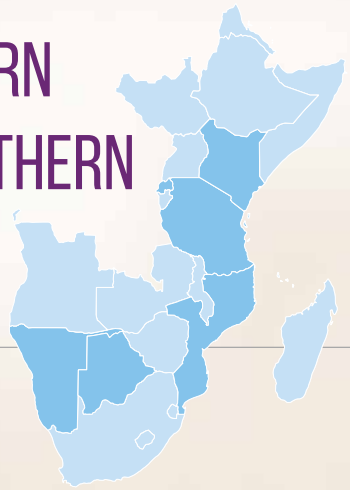
ALL IN

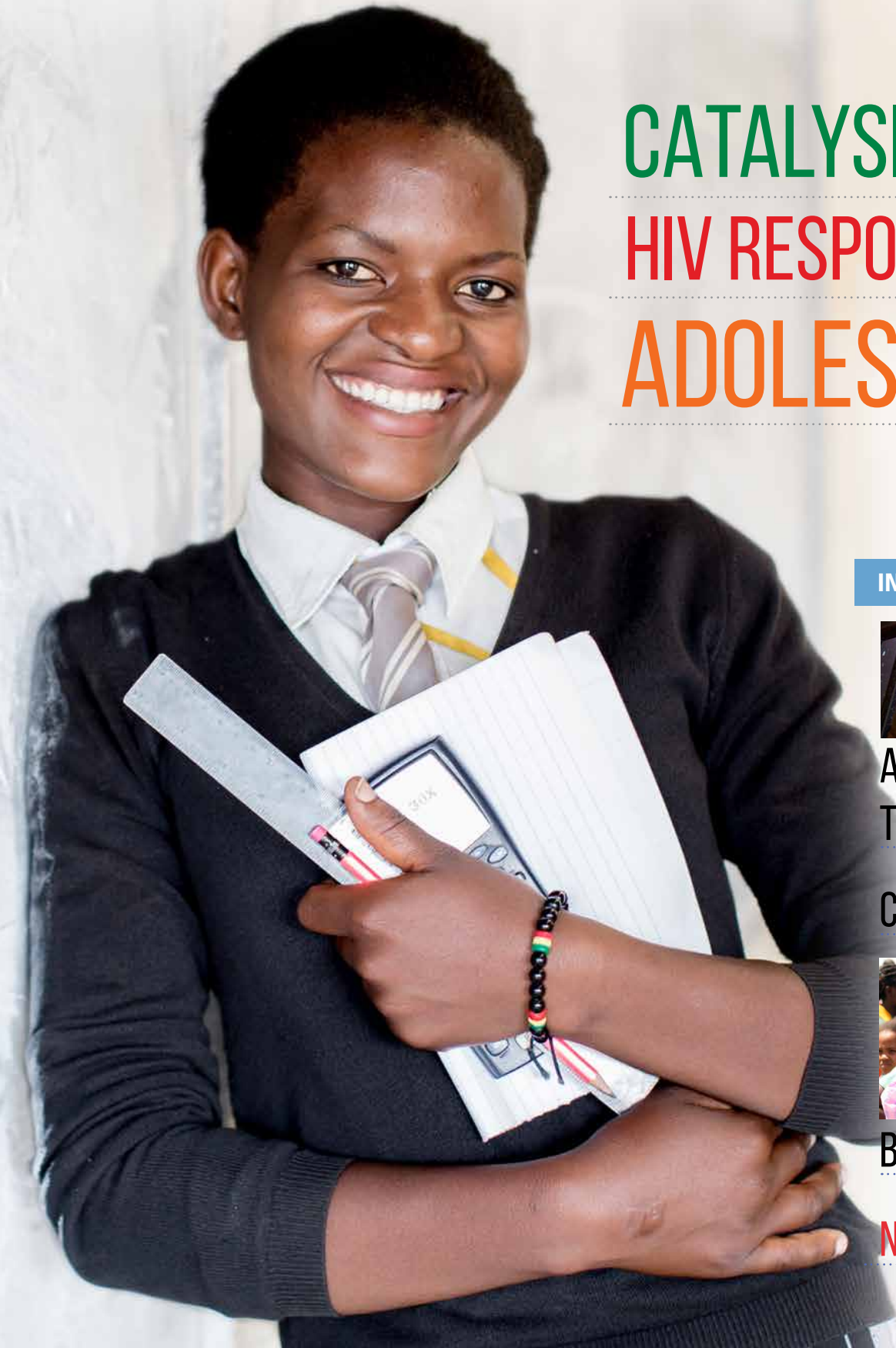
#EndAdolescentAIDS

IN EASTERN AND SOUTHERN AFRICA



JULY 2018

CATALYSING THE HIV RESPONSE FOR ADOLESCENTS



INSIDE :

ALL IN

#EndAdolescentAIDS

unicef
for every child

UNAIDS

This report brings together information and data from the ***All In*** process in Eastern and Southern Africa. The report was led by Anurita Bains, and compiled by Alice Armstrong. It benefited from reviews and editing by colleagues from the UNAIDS Regional Support Team for Eastern and Southern Africa and the UNICEF Eastern and Southern Africa Regional Office. The report incorporates contributions from ***All In*** country assessment reports and in-person and virtual interviews with over 40 government officials, UN partners and other organizations. The insights and technical contributions by all those interviewed were invaluable.

Graphic design and layout by Edgar Mwakaba

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FOREWORD from the Regional Directors, UNICEF and UNAIDS

The Eastern and Southern Africa Region (ESAR) is home to approximately 60 per cent of the world's adolescents aged 10-19 years who are living with HIV. Nearly half of the 254,000 new HIV infections among adolescents globally in 2016 occurred in the region. Yet, only a few short years ago, adolescents were barely visible in the global HIV response. So, when data became available in 2014 showing that HIV-related health outcomes had improved for other age groups but had worsened for adolescents, we knew it was time to act.

Building on the collaborative effort that resulted in tremendous progress in scaling up lifesaving anti-retroviral treatment and preventing mother-to-child transmission of HIV in ESAR, UNAIDS and UNICEF launched a campaign titled ***All In to End Adolescent AIDS (All In)*** in 2015 in Nairobi, Kenya. The aim was to inspire governments and partners to collaborate across sectors and accelerate the HIV response for adolescents by reducing AIDS-related deaths and new HIV infections among 10-19 year olds.

Since then much has been achieved. In the 14 high-burden HIV countries in ESAR, UNAIDS and UNICEF have supported governments to convene key stakeholders - including donors, UN agencies, and young people - to take stock of the health and well-being of adolescents. Through intensive data reviews and consultations at both national and district levels, policymakers and programmers identified critical data gaps on adolescent health and discussed strategies to address the unique needs of adolescents living with HIV and those at risk of infection. Central to ***All In*** was the meaningful engagement of adolescents. During ***All In*** consultations, adolescents spoke of the challenges they faced in being able to access HIV treatment, of wanting to take an HIV test but being afraid to, and the stigma they faced as a child of a parent living with HIV.

We are proud to launch this report, which highlights how ***All In*** mobilized partners, engaged adolescents and young people and influenced policies and programmes. The report documents the progress made in a few short years on adolescent HIV, and offers suggestions and recommendations on how to strengthen strategic information, apply evidence-based programming and mobilize resources for adolescents in the HIV response.

With this report, we hope partners in ESAR will be better equipped to apply and support efforts to end adolescent AIDS.

Leila Pakkala

Regional Director
United Nations Children's Fund
Eastern and Southern Africa

Catherine Sozi

Director
UNAIDS Regional Support Team for
Eastern and Southern Africa

A GLOBAL CALL TO ACTION

Four years ago adolescents were a forgotten population in the global HIV response. In Eastern and Southern Africa and other regions, programmes typically targeted either infants and young children or adults, neglecting the needs of this unique group of adolescents aged 10 to 19 years.

Adolescence is a critical life stage characterized by rapid biological and social changes. Adolescents require targeted HIV programmes, but as recently as 2014 many adolescents had only limited access to information, services and testing. Adolescents living with HIV often struggled to adhere to treatment regimens, due to lack of support and understanding of their treatment. Uptake and coverage of basic HIV prevention interventions – such as comprehensive sexuality education, condoms and sexual and reproductive health (SRH) services – among adolescents was low in many places.[1]

In addition, countries lacked critical information and data on adolescent health, including the socio-economic factors that contribute to HIV infection, age- and sex-disaggregated data, modes of HIV transmission, barriers to treatment adherence and access to anti-retroviral therapy and other services. Data for the youngest adolescents (aged 10-14) was particularly limited, due to the challenges of designing age-appropriate surveys and to age-related consent barriers. As a result, countries did not have a complete picture of how adolescents were affected by HIV and how interventions could address their needs.[2]

Then, in 2014, the HIV community was confronted by new modelling indicating that AIDS was the leading cause of death for the 10-to-19 age group in Africa, and the second most common cause of death among adolescents globally.[3] While HIV-related health outcomes had improved for other age groups, they had worsened for adolescents. Suddenly everyone - from local-level programmers to national policymakers - was discussing how to do more for adolescents, so that young boys and girls could avoid HIV infection or live positive, healthy lives with HIV. This flurry of interest in adolescent health was welcome news to researchers, civil society and adolescent activists who for years had been advocating for targeting adolescents as a distinct population group.

The new findings also spurred global leaders into action. Building on other initiatives, UN partners initiated a series of consultations with civil society groups, youth-led organizations, researchers and governments to identify key issues, gaps in the current response and urgently needed solutions. The *Global Strategy Consultation on All In to End Adolescent AIDS* meeting held in Geneva, Switzerland, in December 2014 highlighted several key problems, including the lack of adolescent-specific health data. Other challenges noted were the lack of adolescent engagement in policy and programmes, the absence of sufficient resources and the need for programme changes at all levels of the response.

1,3 World Health Organization, Health for the World's Adolescents: Second chance for a second decade, WHO, Geneva, 2014. http://www.who.int/maternal_child_adolescent/topics/adolescence/second-decade/en/.
2 Idele P, et. al, Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps. J Acquir Immune Defic Syndr. 2014 Jul 1;66 Suppl 2:S144-53.

A GLOBAL CALL TO ACTION

All In – a collaborative platform

The result of these global deliberations was ***All In to End Adolescent AIDS (All In)*** – a joint initiative launched in February 2015 by UNAIDS and UNICEF that aimed to inspire actors to collaborate across sectors to accelerate reductions in AIDS-related deaths and new HIV infections among adolescents. Aligning with the UNAIDS Fast-Track Strategy, the goal is to end the AIDS epidemic by 2030.[4] Although ***All In*** was convened by UNAIDS and UNICEF, its approach depends on leadership and active engagement by countries at every step of the process, as well as on meaningful participation by adolescents.[5]

Three years after its launch, countries in ESAR have experienced far-reaching progress across multiple areas of adolescent HIV programming, laying the groundwork for improved adolescent HIV outcomes.

All In focused on four action areas:

1. **Engage, mobilize** and **support** adolescents as leaders and agents of social change
2. **Sharpen** adolescent-specific elements of national AIDS programmes by improving data collection and analysis and using evidence to drive programming
3. **Foster** innovative approaches that improve the reach of services for adolescents and increase the impact of prevention, treatment and care programmes
4. **Advocate** and **communicate** at the global, regional and country levels to generate political will to invest in eliminating adolescent HIV and mobilize resources[4]

All In in Eastern and Southern Africa

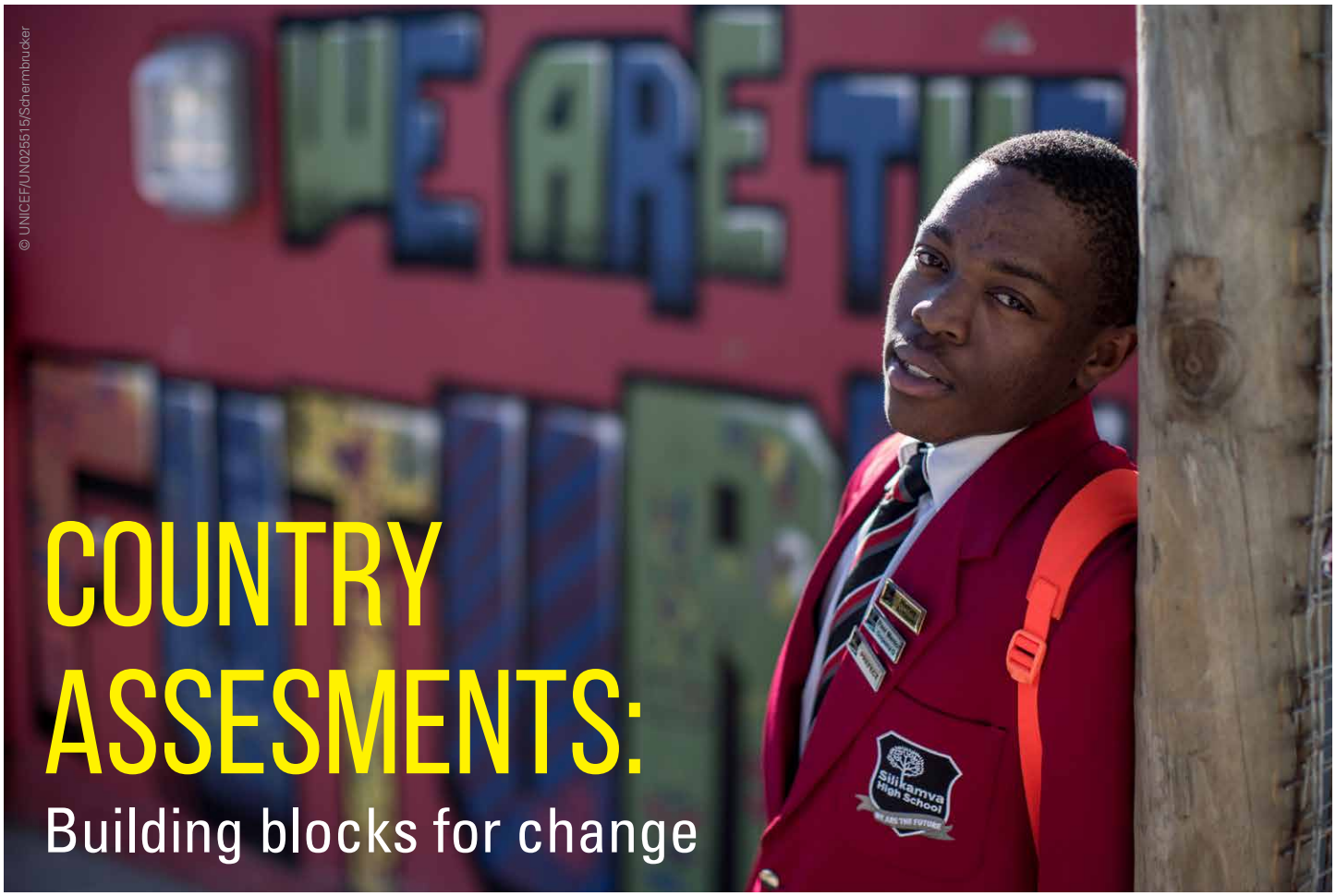
The Eastern and Southern Africa region (ESAR) has been an important focus area of the ***All In*** initiative, since many countries in the region have significant adolescent populations and HIV burdens. Of the initial 25 ***All In*** priority countries, 14 are in ESAR: Botswana, eSwatini, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. Many governments in the region have committed to taking action for adolescents' health and rights, creating an enabling environment for addressing adolescent HIV issues.

This report captures some of the major progress made in nine countries under the ***All In*** initiative, and how it has affected the lives and future of adolescents across the region.[6] It incorporates a series of case studies, blogs and videos showcasing progress in individual countries. The impact of ***All In*** country assessments was appraised through a desk review of ***All In*** country assessment reports, country visits and both in-person and virtual interviews with 43 key government officials primarily from ministries of health and national AIDS coordinating councils at both national and subnational levels and representatives of UN agencies, funding partners and implementing organizations.

Qualitative in approach, this report sets out to explore implemented actions and changes in programming that came about as a result of the ***All In*** country assessments. In particular,

it considers how ***All In*** influenced key programmatic areas such as engagement and collaboration, strategic information, policies and plans, implementation and resource mobilization. Data collated as part of the country assessments, which informed and supported programme changes are summarized in the 2016 ***All In*** Progress Report.[7] Ultimately, the changes implemented should result in better HIV and related outcomes for adolescents and will be measured through repeated country assessments or by embedding the assessment into country programming.

4 United Nations Children's Fund and United Nations Joint Programme on AIDS (UNAIDS), ALL IN to End the Adolescent Aids Epidemic, launch document, UNICEF and UNAIDS, New York, 2016. https://childrenandaids.org/all-in-to-endadolescentAIDS.
5 United Nations Children's Fund, Synthesis Report of the Rapid Assessment of Adolescent and HIV Programme Context in Five Countries: Botswana, Cameroon, Jamaica, eSwatini and Zimbabwe, UNICEF, New York, 2015. https://www.childrenandaids.org/synthesis-report-rapid-assessment-adolescents.
6 Information on All In countries in other regions can be found at: https://www.childrenandaids.org/UNAIDS-UNICEF_all-in-progress-report_2017
7 https://www.childrenandaids.org/UNAIDS-UNICEF_all-in-progress-report_2017



COUNTRY ASSESMENTS:

Building blocks for change

Central to ***All In*** is the promotion and use of evidence to support the development of more effective strategies, policies, programmes and services for adolescents living with or affected by HIV. Many countries face challenges in obtaining data to inform the adolescent component of national AIDS programmes. ***All In*** country assessments were designed to serve as a first step toward addressing this critical gap, providing - for the first time - a systematic way to identify performance gaps affecting adolescent HIV programming. The assessments facilitated the defining of adolescent target populations, interventions, geographic areas and priority actions to improve the effectiveness of national adolescent HIV responses. These assessments were centred around HIV outcomes, but included a broad range of multi-sectoral data and analysis to further contextualize HIV-related gaps for adolescents within the broader perspective of their holistic health, protection, education and overall wellbeing.

The country assessments adopted a three-phase approach:

Phase I: rapid assessment of the adolescent programming context

Phase II: in-depth analysis of bottlenecks

Phase III: evidence-informed planning

The leadership role played by governments (most often national AIDS coordinating councils and ministries of health) in convening key stakeholders from across the country to contribute to the assessments was key to ***All In***'s success. Governments also provided strategic direction for the assessments, while UNICEF, UNAIDS and other UN agencies (e.g. UNESCO, UNFPA, ILO, WHO and UN Women, among others) and strategic partners provided technical support. ***All In***'s multi-sectoral approach provided a unique opportunity to look beyond HIV-specific data and programmes and review the broader health, policy and development context for adolescents, with the aim of addressing cross-cutting structural drivers of the HIV epidemic.

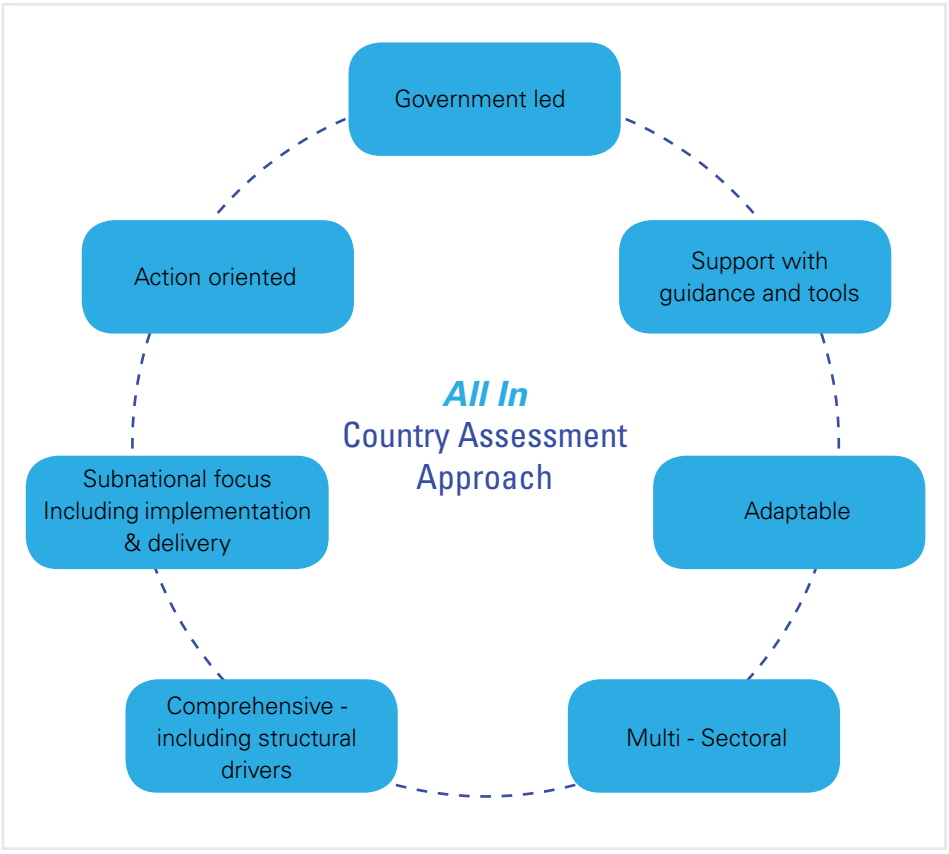
> *All In was a call to action. Much as adolescents were being talked about in the country, there was not a clear, structured way of looking at their needs.*
>
> Fabian Mwanyumba, UNICEF Rwanda

Standardized tools and guidance supported the country assessment process, including the Adolescent Assessment and Decision-Makers' Tool (AADM). The AADM provided countries with the necessary platform and analytics to validate data, inform review and analysis of adolescent programming gaps and facilitate the programmatic decision-making process (see page 40 for key resources). Its interactive dashboard enabled visualization of data, optimized data usage and provided a way to monitor progress for adolescents across key HIV indicators.

COUNTRY ASSESMENTS: A building block for change

Although all country assessments shared a structured, systematic approach, individual countries adapted the assessment process and tools to meet unique disease, programmatic and geographic contexts. This approach empowered individual countries to take ownership of their assessments. For example, to reflect its devolved health system structure, **Kenya's** entire ***All In*** assessment used a sub-national approach. In **Rwanda**, after the phase I rapid assessment, a national operational plan was prioritized before the phase II sub-national bottleneck analysis was conducted. The focus on sub-national data allowed for in-depth analysis of implementation and delivery-level challenges. Some countries that did not carry out the whole process used the AADM for programmatic assessment and analysis on adolescents, such as **Lesotho, Malawi,** and **Zambia**.

The final phase of the assessments was designed to transform available data into action through the development of work plans and evidence-informed planning. Perhaps most importantly, the assessment process and results generated significant momentum around adolescent health and rights – the results of which have been long-lasting across the region.



> *All In catalyzed a whole range of actions to put adolescents much more firmly in the center of attention.*
>
> Ulrike Gilbert, UNICEF United Republic of Tanzania

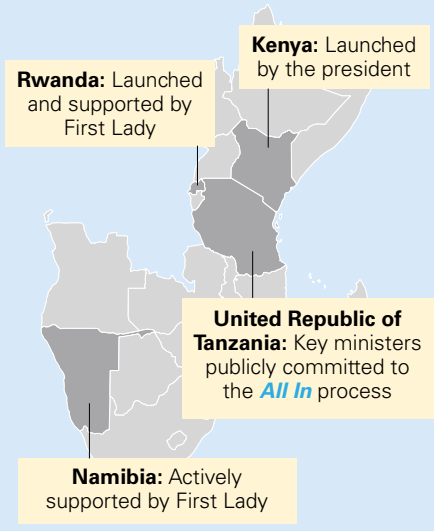
ALL IN FOR IMPACT:
Effects on HIV programming for adolescents

Across ESAR, ***All In*** has increased the visibility of adolescents, calling attention to their risk for their overall health and wellbeing. ***All In*** has helped to ensure that adolescent HIV issues are now on the radar of prominent policymakers and health programmers, resulting in an improved response to adolescents as a distinct population group with specific needs. Political will and commitment were instrumental to the uptake and implementation of ***All In***; prominent leaders across the region have launched and promoted the initiative.

All In country assessments set the stage for the collection and generation of sharper strategic information to inform adolescent programming. The ***All In*** assessments generated a significant amount of data, which now forms the basis for the HIV response in countries and serves as a critical advocacy tool to advance HIV programming for adolescents. Across the region, stakeholders supporting adolescent HIV initiatives, health and rights now have a mandate and the tools to do more to reduce new HIV infections and ensure that adolescents living with HIV have access to treatment, care and support.

> *It has been an eye opener. We need to look at adolescents separately and target our programmes accordingly.*
>
> Ketlaantshang Monyadiwa,
> District AIDS Coordinator, Botswana

Examples of political commitment to All In



The following sections outline the impact of the ***All In*** country assessments on multiple areas: adolescent engagement, collaboration and partnerships, strategic information, policies and plans, HIV programming, resource mobilization and coordination in ESA countries.

ALL IN FOR IMPACT: Effects on HIV programming for adolescents

Adolescent engagement

Adolescent engagement in the HIV response provides policy-makers and programmers with better understanding of how HIV programmes can respond to their particular needs. The country assessment process served as an opportunity to strengthen existing mechanisms for engaging adolescents in programme design. The majority of ***All In*** countries in ESAR held consultations, focus groups or adolescent and youth stakeholder meetings and included adolescent representatives in technical working groups (TWGs).

Botswana's consultations generated engagement by a diverse group of adolescents across the country – including those from rural areas, high-risk populations and those with disabilities. **Ethiopia** leveraged existing youth networks, including those for adolescents living with HIV, to actively engage in the ***All In*** process, and facilitated the involvement of younger adolescents who are often overlooked. Likewise, in **Namibia**, partnerships with active youth networks supported consultative processes, particularly during phase II of the adolescent assessment.

Mozambique's national youth meeting brought adolescents together to identify core issues and interventions for improving the national HIV response (see p 14). Mozambique also utilized mobile technology (the U-Report platform) to gather and better understand adolescent views on key interventions, such as condoms. In **Zimbabwe**, adolescent representatives were crucial members of the technical working group leading the country assessment process. At the **United Republic of Tanzania's** national youth stakeholder meeting, adolescents produced a declaration that outlined the key actions and programming requirements that they supported.

In **Kenya**, the ***All In*** process continues to strengthen the response of networks of adolescents living with HIV (known as Sauti Skika); network members lead programming efforts such as promoting demand for HIV testing and stigma reduction campaigns (see p 16). Consultations organized for ***All In*** in **Rwanda** represented the first time that this group had engaged in policy and programming efforts at the national level.

Key lessons learnt by countries throughout the process can now inform longer-term engagement with this age group. The momentum generated by ***All In*** has sparked and sustained adolescent participation in both policy and programming spaces; not only in relation to HIV and SRH, but across other health and development areas.

KEY ACHIEVEMENTS

- Adolescents as key technical working groups members, including at sub-national level
- Adolescent consultations, focus groups and stakeholder meetings
- Leveraging partnerships between the UN and governments with existing youth networks
- Strengthening of national adolescents living with HIV networks
- Use of mobile technology to support programme research
- Catalysed adolescent participation in other health and development areas

They traveled so far to discuss HIV issues, and they were so engaged and involved – they really understood what they were talking about. The adults were the shy ones in the back and the teenagers were in front. There was a power in the air.

Cecilia, youth advocate and meeting facilitator, Mozambique

We can't talk about ending AIDS or getting to zero without including adolescents in every decision-making platform. Adolescents are the group most affected by HIV and they are tomorrow's leaders.

Consolata Opiyo, Y+, the Global Network of Young People Living with HIV

ALL IN FOR IMPACT: Effects on HIV programming for adolescents

Collaboration and partnerships

All In *aligned with and aimed to* galvanize existing efforts, specifically for adolescents, such as UNAIDS Fast-Track initiative;[8] PEPFAR's Accelerating Children's HIV/AIDS Treatment (ACT) Initiative;[9] and the Eastern and Southern Africa Ministerial Commitment[10] on sexuality education and sexual and reproductive health services for adolescents and young people. Since ***All In***'s launch a number of global and regional adolescent health and HIV-related initiatives have been implemented, including: the Global Strategy for Women's, Children's and Adolescents' Health;[11] the PEPFAR DREAMS Initiative;[12] the Start Free, Stay Free, AIDS Free Fast Track Framework;[13] and the Global Accelerated Action for the Health of Adolescents.[14] ***All In*** is working in support of these initiatives, leveraging, informing and supporting them to achieve further country-level progress toward addressing the adolescent HIV epidemic.

In countries, to prevent unnecessary overlap of efforts and address important programming gaps, ***All In*** brought multi-sectoral stakeholders together to coordinate efforts for adolescents. For a number of countries, this was the first-time coordination had occurred in a structured way to accelerate adolescent HIV programming.

Botswana, Kenya, Mozambique and **Namibia** established subnational technical working groups. Led by government, these mechanisms provided a platform for partnership, strengthened knowledge and data sharing, joint planning and work plan implementation. In other countries such as the **United Republic of Tanzania**, partners are now strongly advocating for the formation of sub-national technical working groups. For most countries, ***All In*** technical working groups have evolved into formal structures to support ongoing adolescent programming and drive new initiatives.

The ***All In*** process further strengthened governments, especially national AIDS councils and coordinating committees and ministries of health, as well as ministries of social welfare, justice, youth, gender and others - depending on the country context - to lead and coordinate on adolescent health. Particularly for countries undertaking ***All In*** activities in priority districts, the processes facilitated more effective working relationships between national and sub-national departments. The assessments also engaged and mobilized personnel in monitoring and evaluation to support data analysis and data-driven advocacy.

All In's multi-sectoral approach led to the engagement of stakeholders beyond HIV. For example, in **Lesotho** it built a strong advocacy case for cross-sectoral involvement when addressing adolescent HIV. **Ethiopia** saw the inclusion of adolescent HIV issues in social protection programming, and in **Mozambique** ***All In*** led to a study of social norms. In both **Kenya** and **Ethiopia**, other departments and sectors are now focusing on adolescent programming.

KEY ACHIEVEMENTS

- Established or strengthened technical working groups on adolescents at the national and sub-national levels
- Strengthened government coordination mandate on adolescent health
- Facilitated more effective national and sub-national work
- Increased cross-sectoral coordination
- Aligned with other adolescent and HIV initiatives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8 http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report
9 https://www.pepfar.gov/partnerships/ppp/234538.htm
10 http://youngpeopletoday.net/the-commitment/
11 http://www.who.int/life-course/partners/global-strategy/en/
12 https://www.pepfar.gov/partnerships/ppp/dreams/
13 https://free.unaids.org/
14 http://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/

ALL IN FOR IMPACT: Effects on HIV programming for adolescents

Strengthening strategic information

Lack of age disaggregation in the collection and analysis of data makes it difficult to design or implement programmes for adolescents. Through the country assessments, ***All In*** has helped to address this lack of strategic information. The assessments brought together available adolescent data and, in several countries, generated new data for the first time — including critical strategic sub-national information that was used immediately to inform adolescent programme planning. The assessments also highlighted data gaps that require further attention, including important aspects of programming such as supply and demand.

In **Kenya** and the **United Republic of Tanzania**, changes were made to key data collection tools to ensure that national data is disaggregated by age (see pp 14, 28). The revision of tools used by the national health management information system, the United Republic of Tanzania's health indicator survey and Kenya's population-based HIV impact assessment will ensure routine availability of adolescent-specific data to support targeted programming for this population. In addition, this data is being used to strengthen country HIV estimates through estimation and projection package (EPP) Spectrum modelling.[15]

In **Lesotho** and **Namibia**, ***All In*** accelerated advocacy efforts to ensure a priority focus on collecting and reporting age-disaggregated data, and to push for increased funding and capacity to strengthen data collection. ***All In*** assessments in **Botswana** strengthened strategic information components of the new national programming framework for adolescents and young adults. In **Rwanda**, data collection already allowed for age disaggregation, however the data was not analysed or reported accordingly. ***All In*** focused attention on the need for reporting adolescent data, which is now ongoing.

To further understand which HIV services were available to adolescents, the **United Republic of Tanzania** conducted a national mapping exercise. **Botswana** and **Namibia** are planning implementation science research projects to monitor implementation of their ***All In*** work plans and to understand the requirements for scaling-up services for adolescents.

KEY ACHIEVEMENTS

- Changes to data collection tools to allow for age disaggregation
- Strengthened HIV estimates
- Accelerated advocacy for adolescent specific data
- Mapping of HIV and SRH services
- New implementation science projects to inform scale up

> *We now have the data that speaks. We are able to utilise the data to plan. It helps us to see what we need to do for adolescents*
>
> Caren Ayieko, Adolescent Focal Person, Kenya

15 Further information on EPP Spectrum modelling can be found at http://www.unaids.org/en/dataanalysis/datatools/spectrum-epp

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The Operational Plan uses a multi-sectoral approach to addressing the HIV prevention and sexual and reproductive health needs of young people and adolescents in Rwanda. It demonstrates the power of partnerships and collaboration, with the involvement of young people at the centre. These are the principles that lie at the heart of the All In initiative.

Betru Woldesemayat,
UNAIDS Country Director, Rwanda

BLOG

MOZAMBIQUE

Adolescent participation: The story of Cecilia

© UNICEF Mozambique

"There was a power in the air"

Catalyzing adolescent participation around HIV in Mozambique

Young people packed the conference space; an 'electric current' ran through the room. For the first time, adolescents from across Mozambique, including some living with HIV, had been provided with a platform to share their ideas on improving the HIV response for young people with their government and UN officials.

The consultation, which occurred in November 2015, was urgently needed. At the time, in Mozambique, an estimated 110,000 adolescents were living with HIV. Adolescent girls are more than twice as likely to be living with HIV than adolescent boys. Half of Mozambican girls are married before their 18th birthday. The meeting was convened as part of the ***All In*** initiative.

To kick off ***All In***, institutions working on health in Mozambique – including the government, international organizations and civil society – conducted a rapid assessment to better understand how HIV affects adolescents. As is the case throughout ESAR, the data indicated that from the age of 15, girls are significantly more likely to contract HIV than boys of the same age. It also revealed a growing number of AIDS-related deaths among adolescents aged 10 – 19, with 4,400 deaths in 2016, a 76 per cent increase since 2010.[16] After the assessment, the National AIDS Council, UNICEF, UNAIDS and others organized opportunities for adolescent dialogue.

Twenty-eight adolescents from eleven provinces across the country gathered in Maputo for the intense debate.

Cecília Dimande is one of the young leaders who participated in the consultation as the Mistress of Ceremony. Cecília first became involved with ***All In*** when she was 18, but her contribution as a youth activist started much earlier.

When she was 10, Cecília joined Radio Mozambique as a radio announcer and producer for children's programmes.

16 UNAIDS Estimates 2017 http://aidsinfo.unaids.org

As part of her work, she travelled to orphanages in Mozambique and met many children whose parents had died of AIDS.

"When I saw how many children were in the orphanages, I knew I needed to continue doing something," she said.

At the ***All In*** consultation, Cecília was one of the older participants – and meeting so many young adolescent activists was inspiring.

"They traveled so far to discuss HIV issues, and they were so engaged and involved – they really understood what they were talking about. The adults were the shy ones in the back and the teenagers were in front. There was a power in the air," said Cecília.

Mozambique's National AIDS Committee worked to make sure that the young people involved felt in charge of the process. They fostered a safe space for adolescent participation including the establishment of a youth Steering Committee; selected young facilitators and relied on local organizations to choose participants.

During the meeting, adolescents and young people made recommendations for an improved national HIV response. These included appropriate health information tailored to different age and key groups, increasing the coverage of adolescent and youth friendly services at government health units, counselling on alcohol and drugs, and improving the curriculum, so that teachers provide high quality comprehensive sexuality education. They also shared personal stories, as well as perspectives from their peers at home, providing critical context to the numbers derived from the national assessment.

The consultation sent a clear message to government and partners: adolescents participation must be taken seriously in order to see progress on preventing HIV among adolescents. It also helped to spur the involvement of adolescents in different health spaces around the country, including as members of provincial-level HIV working groups, particularly during the implementation of the ***All In*** phase II in 2017.

In the context of the national programme on adolescent sexual reproductive health called Geração BIZ, the Government, along with UNFPA, UNICEF and other key partners, continues to engage over 125,000 adolescents and young people on sexual and reproductive health topics through the mobile phone platform U-Report (or SMS Biz, as it's known locally). Through U-Report, adolescents can be polled for their opinions on topics such as how to encourage condom use or make health services more youth friendly. Users can also direct questions about their health to one of 48 available peer counsellors.

For Cecília, now 20, participation in the adolescent consultation has expanded her horizons. She recently traveled to Geneva, Switzerland as part of her country's delegation for the launch of the Global Coalition on HIV Prevention, where she represented the voices of young people in Mozambique. These kinds of linkages are exactly what ***All In*** hopes to facilitate through its support for meaningful youth participation.

Cecília says the consultation continues to motivate her to fight the stigma faced by young people living with HIV. "The way we treat people affects their health," she said. "I want to do my part – whenever I have an opportunity to do something, I will."

ONLINE RESOURCES

To watch a video of the **adolescent consultation** in Portuguese, please click on the image below:

Link: **https://bit.ly/2uebvsY**

To find out more on U-Report in Mozambique please use this link:
http://mozambique.ureport.in/

To find out more about **UNICEF's** work in Mozambique please use this link:
http://www.unicef.org.mz/en/

To find out more information on ***All In*** please use this link:
https://childrenandaids.org/all-in-to-end-adolescent-AIDS

To find out more about **UNAIDS'** work in Mozambique please use this link:
http://www.unaids.org/en/regionscountries/countries/mozambique/

CASE STUDY

KENYA

10,200,000

10 -19 year olds population
(Ref: UNAIDS Estimates 2017
http://aidsinfo.unaids.org)

18,000

New HIV infections among adolescents

Ref: UNAIDS Estimates 2017
http://aidsinfo.unaids.org

Strengthening adolescent strategic information: Revising tools/systems for disaggregation

Background

Kenya is one of five countries – alongside India, Nigeria, South Africa and the United Republic of Tanzania – that are home to nearly half of all adolescents worldwide living with HIV.[17] Adolescents (10 –19-year-olds) account for 22.4 per cent of Kenya's total population of 44 million.[18] An estimated 1.5 million Kenyans were living with HIV in 2015, including some 133,000 adolescents.[19]

In recognition of both the large number of adolescents living with HIV and the importance of their health and development to the larger society, Kenya is committed to addressing the gap in adolescent HIV programming. The ***All In*** initiative convened by UNICEF and UNAIDS provides a platform for doing so.

The global ***All In*** initiative was launched in Kenya in February 2015 by President Uhuru Kenyatta. Since then, a key focus has been on improving strategic information on adolescents living with HIV. In Kenya, this process revealed that information on adolescent health was incomplete. The way in which data are collected and analysed can mask differences for sub-populations (especially by age and sex), and differences across provinces within countries. This lack of data presents a major obstacle to designing and or implementing programmes that are urgently needed to improve outcomes for adolescents.

All In addresses this gap through country assessments, which help to identify whether and where disaggregated data are available. Once the gaps are highlighted, a plan can be created for addressing them, including sustained advocacy for more permanent measures to ensure ongoing availability of granular data.

Responding to the challenge: How the process worked

Led by the Kenyan Ministry of Health and working with other partners, Kenya adapted the ***All In*** process to the national context. Given the country's decentralized health system, the approach to ***All In*** focused directly on provinces, prioritizing six counties: Homa Bay, Kisumu, Mombasa, Nairobi, Siaya and Turkana.

Using the guidance materials and the AADM tool specifically designed for ***All In***, government and partners in Kenya decided to adapt the assessment process by combining the data tool and key components of the analysis designed to identify bottlenecks to scaling-up services that meet adolescents' needs.[20] Both steps helped to define target populations, interventions and geographic settings for priority actions to improve the effectiveness of the HIV response for adolescents.

The resulting sub-national adolescent assessments highlighted the limited availability of disaggregated data for key indicators. Several data systems provided age and sex disaggregation nationally, whereas others offered sub-national data without age group or sex. Additionally, while disaggregated denominators were readily available, numerators were not. For indicators that are not routinely collected – for example, correct knowledge of HIV - the number of adolescents was too small to allow for age disaggregation. To produce sub-national age-disaggregated HIV estimates additional data was extracted from health facilities using electronic medical records and registers and EPP Spectrum modelling.[21]

17 United Nations Children's Fund, 'ALL IN to End the Adolescent Aids Epidemic: A Progress Report', UNICEF, New York, 2016. https://childrenandaids.org/UNAIDS-UNICEF_all-in-progress-report_2017
18 UNAIDS Estimates, July 2017
19 Ministry of Health, Kenya HIV Estimates 2015.
20 United Nations Children's Emergency Fund, 'Guidance on Strengthening the Adolescent Component of National HIV Programmes through Country Assessments', UNICEF, New York, 2016. https://childrenandaids.org/guidance-on-strengthening-adolescent-component
21 For more information on EPP Spectrum modelling see http://www.unaids.org/en/dataanalysis/knowyourresponse/HIVdata_estimates

CASE STUDY

Sub-national adolescent assessments

Actions taken:

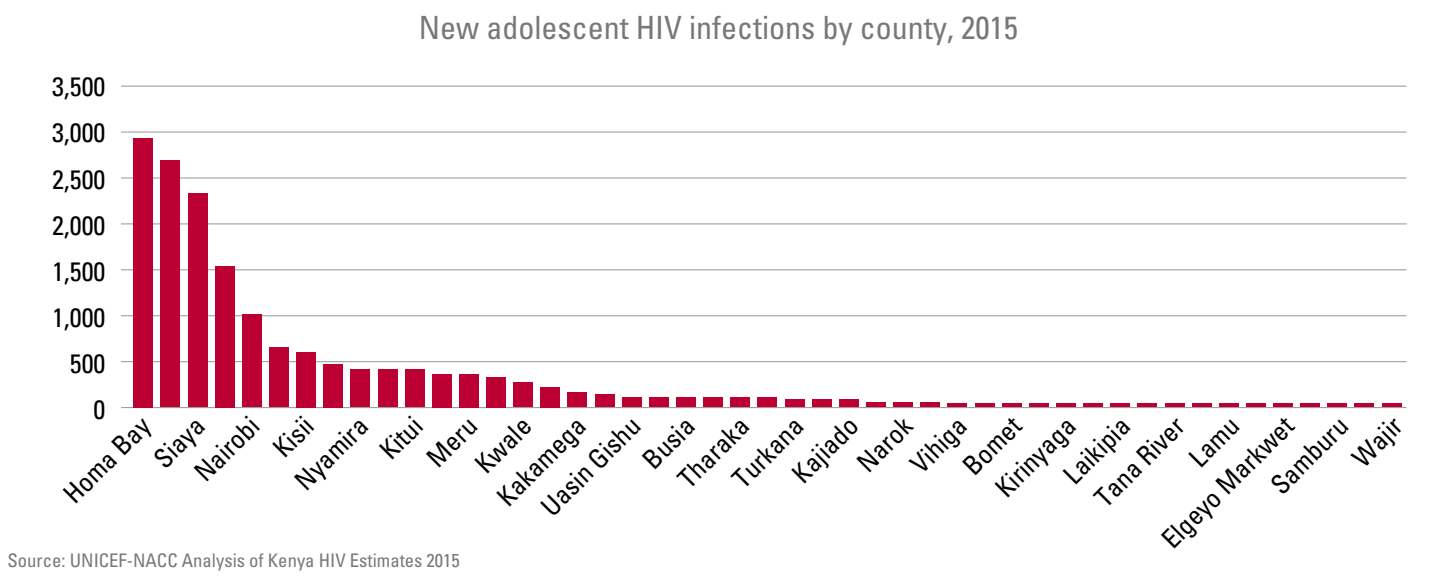
1. Established technical working groups to provide guidance and support
2. Decided which key indicators to assess across the HIV cascade and within other sectors
3. Conducted desk review of reports to identify and map out available denominators and numerators (for key indicators)

Additional actions to address data gaps:

4. Extracted data by age proportion from facility electronic medical records and registers to estimate age-disaggregated numerators
5. Calculated sub-national adolescent HIV estimates using EPP Spectrum modelling by using proportions from larger (regional) geographical data to estimate smaller (county) area/ population data.

These additional steps were critical to gaining a clearer understanding of which adolescents are most affected, where service uptake and coverage gaps exist, which actions and interventions need to be prioritized and where they should be targeted.

> *We didn't have the data we needed – so we went and looked for it! We utilized primary level data and tools. Knowing how to programme for adolescents is critical, we couldn't afford to be lazy*
>
> Adolescent Focal Person, Kenya



Source: UNICEF-NACC Analysis of Kenya HIV Estimates 2015

Outcomes

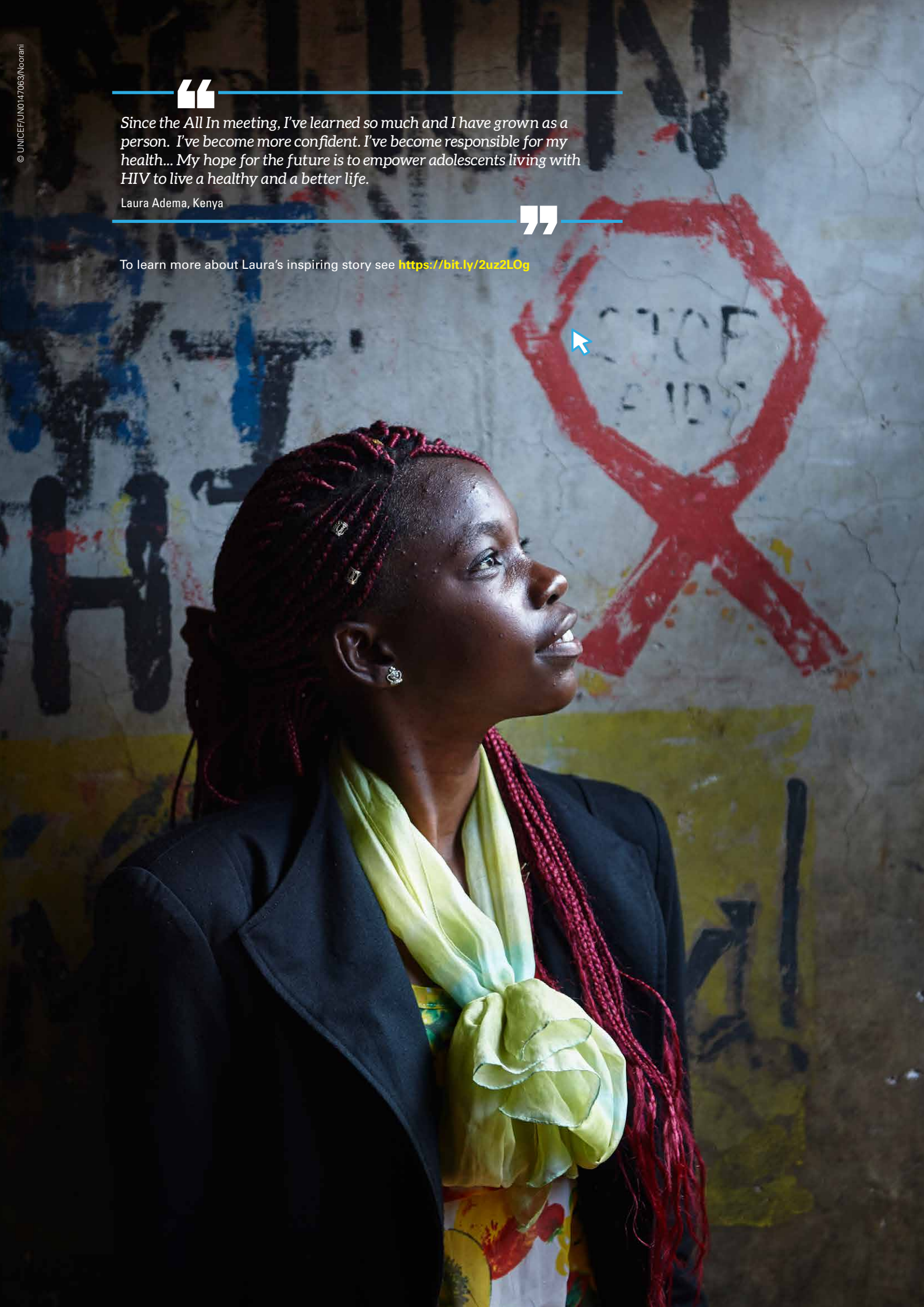
The results highlighted an alarming increase in the number of new HIV infections among adolescents. Nearly a quarter of all new infections were among those aged 10 – 19 years, 62 per cent of which occured in just in six of Kenya's 47 counties. The assessments also indicated low uptake for HIV testing and low ART coverage. Only half (50 per cent) of adolescents and young people aged 15 – 24 years had received an HIV test within the last 12 months.[22] Nonetheless adolescent HIV-related deaths since 2010 appear to have declined by 14 per cent in Kisumu and 40 per cent in Nairobi.

These findings led to important discussions and a Government commitment to review and scale-up targeted programming for adolescents, and work to address the programmatic gaps that were identified. The process and results point to the critical need to strengthen and use strategic information to better understand the needs of this population. As a result, the national Health Management Information System (HMIS) data collection tools for HIV were revised to include age disaggregation. Training for sub-national personnel on the revised tool was undertaken by the national government, in preparation for national roll-out in 2018.

The adolescent assessments and changes to the HMIS also served as a catalyst for disaggregating sub-national age and sex data in other data collection tools, including:

1. EPP Spectrum estimates
2. Kenya population-based HIV Impact assessment (KEN-PHIA)
3. New viral load monitoring systems.

22 https://dhsprogram.com/pubs/pdf/fr308/fr308.pdf



Since the All In meeting, I've learned so much and I have grown as a person. I've become more confident. I've become responsible for my health... My hope for the future is to empower adolescents living with HIV to live a healthy and a better life.

Laura Adema, Kenya

To learn more about Laura's inspiring story see **https://bit.ly/2uz2LOg**

CASE STUDY

LESSONS FROM KENYA'S *ALL IN* PROCESS

- Political will and leadership by the ministry of health is critical for driving the assessment process.
- Conducting sub-national data assessments increases ownership and accelerates the assessment process.
- Working with a range of stakeholders – local governments and facilities, partners supporting HIV efforts, adolescents and service providers – strengthens support at the sub-national level.
- Collaboration between national and subnational HIV programming, monitoring & evaluation and HMIS staff builds capacity.
- Data gaps can be addressed by actively seeking data from alternative sources to generate new, comprehensive data sets.
- The AADM tool can be adapted to data availability and country context.
- Aligning timelines with other data or programming processes provides opportunities to share and advocate for robust data collection on adolescents.
- Allocating time and flexibility to allow for competing priorities is necessary when undertaking assessments.
- The data have limitations, in particular regarding the use of estimates. However, future use of the newly revised data collection tools, allowing age disaggregation, will reduce these limitations.
- Sharing assessment results is a critical advocacy tool for improving programmes and strategic information related to adolescents.

The revised tools will ensure routine availability of adolescent-specific data to support targeted programming for this population. Many of the data challenges and limitations experienced in the assessments will now be mitigated, facilitating interpretation and use of the data. The revised data collection tools should enable responsive programming and tracking of implementation by providing an ongoing mechanism to measure indicators and outcomes among adolescents over time.

> *The closer to the ground the assessment, the easier it is to obtain the information needed and to act upon it accordingly.*
>
> County level adolescent focal person

Next steps for strengthening strategic information on adolescents in Kenya

- Review progress with the data generated from the revised HMIS tools and the subnational adolescent assessments
- Utilize HMIS disaggregated outputs to inform future EPP Spectrum modelling estimates for Kenya. Additionally, this data will help strengthen Spectrum outputs for adolescents in the region, and globally
- Support upcoming data quality assessments to ensure that they adequately cover adolescents
- Conduct special data reviews to generate new insights, focusing on the adolescent HIV/AIDS cascade
- Advocate for sub-national age and sex disaggregation in other areas affecting adolescent health and well-being

A significant gap area, both globally and in ESAR, is adequate information on adolescent HIV treatment, including the transition from paediatric to adult HIV treatment; adherence; disclosure of HIV status; and mapping of laws and policies that constitute barriers to access to health and HIV services for young people. Future country assessments will take these issues into account, where information is available.

To watch the **Step Up for HIV Prevention** video, please click on this image >>

Link: **https://bit.ly/2uz2LOg**

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ALL IN FOR IMPACT: Effects on HIV programming for adolescents

Informing national policy and plans

Adolescent-specific recommendations and activities are often missing from national health policies and plans. ***All In*** enabled the identification of adolescent sub-populations, interventions and geographic areas, dialogue on issues such as age of consent, facilitating the inclusion of adolescents in relevant policy changes and planning.

Botswana's ***All In*** process informed the development of the new *National Programming Framework for Adolescents and Young Adults*, which in turn will play a vital role in the implementation of the national *HIV Strategic Framework* during the next five years. Likewise, in **Namibia**, adolescents now feature prominently in the *National Strategic Framework 2017–2019*, and the country's policy on adolescents living with HIV is being updated to account for the new data and programme changes generated by ***All In***. Data produced by the country assessment in **Zimbabwe** was instrumental in informing the *Accelerated Action Plan* for the national scale-up of anti-retroviral therapy for infants, children and adolescents. For **Rwanda**, the ***All In*** process led to development of the first *National Operational Plan for HIV and Sexual and Reproductive Health among Adolescents and Young Adults* (see p 22).

KEY ACHIEVEMENTS

- Informed adolescent -specific programming frameworks and plans
- Sparked development of separate adolescent national and sub-national work plans
- Informed adolescent components of national strategic plans

In **Ethiopia**, the country assessment informed the national *Adolescent Sexual and Reproductive Health Plan*. The advocacy and attention to adolescents generated by ***All In*** also led to the inclusion of 10-to-14 year olds as a specific age group in the *National Strategic Plan for HIV*. Planning changes also occurred at the sub-national level. In **Botswana, Kenya, Mozambique** and **Namibia** targeted adolescent activities are now planned at the sub-national level, showing that change can devolve from the national to the local level.

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Evidence-based programming

Historically, HIV programming has failed to focus on different populations of adolescents through specific interventions and service delivery approaches. Since ***All In***, countries have made an important shift towards more targeted programming for adolescents.

In **Kenya**, significant programming changes have been seen across the HIV cascade. Priority counties – including Kisumu, Siaya and Nairobi – have increased outreach programmes to reach adolescents with HIV and SRH information, expanded HIV testing beyond testing centres by training hospital and clinic staff and increased the provision of psycho-social support for adolescents living with HIV at facilities. Youth-friendly services have also been revitalized, and key changes made to services for adolescents living with HIV such as 'adolescent only' times or queues.

Since the ***All In*** country assessment, **Namibia** has expanded psycho-social support for adolescents living with HIV through support groups and is moving towards national scale-up. **United Republic of Tanzania**'s health sector, catalysed by the ***All In*** process, collaborated with other sector partners to develop an integrated, multi-layered intervention called **Cash Plus** (see p 30). In **Lesotho**, ***All In*** assessment outcomes informed the development of a national adolescent health training package and comprehensive sex education training curriculum. In **Ethiopia**, ***All In*** facilitated the mainstreaming of adolescent HIV programming in other sectors.

All In has also built the capacity of service providers and others working on adolescent health, improving their understanding of targeted interventions and of the importance of age and sub-national data to inform adolescent programming. In **Botswana**, the phase II bottleneck analysis in priority districts played a significant role in strengthening the capacity of implementers at the sub-national level (see case study, p 24). **Namibia** further supported its bottleneck analysis by providing additional training for both national and district teams on adolescent HIV during phase II.

A number of countries increased capacity by appointing additional personnel to address adolescent issues. **Kenya** appointed sub-national adolescent officers in priority counties. In **Mozambique** funds were provided to the National AIDS Council for technical assistance on adolescent programming, and in **Namibia** three new positions were created at the national Ministry of Health.

KEY ACHIEVEMENTS

- Creation of more targeted adolescent programming
- Expansion and scale up of existing adolescent programmes and interventions
- Multi-sectorial collaboration for integrated adolescent interventions
- Increased understanding of adolescent programming and importance of age disaggregated and subnational data
- Increased capacity of subnational implementers

> *If you approach something as a team you are able to complement each other.*
>
> District Health Management Team Coordinator, Botswana

BLOG

RWANDA

Developing an Adolescent Operational Plan

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Gearing up for success: Rwanda's operational plan for adolescent HIV and sexual and reproductive health

How does a country accelerate improvements in HIV and SRH programming for adolescents? We may be drawn to think it is technological innovation or new ways of engagement through celebrities and social media. But in fact, it is much simpler, calling mainly for proper analysis and planning.

Although Rwanda has high coverage of HIV services, the government was aware that programmes were not adequately reaching adolescents aged 10–19 years. At the same time, authorities lacked a thorough understanding of why that was the case and how coverage could be improved.

In response to these challenges UNICEF and UNAIDS launched ***All In*** to end Adolescent AIDS (***All In***).

*"**All In** was a call to action,"* said Fabian Mwanyumba of UNICEF Rwanda. "Much as adolescents were being talked about in the country, there was not a clear, structured way of looking at their needs."

Through ***All In***, the Government of Rwanda and partners conducted a rapid assessment to better understand HIV and sexual and reproductive health trends and programme gaps related to adolescents. Although consistent with global trends, the results were alarming. They showed that those aged 15 to 24 years accounted for more than one out of every four new HIV infections,[23] 8 per cent of adolescents get married before age 18[24] and adolescent pregnancy rates were on the rise.[25]

The reason for these findings soon became clear: low knowledge and utilization of sexual and reproductive health services, including HIV services, by adolescents. The assessment identified coverage gaps in key interventions including: condoms to prevent pregnancy and HIV infection. family planning, voluntary medical male circumcision, HIV testing and HIV treatment. Programming often took place in silos, with little collaboration within and across different ministries, agencies and providers responsible for adolescent health.

The next step brought together Rwanda's brightest minds to outline a clear plan for addressing these gaps. The result, the *National Operational Plan for HIV and Sexual and Reproductive Health among*

23 UNAIDS, HIV Estimates. 2017 http://aidsinfo.unaids.org
24 https://www.unicef.org/infobycountry/rwanda_statistics.html
25 https://dhsprogram.com/pubs/pdf/FR316.pdf

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Adolescents and Young Adults 2017-2022,[26] creates clear targets and indicators for scaling up the HIV response for adolescents across Rwanda.

"This plan is unique for Rwanda because we went in deep to analyse the reasons behind the service coverage gap," said Dr Mpundu Ribakare, from the Rwanda Biomedical Centre, an arm of the Ministry of Health. "We also created the plan through a participatory process." This process included representatives of adolescent and youth networks, since another key tenet of ***All In*** is to improve meaningful adolescent participation. When adolescents are involved from the beginning in shaping policies, they have greater ownership of the results.

The resulting operational plan took into account programmatic challenges, often referred to as bottlenecks that prevent optimal service coverage. These include issues such as drug supply levels and whether enough trained health care workers are present in each district.

The operational plan breaks down appropriate interventions by age, so that the needs of younger adolescents can be addressed differently from those of older adolescents. And it includes targets for all interventions, which is key to tracking implementation progress.

The ***All In*** assessment and ensuing Operational Plan have now influenced implementation of the country's National HIV Strategic Plan, helping to create a consensus about adolescent HIV and SRH. The plan also helped allocate domestic and donor funds (e.g., from the Global Fund) appropriately and served as a blueprint for fundraising efforts and partner coordination by the government.

In coming months, district level partners will start adapting the operational plan to their local contexts. In Rwanda's capital, Kigali, city officials, and relevant national government colleagues will take the lead in overseeing the plan's implementation and ensuring that all adolescents gain access to the information and services they need. As new data emerge, the plan will be continually updated to ensure that it works for adolescents.

© UNICEF Rwanda

26 Republic of Rwanda Ministry of Health, Rwanda Biomedical Centre. National Operational Plan for HIV and SRH for adolescents and young people 2017-2022. Kigali, Rwanda

ONLINE RESOURCES

To find out more about Rwanda's ***All In*** assessment use this link:
https://www.unicef.org/rwanda/events_20676.html

To find out more about **UNICEF's** work in Rwanda please use this link:
https://www.unicef.org/rwanda/

To find out more information on ***All In*** please use this link:
https://childrenandaids.org/all-in-to-end-adolescent-AIDS

To find out more about **UNAIDS'** work in Rwanda please use this link:
http://www.unaids.org/en/regionscountries/countries/rwanda

CASE STUDY

BOTSWANA

506,000

10 -19 year olds population
(Ref: UNAIDS Estimates 2017
http://aidsinfo.unaids.org)

17,000

Adolescents living with HIV

1,400

New HIV infections among adolescents

Ref: UNAIDS Estimates 2017
http://aidsinfo.unaids.org

Building capacity for sub-national data driven programming

Background

Despite Botswana's progress on HIV programming, adolescents – who form almost a quarter of the country's population – have been underserved by the response. HIV prevalence increased alarmingly (up to three-fold) between 2004 and 2013 among adolescents and young people aged 10-to-24 years.[28] By 2016 an estimated 17,000 adolescents were living with HIV and an additional 1,400 were newly infected.[29] There was an urgent need to strengthen targeting and programming efforts for this population.

To better understand and improve the HIV response for adolescents, Botswana commenced the ***All In*** country assessment in 2015. The initial rapid assessment helped identify populations, interventions and geographic settings for priority actions. The assessment findings indicated national progress in terms of treatment coverage, which increased from 65 per cent in 2013 to 83 per cent in 2016, and viral suppression, which stood at 78 per cent in 2016.[30] However, insufficient progress had been achieved in reducing new infections, which declined only from 13,000 in 2013 to 10,000 in 2016. This can be attributed in part to: low uptake for HIV testing and services and combination prevention, high incidence of sexually transmitted infections and lack of comprehensive HIV knowledge.[31] The assessment also stressed the lack of sub-national data and the need for better understanding of key HIV drivers among adolescents.

Since the phase I rapid assessment, Botswana has drafted a new *National Programming Framework for Adolescents and Young Adults*, aimed at guiding and coordinating the implementation of their HIV programmes. Given geographical disparities across HIV, social, demographic and service delivery indicators, strengthening sub-national programming is required to ensure successful implementation of the framework and outcomes for adolescents. To date, experience on targeting interventions to this population has been limited. Successful adolescent HIV programming demands strengthening the capacity of the agencies and institutions planning and delivering services, to ensure appropriate sub-national action.

Process

The ***All In*** phase II in-depth bottleneck analysis was fundamental to strengthening sub-national adolescent HIV programming in Botswana. Led by the Ministry of Health and Wellness through the National AIDS Coordinating Agency, with technical support provided by UNICEF, phase II was carried out in collaboration with sub-national stakeholders: district AIDS coordinators, district health management teams and representatives from the Ministry of Youth and Ministry of Education. Strategic support on data was provided by UNAIDS. Four districts (Selebi-Phikwe, Goodhope, Boteti and Ghanzi) were prioritized, on the basis of: HIV prevalence, the presence of key HIV socio-economic and other contextual factors, the combined geographic and demographic setting and past performance on priority interventions.

Utilizing pre-defined standardized guidance materials, phase II identified bottlenecks and performance gaps, their associated causes and key actions required to catalyse the sub-national HIV response for adolescents. Priority interventions included: 1) HIV testing and counselling; 2) anti-retroviral treatment; 3) condom access and use; 4) voluntary medical male circumcision; and 5) addressing gender-based violence, alcohol and drug abuse and other psychosocial issues. Data on key indicators related

28 Statistics Botswana, BAIS IV, 2013.
29 UNAIDS, HIV Estimates. 2017 http://aidsinfo.unaids.org
30 UNAIDS HIV Estimates, 2017 http://aidsinfo.unaids.org
31 National AIDS Coordinating Agency, Strengthening the Adolescent Component of National HIV Programmes through Country Assessments in Botswana: Preliminary Report of Rapid Assessment, 2015.

to supply, demand and quality of these interventions was collected and analysed utilizing the adolescent assessment and decision-makers' tool. A causality analysis was undertaken in collaboration with sub-national stakeholders to further identify and understand bottlenecks and performance gaps.

Outcome

The in-depth bottleneck analysis provided valuable evidence and insights to inform future sub-national and national adolescent HIV programming. Not only did the analysis enhance strategic information on adolescents, but it also strengthened the capacity of planners, programmers and service providers to implement data-driven adolescent HIV programming.

Focusing on capacity development, the outcomes presented below are based on a desk review of the ***All In*** country assessment, interviews with key national and subnational level stakeholders in Botswana, and the findings of the ***All In*** phase II in-depth bottleneck analysis. The extent of the impact of the reported increase in capacity will be measured in future country assessments.

Capacity was developed in several areas:

Understanding adolescents

- Increased awareness of adolescents as a distinct population group requiring targeted programmes and interventions

Partnership and collaborative working

- Allowed structured, dedicated opportunities for multi-disciplinary and sectoral discussions focused on adolescents
- Established sub-national technical working groups, providing a platform for partnership and knowledge-sharing across sectors to support decision making

IN-DEPTH BOTTLENECK ANALYSIS PROCESS

- Select priority geographic areas and priority interventions
- Mobilize sub-national partners and form a sub-national technical working group in priority geographical areas
- Identify supply, demand and quality indicators for priority interventions
- Map different service delivery platforms for data collection
- Gather sub-national data available through centralized databases
- Collect primary-level data from selected sub-national services
- Utilize the AADM tool to analyse the data in order to identify bottlenecks
- Conduct key informant interviews with sub-national stakeholders and focus group discussions with adolescents in and out of school to further explore causes of identified bottlenecks and gaps
- Hold a sub-national technical working group workshop to review bottlenecks and gaps, further identify their causes, synthesize findings and agree on key actions
- Document and present findings to national and district leaders, to undertake evidence-informed planning during phase III.

Strategic information

- Improved understanding of the importance of age-disaggregated sub-national data to inform adolescent programming
- Provided district-level data on adolescents that was previously not available
- Identified data availability and gaps, including important aspects of supply, demand and quality
- Stressed the importance of utilizing data from other sectors, beyond HIV

Adolescent programming

District level

- Improved understanding of the need for interventions and programmes targeted to adolescents
- Identified delivery gaps in adolescent services and revealed implementation bottlenecks
- Informed district-level planning; previous plans did not include targeted adolescent programming or interventions

National level

- Further informed the draft national programming framework for adolescents and young adults, as well as the national strategic framework and guidance on HIV and adolescent health
- Informed proposal development for the Global Fund
- Highlighted the diversity of challenges experienced by priority districts
- Improved understanding of 'on the ground' realities of sub-national programming for adolescents
- Identified ongoing adolescent programmatic technical assistance needs at the sub-national level

> *"Having concrete data really helps us plan for this population."*
>
> Hospital Matron

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It is evident that there is a notable gap (in HIV programming for adolescents)... this provides us with the opportunity to address it

Nametsego Tswetla,
IEC chief, National AIDS Council, Botswana

Lessons from Botswana's sub-national in-depth bottleneck analysis

- Scheduling the analysis prior to district planning maximizes programming impact.
- Allocating sufficient time at the sub-national level to undertake the analysis facilitates joint work and capacity building.
- Bringing together a wide range of stakeholders from different departments and ministries improves understanding of the current situation and future work-plan needs.
- Planning and national leadership are important to ensure that appropriate sub-national stakeholders become engaged.
- Working collaboratively with a range of national and sub-national stakeholders ensures sufficient technical support for capacity building.
- Engaging monitoring & evaluation and programme staff strengthens future data collection.
- Developing country-specific guidance on how to carry out the sub-national analysis (i.e., what data is available, where it comes from and potential system challenges) will facilitate carrying out the analysis in other districts.
- Utilizing a variety of data systems and sources – including primary data – highlights programme needs and data gaps.
- Data on key quality indicators are not readily available, requiring a separate assessment process.
- Adolescent programming capacity is needed at the national level to adequately support both the sub-national analysis and ongoing adolescent programming.
- Sharing data from sub-national findings is critical to improving programmes and strategic information on adolescents.

NEXT STEPS FOR STRENGTHENING ADOLESCENT PROGRAMMING IN BOTSWANA

- Launch the national programming framework for adolescents and young adults
- Undertake the in-depth bottleneck analysis in other districts to achieve nationwide results
- Revise current HIV programming templates to include adolescents
- Provide ongoing technical support at the sub-national level to ensure inclusion of adolescents in sub-national plans and implementation of programme changes
- Strengthen routinely collected data for adolescent HIV by revising data tools to include age-disaggregation and aligning M&E systems
- Utilize new sub-national plans to leverage domestic and external funding, in particular from the Global Fund
- Improve understanding of targeted adolescent interventions through implementation science

EXAMPLES OF KEY INDICATORS:

- **Supply**
  - Commodities
  - Human resources
  - Accessibility
- **Demand**
  - Utilization
  - Continuity of use
- **Quality**
  - Trained providers
  - Policies and procedures

ALL IN FOR IMPACT: Effects on HIV programming for adolescents

Mobilizing resources

Since the launch of ***All In*** in 2015, international and domestic resource investment in adolescent HIV programming has increased in the countries that conducted assessments. The ***All In*** process has assisted programmes to be more targeted and evidence-informed, facilitating funding requests and allocations for these programmes. Resources have also been leveraged to implement work plans generated as part of the ***All In*** process and for the expansion and scale- up of key adolescent interventions.

Across the region funds from partners and donors, including UNICEF and UNAIDS, have supported key milestones of the ***All In*** country assessments. In Lesotho, partners provided funds to further strengthen strategic information on adolescents.

Kenya and **Namibia** were particularly successful in integrating adolescent activities into larger international development partners' operational plans and initiatives. In **United Republic of Tanzania** and **Ethiopia** ***All In*** assessment outcomes were instrumental in mobilizing further funds for multi-sectoral programme proposals. In **Kenya, Mozambique** and **Namibia** funds were allocated to increase national and sub-national technical capacity on adolescents.

Most significantly, ***All In*** leveraged resources within overall country funding processes for the Global Fund to Fight AIDS, TB, and Malaria. Country assessments provided critical data and direction to inform the adolescent components of concept notes and proposals for special initiatives, such as on adolescent girls and young women, including in Kenya, Lesotho, Mozambique, Namibia, the United Republic of Tanzania and Zimbabwe. In **Mozambique**, ***All In*** contributed to improved understanding of in-school and out-of-school health service needs among adolescent girls and young women, informing the revitalization of these services through the country's Global Fund grant. With the generation of strategic information and changes to key policies and plans, further domestic and international funds for adolescent HIV activities are expected, including resources for programme implementation.

KEY ACHIEVEMENTS

- Increased international and domestic resource allocation
- Informed concept notes and proposals to the Global Fund
- Adolescent activities incorporated into larger programming proposals and other funding initiatives
- Resources allocated to implementation of workplans, scale up of adolescent interventions and dedicated adolescent personnel

> *The Global Fund strives to make equitable funding decisions that prioritize marginalized populations. But in order to do so effectively, we need to see data that illustrates the problem and outlines a clear case for investment. When it comes to adolescents, getting the data is often challenging, but All In has sharpened country level data, leading to more strategic investment in a number of countries.*
>
> Heather Doyle, Senior Gender Advisor, Global Fund

BLOG

TANZANIA

Ensuring a healthy future for adolescents: The story of Halima

Halima was still a child when she became the primary breadwinner and caregiver for her family.

Now a bubbly 19-year-old, Halima is from a village in Rungwe, in southeast Tanzania. When she was nine, her grandmother fell ill, forcing Halima to drop out of school and start working.

Halima now runs a small-scale business, purchasing bananas from local farmers and reselling them at a weekly market. Each month her total income is about Tsh40,000 (approximately US$20).

Although her dream is to complete secondary school, Halima says her main challenge is not earning enough to support her family. "I want to expand my business and get more capital to start a new [business], which will help me and my family live comfortably," she says.

Halima volunteered to be part of the pilot phase of a new initiative, **Cash Plus**, to support adolescents as they navigate the bumpy transition to adulthood. The Government of the United Republic of Tanzania, with support from UNICEF, introduced **Cash Plus** last year in four rural districts in the Southern Highlands.

Cash Plus provides tailored support to 2,500 adolescents (aged 14–19 years), who live in households enrolled in the Government's social protection programme, the Productive Social Safety Net (PSSN). The PSSN provides a cash transfer of Tsh10,000 per household (US$4.50) – plus up to an additional Tsh28,000 (US$12.50) for households with children that regularly attend school and get health check-ups. A recent evaluation[32] demonstrated the powerful impacts of the PSSN on household well-being, including increased school enrolment. Nevertheless, this evaluation also highlighted that a significant number of adolescents in PSSN households had already dropped out of school. In an effort to support this vulnerable population, the Adolescent **Cash Plus** pilot was layered on top of the PSSN. Implemented through government structures, the "Plus" provides training and mentorship and facilitates linkages to HIV and SRH

32 https://transfer.cpc.unc.edu/wp-content/uploads/2018/04/PSSN-Youth-Endline-Report-2018.pdf

services for adolescents.

While many programmes for adolescents tend to focus on just one area of concern – such as health or livelihoods – **Cash Plus** is unique in bringing together different sectors to provide a comprehensive package of support, recognizing that adolescents require strengthened capacities across multiple dimensions to safely transition to adulthood.

But the innovative programme didn't arrive in the country overnight. Two key factors laid the groundwork for **Cash Plus**. One was the ***All In*** initiative.

"***All In*** catalysed a whole range of actions that placed adolescents much more firmly at the centre of national attention," said Ulrike Gilbert, HIV Chief for UNICEF Tanzania.

All In also encouraged programmers to see adolescents as a distinct population group, with different needs from children and adults. As part of ***All In***, the United Republic of Tanzania conducted an assessment that reviewed available data on issues affecting adolescent well-being – including social protection, education and health – and the programmes available to meet their needs.

The other factor influencing the introduction of **Cash Plus** was the growing evidence that cash transfer programmes have multiple, overlapping benefits, including the potential to reduce the risk pathways of HIV infection among children and adolescents. For example, cash transfer programmes can reduce poverty and improve access to food and nutrition. Families that receive cash transfers also have higher rates of enrolling children in secondary school, creating a long-term benefit for young people. Additionally, in some countries cash transfers have been linked to delayed sexual debut, reduced teenage pregnancy and improved mental health for adolescents.

But cash alone is not a silver bullet. That's why **Cash Plus** includes training on livelihood and economic empowerment, as well as education on SRH and referrals to youth-friendly health services.

"The reason we've been focusing jointly on livelihoods, sexual and reproductive health and HIV knowledge is because the evidence shows that youth need more than just economic empowerment," said Tia Palermo, a social policy specialist at UNICEF's Office of Research-Innocenti Centre, in a recent podcast.[33] "It's not enough to economically empower an adolescent if they're not able to make decisions about their lives – when to get pregnant and when to have a family. We want to simultaneously empower them on the economic front and the social and health front."

Cash Plus also links young people like Halima with a community-based mentor, who meets with them to build and strengthen their confidence and connection with their community, support their aspirations and help them to make decisions affecting their health. Mentoring involves connecting young people to education, vocational training, financial counselling and other opportunities.

The United Republic of Tanzania, like other countries in the region, has a growing population of adolescents, which is forecast to more than double by 2050. Governments across Africa now have an opportunity to turn this increase in population into economic potential – but they can only do so if adolescents are equipped for healthy futures.

If evaluations demonstrate the effectiveness of **Cash Plus**, it could be scaled-up across East Africa – putting more power and decision-making into the hands of adolescents to take charge of their health and livelihoods.

Halima is already applying the new skills she learned during **Cash Plus** trainings, such as record-keeping and managing her savings.

Halima and others in the programme have also taken the initiative to form a peer support group, which meets regularly to discuss business strategy, provide mutual encouragement on savings goals and swap advice on life in general.

Fostering these connections is an important outcome of **Cash Plus** – a programme worth following into the future.

> *Research has shown that providing young women and adolescent girls a modest cash transfer to stay in school, works. And we know that staying in school is a protective factor against early marriage, unintended pregnancy and HIV infection.*
>
> Léopold Zekeng,
> UNAIDS Country Director, Tanzania

33 https://soundcloud.com/unicef-office-of-research/cash-plus-tanzania

ONLINE RESOURCES

To find out more about **CASH Plus** in Tanzania, please use the link:
https://www.unicef.org/tanzania/resources_21267.html
PDF: **https://bit.ly/2xNqd9O**

To listen to the CASH Plus podcast, please use this link:
https://soundcloud.com/unicef-office-of-research/cash-plus-tanzania

To read more about Halima's story, please use this link:
https://www.unicef.org/tanzania/media_20638.html

To find out more information on ***All In*** please use this link:
https://childrenandaids.org/all-in-to-end-adolescent-AIDS

To find out more about HIV in Tanzania please use this link:
http://www.unaids.org/en/keywords/united-republic-tanzania

CASE STUDY

NAMIBIA

534,609
10 -19 year olds population

13,000
Adolescents living with HIV

1,300
New HIV infections among adolescents

Leveraging resources for adolescent HIV programming

Background

Adolescents represent almost one quarter of Namibia's population and face unique needs for HIV prevention, treatment, care and support. In 2016 in Namibia there was an estimated 1,300 new HIV infections occurred among adolescents. While prevalence is equal among adolescent females and males in the 10-to-14 age group, gender disparity increases with age; the rate for females aged 20–24 (67 per cent) is twice as high as for their male peers (33 per cent).[34]

Adolescents in Namibia do not have adequate access to HIV-related interventions. Uptake and coverage of key HIV prevention interventions among adolescents is low; for example, only 28.5 per cent of females and 13.9 per cent of males aged 15–19 were tested for HIV during the last 12 months. Although significant progress has been made among those who test positive, this age group also lacks universal access to HIV treatment, ART coverage among adolescents aged 15-19 years is at 61 per cent among girls and 76 per cent among boys.[35]

Namibia's HIV response needs to be based on a better understanding of why adolescents are falling behind, and to adapt existing programmes to meet their needs.

Adolescent HIV programming in Namibia was challenging before 2015. Adolescent-specific components within national and subnational plans were lacking, making it difficult to target adolescents and allocate funds essential for adolescent HIV programming. These gaps were further compounded by a lack of adolescent-specific data to inform policy development and programming. In response to these challenges, in 2015 Namibia carried out an *All In* assessment.

Process

The three-phase assessment utilized the *All In* guidance materials and tools. Phase I called for a rapid assessment of the adolescent programming context, which was conducted under the leadership of the Ministry of Health and Social Services (MoHSS) through consultations with a technical working group. The technical working group included representatives of adolescent and youth groups and adolescents living with HIV were key participants in both assessments. Phase I consolidated available data from various national sources using the adolescent assessment and decision maker's (AADM) tool to identify priority adolescent groups, high-impact priority interventions and high-burden geographical areas. A review of the adolescent policy and programme environment was also carried out, highlighting the need to strengthen resource allocation and mobilization.[36]

Phase II involved conducting an in-depth analysis of bottlenecks in the seven high-burden regions for adolescent HIV identified during the assessment. Workshops, focus-group discussions and in-depth interviews with key stakeholders including adolescents living with HIV led to the identification of bottlenecks, their associated causes and key actions for overcoming them. One of the key findings across the seven regions was the presence of large data gaps – most of the interventions lacked data for 10 – 14 year

ALL IN COUNTRY ASSESSMENT PHASES:

- **Phase I:** Rapid assessment of the adolescent programming context
- **Phase II:** In-depth analysis of bottlenecks
- **Phase III:** Evidence-informed planning

34 UNAIDS Estimates 2017 http://aidsinfo.unaids.org
35 https://www.unicef.org/namibia/na.Namibia_ALL-IN_Adolescent_HIV_Programme_Summary_Report_Phase_2_2017.pdf
36 MoHSS, Report on Phase 2 of the Namibia All In Country Assessment 2016-2017

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olds, as well as for intervention indicators. The bottleneck analysis signalled that adolescents were not accessing health care and that urgent action was required to train health workers on adolescent issues, provide adolescent-friendly health services and improve data collection.

Based on the outcomes of the rapid and in-depth assessments, Phase III involved evidence-informed planning to address the programming gaps. Based on the assessment findings, regional workplans were developed, in which different partners took on responsibility for future adolescent HIV programming efforts. The MOHSS and other stakeholders also worked to ensure that these work plans fed into ongoing national efforts and existing mechanisms.

Outcomes

Through its unique approach, ***All In*** has helped Namibia's adolescents to gain recognition as a distinct population group that requires tailored programming. ***All In*** also set the stage for the collection and generation of sharper, better targeted and more strategic information to inform future programming. As a result, Namibia has been successful in leveraging international and domestic resources to advance adolescent HIV programme planning and implementation.

The outcomes and gaps highlighted in the Phase I assessment served as a catalyst prompting key members of the technical working group to contribute funds to ensure that Phase II was prioritized. National adolescent HIV technical capacity was also strengthened through the creation of three new positions at the MoHSS. Domestic funds secured the recruitment of an adolescent HIV focal point, while international donors provided funding for technical advisors on programming for adolescent girls and young women, as well as adolescent and paediatric testing, treatment and care.

International development partners have integrated priority districts' work-plans, developed during Phase III, into their development and operational plans. Funding to implement the activities was allocated to designated implementing partners and through co-working agreements for special activities (mainly the first violence against children and adolescent survey, which includes HIV indicators). Additionally, UNICEF's HIV team received additional funding to support implementation of the work-plans. Since the ***All In*** assessments, the Global Fund to Fight AIDS, TB, and Malaria agreed to fund the expansion of support groups for adolescents living with HIV and plans for national scale-up. Key ***All In*** assessment findings also informed the Global Fund's allocation decisions on programming for adolescent girls and young woman, as well as reprogramming of funds for older adolescents from key populations.

The ***All In*** country assessment also served as a critical catalyst for ensuring that adolescents feature prominently in the National Strategic Framework 2017–2019, Namibia's blueprint for HIV programming. With this renewed focus, further domestic and international funds for adolescent HIV activities are expected, including resources to sub-national actors.

RESOURCES SUPPORTED:

- ***All In*** assessment
- National technical capacity on adolescents
- Implementation of national and sub-national work-plans
- Expansion and scale-up of key adolescent activities

Namibian First Lady Monica Geingos launched the #BeFree movement inspired by the drive to ensure an AIDS-Free generation. It is through the leadership of advocates such as First Lady Geingos that we will be able to improve the health of adolescent girls and young women.

LESSONS FROM NAMIBIA'S *ALL IN* PROCESS

- Engaging a wide range of government and non-government partners from the very beginning of the assessment process is essential to securing broad ownership and commitment.
- Leadership from the national ministry of health is critical to driving the assessment process
- Technical support from other UN organizations increases political commitment and supports advocacy efforts throughout the process.
- Building on existing technical working groups strengthens leadership and collaboration.
- Analysing existing adolescent-specific data offers a powerful advocacy tool for leveraging resources.
- Advocating for the inclusion of adolescents during strategic funding and programming discussions ensures that adolescents are recognized as a priority population.
- Aligning advocacy efforts among multiple stakeholders increases impact and the probability of a successful response.
- The development of work-plans is crucial to guiding the allocation of resources, particularly at sub-national levels.
- Collaboration between national and sub-national stakeholders enables the effective review of relevant policies and their implementation.
- The clearly established three-phase All In process, including supportive guidance tools, lends credibility to the initiative and provides greater confidence for stakeholders invested in its outcome.
- Coming together as partners around data and advocacy during key decision-making meetings increases the impact and likelihood of a focused response.

Next steps for Namibia

- Develop a comprehensive national plan of action on adolescent girls and young women focused on HIV, sexual and reproductive health, violence and comprehensive sexuality education
- Support adolescent components of the national combination prevention strategy
- Review and update relevant guidance on adolescent HIV including adolescents living with HIV
- Develop tools to facilitate implementation of support groups for adolescents living with HIV
- Strengthen routinely collected data on adolescent HIV by revising data tools for age disaggregation and aligning M&E systems to improve understanding of targeted adolescent interventions through modelling for possible scale up

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NEXT STEPS FOR ADOLESCENT HIV PROGRAMMING IN ESAR

While ***All In*** has contributed to remarkable progress in a short amount of time for adolescents across the region, continuing targeted action for adolescents is crucial. Adolescents still face a number of barriers to accessing the HIV prevention, treatment and care they need. Adapting health and other sectoral systems to be adolescent-responsive and putting in place appropriate adolescent data collection and analysis demands sustained efforts.

In mid-2018, UNICEF, UNAIDS, UN agencies and Youth PACT met to discuss the way forward for ***All In***. Partners reaffirmed the critical importance of the country assessments for forging alliances to examine the data and evidence, and for raising awareness of the multi-faceted needs of adolescents. In many countries, ***All In*** translated into measurable investments in adolescents, yet adolescents at-risk of HIV, including pregnant adolescents and young key populations, continue to be left behind. Moving forward, ***All In*** will continue to sustain and expand meaningful consultation and partnership with a broad constituency – including adolescents, programme practitioners, academics, and policymakers – in order to ensure effective service delivery for adolescents affected by HIV. Championing ongoing dialogue with adolescent and youth networks in policy dialogue with governments and key stakeholders will be critical so that approaches to addressing adolescent HIV are responsive to their needs.

In order to build on the success of ***All In*** in ESAR, some key next steps are outlined below. Now is the time to adapt the lessons learned across the region and transform the HIV response for adolescents.

KEY NEXT STEPS

Collaborations, Partnership and Engagement

- Continue and strengthen technical working groups, to advance collaboration and further facilitate emerging initiatives
- Facilitate opportunities and platforms for adolescents to remain engaged in ongoing decision-making structures, such as Technical Working Groups
- Support the technical, financial and human resource capacity of adolescent and youth networks to engage in policy and programming
- Continue to engage adolescents on whether their views and ideas are being heard, and how to ensure meaningful adolescent participation

Strategic information

- Continue to advocate for routine data collection on adolescent HIV, through revision of data tools for age-disaggregation and aligning M&E systems
- Adapt the All In country assessment as an embedded, systematic practice that informs ongoing HIV programming for adolescents and young people
- Utilize disaggregated outputs to inform future EPP Spectrum modelling estimates
- Support data quality assessments to adequately address adolescents
- Undertake in-depth bottleneck analyses in additional districts to obtain nationwide results; ensuring that sub-national data and analysis inform national planning and programming is critical
- Improve understanding of targeted adolescent interventions through implementation science, including the examination of quality, feasibility and sustainability
- Enhance processes and platforms for documenting case studies and results and for facilitating intra- and inter-country peer-to-peer learning capacity
- Harmonize health and other sector indicators and data systems to ensure comprehensive programming
- Include additional important indicators for measuring prevention interventions and community participation.

Policy and plans

- Revise current national and sub-national HIV programming planning templates to include adolescents
- Ensure the inclusion of adolescent-targeted interventions in newly developed national strategic plans and other HIV, health or social protection strategies
- Develop a separate national adolescent strategy and action plan, where appropriate
- Review and revise relevant HIV guidance to include adolescent-specific recommendation and considerations
- Coordinate advocacy around addressing age of consent barriers to essential HIV and associated services

Programme implementation

- Implement national and sub-national work plans developed through All In
- Provide ongoing technical support at the sub-national level to ensure inclusion of adolescents in sub-national plans and implementation
- Develop implementation tools to support new targeted adolescent interventions (i.e. protocols, training, educational materials)
- Address programming and data gaps for adolescents from key populations
- Continue to explore the use of innovative strategies to improve coverage, access, demand and monitoring of adolescent HIV interventions
- Expand the adolescent health focus beyond HIV to issues such as mental health, substance abuse etc.
- Utilize the outcomes and impact of All In as an opportunity to advocate for increased attention to health during the second decade

Resources

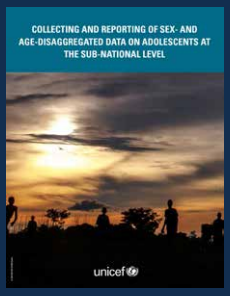
- Utilize new sub-national plans to leverage domestic and external funding allocation
- Ensure ongoing coordination with key funding partners – sharing new data, programming progress and funding gaps
- Work with partners to strategically advocate for inclusion of adolescent interventions with larger national funding processes
- Advocate for national ownership through domestic funding allocation, thus ensuring that adolescent programmes are embedded in government investments rather than *ad-hoc* external funding initiatives

KEY RESOURCES ON *ALL IN*

Guidance on strengthening the adolescent component of national HIV programmes through country assessments, UNICEF, 2015

This guidance document and its accompanying tool, the Adolescent Assessment and Decision-Makers Tool (AADM), were devised to facilitate country assessments aimed at strengthening the adolescent component of national HIV programmes. The purpose of the country assessments are to: (1) support country teams in the identification of equity and performance gaps affecting adolescent HIV programming; and (2) define priority actions to improve the effectiveness of the national adolescent HIV response.

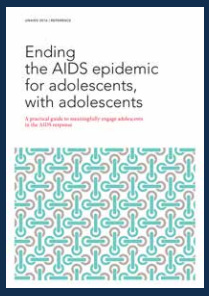
https://childrenandaids.org/guidance-on-strengthening-adolescent-component



Collecting and reporting of sex- and age-disaggregated data on adolescents at the sub-national level, UNICEF, 2016.

This document guides countries through the process of collecting and reporting sub-national data on adolescents to inform programme planning and implementation efforts. It was developed with the specific aim of identifying data gaps for adolescents and informing immediate programme planning needs at the sub-national level.

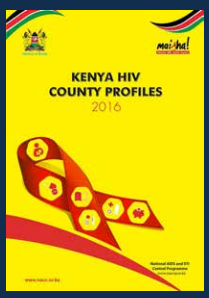
https://childrenandaids.org/collecting-reporting-sex-age-disaggregated-data



UNAIDS, Ending the AIDS epidemic for adolescents, with adolescents: A practical guide to meaningfully engage adolescents in the AIDS response, 2016.

This document provides guidance to programme designers, implementers, policymakers and decision-makers on how to meaningfully engage adolescents in the AIDS response and in broader health programming. It also demonstrates why adolescents and youth are critical in efforts to end the AIDS epidemic by 2030.

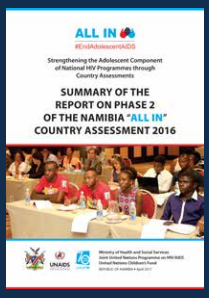
http://www.unaids.org/en/resources/documents/2016/ending-AIDS-epidemic-adolescents



Government of Kenya, Ministry of Health, Kenya HIV estimates report, 2015.

This 2015 HIV Estimates Report is a document published biennially by the Ministry of Health, Government of Kenya. Its aim is to provide an improved understanding of the HIV epidemic in the country amongst various sub-populations. The estimates are derived from several data sources including the Kenya Demographic and Health Surveys, Kenya AIDS Indicator Survey, HIV Sentinel Surveillance among pregnant women, programmatic data and the national census.

http://nacc.or.ke/kenya-hiv-county-profiles/



Namibia ALL IN reports (phase I & phase II), MOHSS, UNICEF & UNAIDS, 2015.

These reports highlight the findings of the ALL-IN End Adolescents AIDS assessment reports on generating and utilising data to sharpen the focus of adolescents and HIV programming within the National HIV/AIDS Response.

https://www.unicef.org/namibia/na.Namibia_ALL-IN_Adolescent_HIV_Programme_Summary_Report_Phase_2_2017.pdf

ALL IN

#EndAdolescentAIDS

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