectors, can facilitate AGYW access to comprehensive services, linkages, referrals and follow-up.
- Data that is routinely shared with stakeholders at all levels can support the identification of risk and vulnerability trends and inform programme adjustments and performance.
- Deliberate identification of opportunities to respond to data trends are key in supporting strategic programmatic change.

5. Taking action now: Using multiple targeting approaches to reach AGYW

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Now, more than ever, reaching AGYW who are most in need of services is critical to achieve zero new HIV infections and improve SRHR outcomes in the ESA region at scale and sustainably. Amid constrained budgets and the introduction of highly effective prevention technologies, the strategic use of targeting approaches becomes even more critical to sustain impact without compromising the multisectoral elements that underpin AGYW wellbeing. Geographical, programme, and individual targeting supported by an understanding of risk pathways will aid in reaching AGYW with the highest needs. Combined with a robust referral system, targeting can assist with successful layering of interventions by providing different interventions as they are needed. On-going collection and use of disaggregated data can both help programmes deliver quality interventions and ensure those interventions and investments deliver value for money.

Moving forward, policy makers and programmers are encouraged to adopt the four targeting approaches, adapted to their local context, alongside enhanced data use and referrals and linkages:

- Geographical targeting using the UNAIDS SHIPP tool is an important first step in identifying sub-national geographies to prioritise programme implementation for AGYW at risk of negative HIV and SRH outcomes. Additional sub-national data on HIV and SRH outcomes and drivers can be triangulated to further target implementation focus by geography. The SHIPP tool can be complemented with community information systems to ensure that targeted interventions reach the identified at-risk AGYW.

- Qualitative and quantitative data at national and sub-national levels will assist with targeting AGYW who are most at risk and determining which interventions should be prioritised for different risk pathways.

- Multiple programming platforms offer opportunities to identify either groups of or individual AGYW who require further assessment and referral.

- Individual targeting through risk assessment is instrumental in delivering appropriate interventions according to need. Individual risk assessments, when implemented in locations identified through geographical targeting methodologies, are effective in identifying AGYW who require additional services.

- Community knowledge systems and structures can help identify where to focus targeting efforts, including individual risk assessments for AGYW who are not currently receiving available services or interventions and may be at high risk. Microplanning, hotspot mapping, community data and community led monitoring are key tools that can be deployed.
- Individual risk assessments can effectively be embedded in existing data collection mechanisms and programme platforms, such as antenatal and postnatal care and SRH clinics that already provide services to AGYW. Education and social protection settings provide further opportunities for risk assessment. Training and supportive supervision of the people administering the risk assessment is critical for quality implementation.
- Well-coordinated linkage and referral systems are important in facilitating access to interventions for AGYW at risk of HIV and negative SRH outcomes. Routine data from referral uptake can be used to improve targeting efforts.

Research Priorities

The Think Tank provided a platform to share and discuss approaches, evidence and promising practices related to targeting interventions for AGYW at high risk. Think Tank members agreed that additional research is needed to bridge gaps in understanding targeting, including the following:

- Individual assessment tools: Further investigation is needed to better understand and measure the effectiveness of individual assessment tools, beginning with defining success and the expected outcomes.

- Unit cost analyses: There is currently limited cost analysis associated with targeting workstreams.

- Effectiveness of referral systems: Additional research is needed to understand the effectiveness of referrals, particularly in providing consistent, high quality services for AGYW.

- Data: How existing and current data can be used to inform approaches is of central importance, and a deeper understanding of promising approaches is needed.

- Target characterization: The characteristics of "at risk" groups in line with local data is needed to better understand who are the groups to target with individual risk assessment.

- Adolescent boys: Additional research on adolescent boys is needed, in particular, how targeting and segmentation could support positive HIV and SRH outcome change.

- Artificial intelligence: With the increasing use of AI and digital tools in health and development programmes, further exploration is needed on how these technologies can enhance precision targeting while ensuring strong safeguards for data privacy, ethics, and equity. Understanding both opportunities and risks will be essential before integrating AI-driven approaches into AGYW programmes.

Annex 1. Resources: Guidance and tools

A location-population approach for HIV prevention with AGYW:

UNAIDS (2016) HIV prevention among adolescent girls and young women: Putting HIV prevent among adolescent girls and young women on the Fast-Track and engaging men and boys. https://www.unaids.org/sites/default/files/media_asset/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women.pdf

UNAIDS. Decision-making Aid for Investments into HIV Prevention Programmes for Adolescent Girls and Young Women. April 2023. https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/AGYW-DMA-2023.pdf

WHO (2020) Preventing HIV and other STIs among women and girls using contraceptive services in contexts with high HIV incidence: actions for improved clinical and prevention services and choices. Policy brief. https://www.who.int/publications/i/item/WHO-UCN-HHS-19.58

Know your HIV epidemic:

Insight 2 Implementation, South-to-South Learning Network. How can we reach and provide HIV prevention programming for young women who sell sex? A summary of evidence and experience. https://www.prepwatch.org/wp-content/uploads/2024/03/i2i-YWSS-Summary-of-Evidence-and-Experience_20240311-vf.pdf

WHO (2015) HIV and young people who sell sex. Technical Brief https://www.unaids.org/sites/default/files/media_asset/2015_young_people_who_sell_sex_en.pdf

Geographical/population level tools for targeting AGYW:

Population Council (2021) Intentional Design: Reaching the Most Excluded Girls in the Poorest Communities – A Guide for Practitioners and Advocates

The Global Fund (2023) HIV Programming for Adolescent Girls and Young Women, Technical Brief

UNAIDS (2021) Naomi Modeling https://naomi-spectrum.unaids.org/

UNFPA (2019) My Body, My Life, My World Operational Guidance

WHO (2019) Adolescent-friendly Health Services for Adolescents Living with HIV: from theory to practice. A Technical Brief

Individual-level targeting tools:

UNAIDS. HIV and social protection assessment tool. https://www.unaids.org/sites/default/files/media_asset/HIV-social-protection-assessment-tool_en.pdf

UNAIDS. HIV prevention self-assessment tools (2024) https://www.hivinterchange.com/events/ssln-webinar-psat

Using the HIV Prevention Self-Assessment Tools (PSAT) to assess and monitor sex workers HIV programmes in selected countries in Africa (2023). https://gatesopenresearch.org/articles/7-51

2gether 4 SRHR (2021). Assessing the vulnerability and risks of adolescent girls and young women in Eastern and Southern Africa: A review of the tools in use. https://www.childrenandaids.org/documents/assessing-vulnerability-and-risks-adolescent-girls-and-young-women-eastern-and-southern

Medina-Jaudes N, Adoa D, Williams A, Amulen C, Carmone A, Dowling S, Joseph J, Katureebe C, Nabitaka V, Musoke A, Namusoke Magongo E, Nabwire Chimulwa T. Predicting Lost to Follow-Up Status Using an Adolescent HIV Psychosocial Attrition Risk Assessment Tool: Results from a Mixed Methods Prospective Cohort Study in Uganda. J Acquir Immune Defic Syndr. 2024 Apr 15;95(5):439-446. doi: 10.1097/QAI.0000000000003381. PMID: 38180899.

WHO. Mental Health Gap Action Programme. https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme

References

1. Africa Union (2023). Ten Year Review of the Addis Ababa Declaration on Population and Development in Africa beyond 2014.

2. UNAIDS (2025). Global HIV & AIDS statistics — Fact sheet | UNAIDS

3. https://esaro.unfpa.org/en/topics/adolescent-pregnancy

4. Kassa GM, Arowojolu AO, Odukogbe AA, Yalew AW. Prevalence and determinants of adolescent pregnancy in Africa: a systematic review and meta-analysis. Reproductive Health. 2018. 15(1),1-17

5. Ajayi AI, Otukpa EO, Mwoka M, Kabiru CW, Ushie BA. Adolescent sexual and reproductive health research in sub-Saharan Africa: a scoping review of substantive focus, research volume, geographic distribution and Africa-led inquiry. *BMJ Glob Health*. 2021 Feb;6(2):e004129. doi: 10.1136/bmjgh-2020-004129. PMID: 33568395; PMCID: PMC7878134.

6. Graybill, L. A. *et al.* Incident HIV among pregnant and breast-feeding women in sub-Saharan Africa: a systematic review and meta-analysis. *AIDS* 34, 761–776 (2020)

7. Flax, V. L. *et al.* After their wives have delivered, a lot of men like going out: Perceptions of HIV transmission risk and support for HIV prevention methods during breastfeeding in sub-Saharan Africa. *Matern Child Nutr* 17, (2021)

8. Harrison, A., Colvin, C. J., Kuo, C., Swartz, A. & Lurie, M. Sustained High HIV Incidence in Young Women in Southern Africa: Social, Behavioral, and Structural Factors and Emerging Intervention Approaches. *Curr HIV/AIDS Rep* 12, 207–215 (2015)

9. Banougnin, B. H., Toska, E., Shenderovich, Y., Zhou, S. 2021. Sexual practices among adolescents and young people in Eastern Cape, South Africa: the association with HIV status and mode of infection. CSSR Working Paper No. 462. doi: 10.13140/RG.2.2.25866.80326

10. Zgambo, M., Arabiat, D. & Ireson, D. We just do it … we are dead already: Exploring the sexual behaviors of youth living with HIV. *J Adolesc* 94, 34–44 (2022)

11. Senn, T. E. & Carey, M. P. Age of Partner at First Adolescent Intercourse and Adult Sexual Risk Behavior Among Women. *J Womens Health* 20, 61–66 (2011)

12. Bruederle, A., Delany-Moretlwe, S., Mmari, K. & Brahmbhatt, H. Social Support and Its Effects on Adolescent Sexual Risk Taking: A Look at Vulnerable Populations in Baltimore and Johannesburg. *Journal of Adolescent Health* 64, 56–62 (2019)

13. Ryan, J. H. *et al.* Sexual Attitudes, Beliefs, Practices, and HIV Risk During Pregnancy and Post-delivery: A Qualitative Study in Malawi, South Africa, Uganda, and Zimbabwe. *AIDS Behav* 26, 996–1005 (2022)

14. Shatkin, J. (2017). *Born to be wild: Why teens take risks, and how we can help keep them safe.* Penguin.

15. Laurenzi, C. *et al.* Social scripts of violence among adolescent girls and young women in Zambia: Exploring how gender norms and social expectations are activated in the aftermath of violence. Soc Sci Med 356, 117133 (2024)

16 UNAIDS (2022) Full report — In Danger: UNAIDS Global AIDS Update 2022

17. core_adolescentgirlsandyoungwomen_technicalbrief_en.pdf (theglobalfund.org)

18. UNICEF (2021) UNICEF-ESARO-AGYW-RV-Assessment-2021.pdf

19. Women's Refugee Commission (2016). I'm Here: Steps to Reach Adolescent Girls in Crisis; Inter-agency Working Group on Reproductive Health in Crises. Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings

20. Howes et al. 2023 Spatio-temporal estimates of HIV risk group proportions for adolescent girls and young women across 13 priority countries in sub-Saharan Africa | PLOS Global Public Health

21. UNAIDS. Decision-making Aid for Investments into HIV Prevention Programmes for Adolescent Girls and Young Women. April 2023. https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/AGYW-DMA-2023.pdf

22. Stevens et al 2022 Key population size, HIV prevalence, and ART coverage in sub-Saharan Africa: systematic collation and synthesis of survey data | medRxiv

23. Eaton et al 2021 Naomi: a new modelling tool for estimating HIV epidemic indicators at the district level in sub- Saharan Africa - Eaton - 2021 - Journal of the International AIDS Society - Wiley Online Library

24. USAID 2021. Size Estimation for At-Risk Adolescent Girls and Young Women in Uganda. PA00XWKF.pdf (usaid.gov)

25. UNAIDS Spectrum Estimates, July 2025

26. SANAC 2023 National Strategic Plan 2023-2028 | SANAC; https://www.nacosa.org.za/2017/11/13/focus-for-impact/

27. Christofides NJ, Jewkes RK, Dunkle KL, Nduna M, Shai NJ, Sterk C. Early adolescent pregnancy increases risk of incident HIV infection in the Eastern Cape, South Africa: a longitudinal study. J Int AIDS Soc. 2014 Mar 19;17(1):18585. doi: 10.7448/IAS.17.1.18585. PMID: 24650763; PMCID: PMC3962027.

28. Graybill LA, Kasaro M, Freeborn K, Walker JS, Poole C, Powers KA, Mollan KR, Rosenberg NE, Vermund SH, Mutale W, Chi BH. Incident HIV among pregnant and breast-feeding women in sub-Saharan Africa: a systematic review and meta-analysis. AIDS. 2020 Apr 1;34(5):761-776. doi: 10.1097/QAD.0000000000002487. PMID: 32167990; PMCID: PMC7275092.

29. Groves AK, Gebrekristos LT, Smith PD, Stoebenau K, Stoner MC, Ameyan W, Ezeh AC. Adolescent Mothers in Eastern and Southern Africa: An Overlooked and Uniquely Vulnerable Subpopulation in the Fight Against HIV. J Adolesc Health. 2022 Jun;70(6):895-901. doi: 10.1016/j.jadohealth.2021.12.012. Epub 2022 Feb 13. PMID: 35172930; PMCID: PMC9113251.

30. Raj A, Boehmer U. Girl child marriage and its association with national rates of HIV, maternal health, and infant mortality across 97 countries. Violence Against Women. 2013;19:536-51.

31. Cluver et al 2022 Food security reduces multiple HIV infection risks for high- vulnerability adolescent mothers and non- mothers in South Africa: a cross- sectional study - Cluver - 2022 - Journal of the International AIDS Society - Wiley Online Library

32. Treibich et al 2022 From a drought to HIV: An analysis of the effect of droughts on transactional sex and sexually transmitted infections in Malawi - ScienceDirect

33. Insight 2 Implementation: a SSLN offering (2023). How can we reach and provide HIV prevention programming for young women who sell sex? A summary of evidence and experience

34. www.zvandiri.org

35. Murewanhema, G. et al 2022 HIV and adolescent girls and young women in sub-Saharan Africa: a call for expedited action to reduce new infections, Science Direct 5, December 2022 pp 30-32

36. UNAIDS 2020 Gender & AIDS fact sheets : HIV/AIDS and gender-based Violence (unaids.org)

37. Chipanta et al 2022 Access to Social Protection by People Living with, at Risk of, or Affected by HIV and AIDS in Eswatini, Malawi, Tanzania, Zambia: Results from Population Based Impact Assessments, *Journal of AIDS Behaviour* 26(9) pp 3068-3078

38. Social protection | UNAIDS

39. Rucinski, K. B. et al. High HIV Prevalence and Low HIV-Service Engagement Among Young Women Who Sell Sex: A Pooled Analysis Across 9 Sub-Saharan African Countries. *JAIDS Journal of Acquired Immune Deficiency Syndromes* 85, 148–155 (2020)

40. Insight 2 Implementation: a SSLN offering (2023). How can we reach and provide HIV prevention programming for young women who sell sex? A summary of evidence and experience

41. Wamoyi J, Ranganathan M, Kyegombe N, Stoebenau K. Improving the Measurement of Transactional Sex in Sub-Saharan Africa: A Critical Review. February 2019. JAIDS Journal of Acquired Immune Deficiency Syndromes 80(4) DOI:10.1097/QAI.0000000000001928

42. https://www.unicef.org/tanzania/reports/cash-plus-model-safe-transitions-healthy-and-productive-adulthood-midline-report

43. Mathur et al 2022 Temporal shifts in HIV-related risk factors among cohorts of adolescent girls and young women enrolled in DREAMS programming: evidence from Kenya, Malawi and Zambia | BMJ Open

44. Population council The Girl Roster™: A Practical Tool for Strengthening Girl-Centered Programming – Population Council (popcouncil.org)

45. UNICEF 2021.Assessing the Vulnerability and Risks of Adolescent Girls and Young Women in Eastern and Southern Africa: A Review of the Tools in Use. UNICEF-ESARO-AGYW-RV-Assessment-2021.pdf

46. The Global Fund 2023 core_adolescentgirlsandyoungwomen_technicalbrief_en.pdf (theglobalfund.org)

47. https://zvandiri.org/

48. Bangounin, B.H. et al (2021) Sexual practices among adolescents and young people in Eastern Cape South Africa: the association with HIV status and mode of infection WP462BanougninToskaShenderovichZhou.pdf (uct.ac.za)

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