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A PROGRESS REPORT

ALL IN TO END THE ADOLESCENT AIDS EPIDEMIC

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The purpose of the report is to showcase the significant contributions of many partners to research, innovations, community mobilization, programmes and policy actions aimed at ending the AIDS epidemic in adolescents in support of the ALL IN! agenda. UNICEF and UNAIDS acknowledge the regional and country office colleagues, national and implementing partners below for the ongoing work to support this global agenda and documented in this report, as well as for their support in the development of this report.

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CONTENTS

PART 1: GLOBAL UPDATE

1. BACKGROUND – SETTING THE SCENE

UNICEF and UNAIDS launched the ALL IN platform in February 2015 to galvanize global action towards HIV and a population that were largely neglected in the global AIDS response – adolescents. The ALL IN initiative, with a focus on 25 lead countries that contribute to 86 per cent of all new HIV infections in adolescents, seeks to bring adolescents into focus in fast-track efforts to end the AIDS epidemic by 2030, and provides three targets for the year 2020 to frame this acceleration agenda:

1. Reduce new HIV infections among adolescents by at least 75 per cent
2. Reduce AIDS-related deaths among adolescents by at least 65 per cent
3. End stigma and discrimination

ALL IN agenda recognizes the importance of a holistic, multi-sectoral approach towards addressing risk and vulnerability in adolescents, seeking to drive this fast-track effort through partnerships that combine forces to improve leadership, commitment, investments and programmes, and strengthen data, implementation and systems for adolescent engagement across a wide range of areas illustrated in the ALL IN strategic framework *(Figure 1)*.

In 2015 and 2016, member states have renewed their political commitment to key areas of sustainable development through high-level agreements, which paves the way for stakeholders to help improve health outcomes for all. These include the launch of the 2030 Agenda for Sustainable Development by the United Nations General Assembly, a landmark set of 17 sustainable development goals calling for action in all countries to "end all forms of poverty, fight inequalities and tackle climate change, while ensuring that no one is left behind"[1]. Goal 3 of this agenda focuses on ensuring healthy lives and promoting wellbeing for all. This goal includes a specific target to end the AIDS epidemic by 2030. Goal 5 of this agenda focuses on achieving gender equality and empowering all women and girls. This goal includes a specific target to ensure universal access to sexual and reproductive health.

Furthermore, in June 2016, member states came together at the UN General Assembly for a High-Level Meeting on HIV/AIDS. The outcome of this meeting was an unprecedented Political Declaration, which takes stock of progress made, lessons learned, and pending gaps in the HIV response, including a renewal of concrete targets to End the AIDS Epidemic by 2030. These include a 95 per cent reduction of new HIV infections among adolescents aged 10-19, and an increase to 81 per cent in those on treatment. A commitment to reduce the risk of HIV infection among adolescent girls and young women by providing them with quality information and education, mentoring, social protection and social services which evidence shows reduce their risk of HIV infection. Member states also committed to a 75 per cent reduction of new HIV infections among young people aged 15-24 to bring down the number of new HIV infections to less than 100,000 among young women (aged 15-24) by 2020. In addition, the specific commitment to tackle the root causes of risk and vulnerability among adolescents, including the review and reform of legislation that may create barriers or reinforce stigma and discrimination, such as age of consent laws, was agreed by member states.

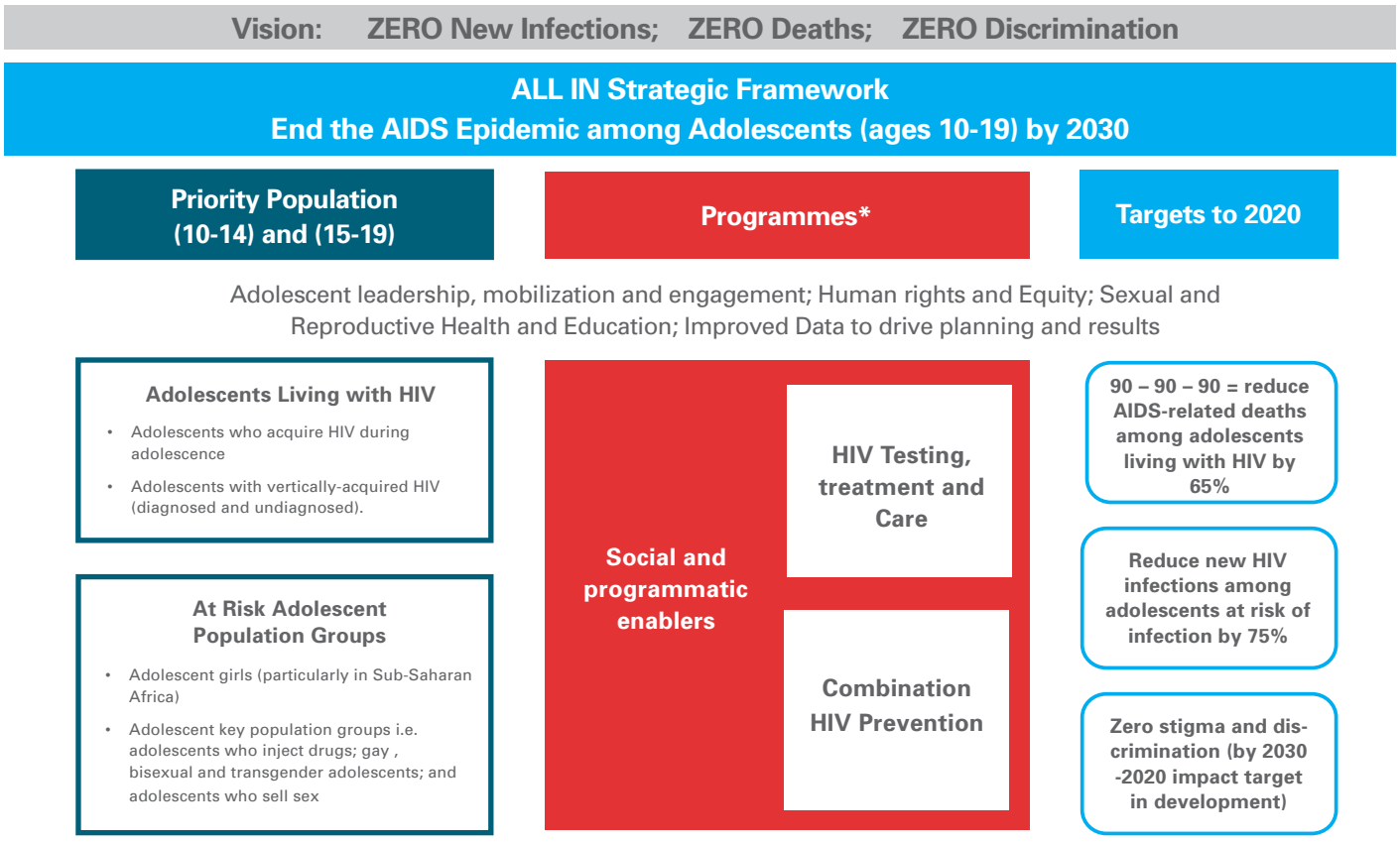
1 http://www.un.org/sustainabledevelopment/development-agenda/

This high-level political momentum to strengthen the global health response, including HIV, with a focus on youth and particularly adolescents, has driven governments in all regions of the world to respond by convening partners to analyze their epidemic, identify key bottlenecks affecting delivery, and sharpen plans for better impact. At the global, regional and country levels, adolescent and youth networks have come together to support the response to HIV in adolescents and lay the foundation for sustained and meaningful engagement for social change. Increased resources and technical assistance have been provided to enable innovations in programming and service delivery for adolescents, improving not only what is done to deliver better HIV prevention, treatment and care results, but how this is done.

Additionally, global partners are looking to further accelerate progress to end the AIDS epidemic through a variety of concurrent initiatives, including the Super-Fast Track (Three Frees) initiative, which includes a life-course approach to ensuring that everyone starts life free from HIV, stays free, and that those living with HIV receive lifesaving treatment. This will build on progress made through the US Government's ACT and DREAMS initiatives which have expanded treatment access for adolescents in 14 countries and broad programmes to reduce vulnerability, accelerate prevention and empower adolescent girls and young women in 10 countries. The Super-Fast Track initiative is also coming at a time when the Global Fund is intensifying its own allocations for programming to reduce vulnerability and improve health in adolescent girls and young women through a new focused initiative targeting high-burden countries.

Young people, including adolescents, have also claimed critical spaces of participation to inform the HIV response, strengthen their advocacy and build further cohesion for country-level action. For example, UNAIDS together with IPPF and the PACT, a global coalition of 25 youth-led networks and organizations working on HIV and SRHR, lead the ACT!2015 social mobilization initiative. This joint effort, which is now entering its fourth phase, focuses on youth-led, data-driven accountability for the SDGs and the HIV Political Declaration in 12 priority countries. National youth

FIGURE 1 All In strategic framework



*PACKAGE appropriate mix of proven programmes for each defined adolescent population group based on epidemiological context

alliances in each of these countries, having identified the key policy barriers that limit young people's access to services, will produce evidence on these barriers and translate their findings into advocacy roadmaps aimed at policy review and reform, where necessary.

This report presents an update of the key results and contributions from the ALL IN agenda in 2015 and 2016, as well as the impact of these on:

1. Global strategic direction, partnerships, resource mobilization and advocacy.
2. Country-level service and programme prioritization, innovation, adolescent engagement and social change.

This report also presents recommendations from both country and global perspectives on immediate priorities, and underlines opportunities for acceleration in priority countries.

The report will be comprised of two components: a global summary and a section of country-specific briefs. The outline below illustrates the major items within each of these two components.

2. STATUS OF THE GLOBAL HIV EPIDEMIC IN ADOLESCENTS

Globally, in 2015, there were an estimated 250,000 **new HIV infections in adolescents** aged 15-19. Of these, nearly 220,000 or 86 per cent were in the 25 lead countries[2] in the ALL IN initiative. Both globally and across this set of 25 countries, the decline in new HIV infections in adolescents has been extremely slow since 2010. While the ALL IN initiative urges a shift in programme focus, quality and leadership – to accelerate the response in order to achieve a 75 per cent reduction by 2020 and to place these countries on track to achieve the global goal outlined in the SDGs – the 25 countries are not on track. As shown in Figure 2, unless there is a strong programme pivot, a dramatic change in leadership support and financing of prevention, and better targeting of effective interventions for prevention in the populations at the greatest risk of infection, the number of new infections in adolescents will change only marginally by 2020. The current status quo suggests that 190,000 adolescents will be newly infected with HIV in 2020 in the 25 ALL IN core countries, out of a projected 250,000 new infections in adolescents globally.

The work done by multiple countries to undertake assessments of the adolescent epidemic and response has been critical because, for many, it has helped to clearly spell out and focus collective attention sharply on these questions:

1. Exactly who are the adolescents at greatest risk?
2. Where are they?
3. Why are they at risk?
4. Is the response adequately addressing their needs and, if not, what needs to be addressed to make it work?

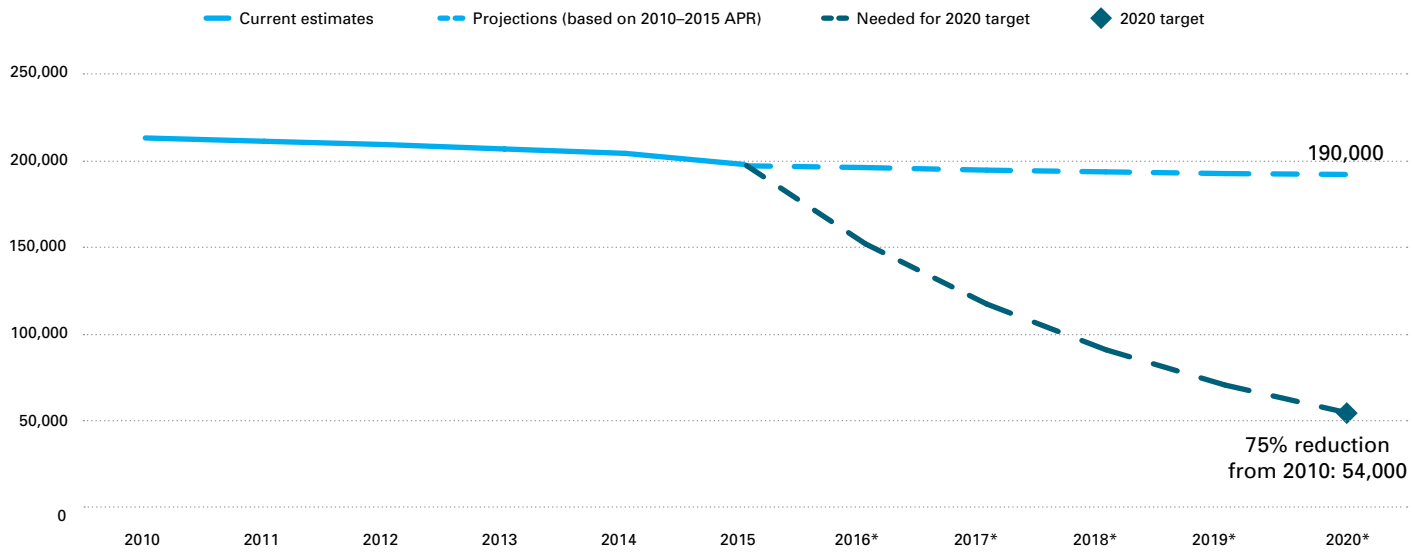
Globally, in 2015, an estimated 41,000 adolescents aged 10-19 died from AIDS-related illnesses. Of these, the overwhelming majority (nearly 36,000 or close to 83 per cent) were in the 25 lead countries in the ALL IN initiative. As shown in Figure 3, while the number of **AIDS-related deaths in adolescents** has declined slightly since the peak in 2012 and is projected to continue to fall slightly through to 2020, the absolute number of AIDS-related deaths in 2015 is more than double the number in 2000 and the 25 countries are not on track to end AIDS deaths in adolescents or achieve the target 65 per cent reduction by 2020. At the current pace, a projected 35,000 adolescents will die from AIDS-related illnesses in the 25 countries in 2020. That is nearly three times the number that would die from AIDS-related illnesses in 2020 if the countries put more efficient and effective strategies in place, and scaled them up to meet the 2020 target and address the urgent life-saving needs of adolescents living with HIV.

AIDS-related deaths in adolescents occur primarily among vertically-infected adolescents and long-term survivors of mother-to-child transmission. Therefore, this urgent reduction in AIDS-related deaths in adolescents can only be achieved if programmes do a better job at finding adolescents living with HIV, linking them to quality care and retaining them or reducing loss to follow-up. Work done through country assessments in the ALL IN lead countries

2 25 All In lead countries: Botswana, Brazil, Cameroon, Democratic Republic of the Congo, Cote d'Ivoire, Ethiopia, Haiti, India, Indonesia, Islamic Republic of Iran, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Swaziland, United Republic of Tanzania, Thailand, Uganda, Ukraine, Zambia, and Zimbabwe.

FIGURE 2 New HIV infection trends and projections in adolescents aged 15-19

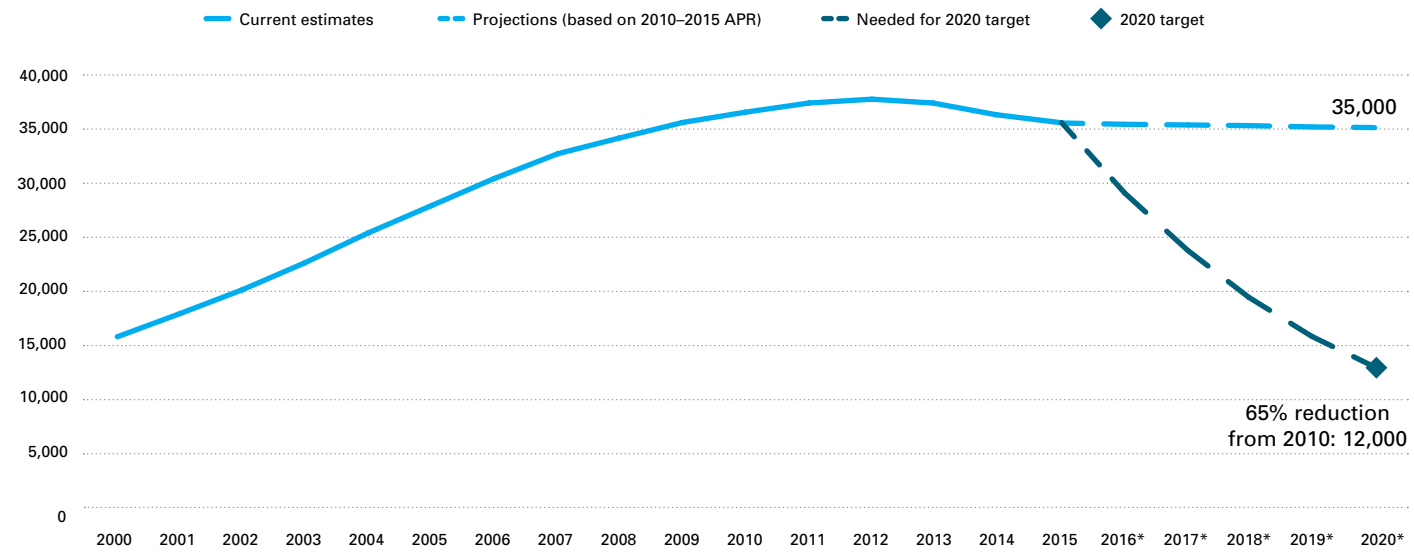
Estimated number of new HIV infections among adolescents (aged 15-19), 2010-2015 with 2016-2020 projections and ALL IN! targets, 25 ALL IN! core countries



Source: UNICEF analysis of UNAIDS 2016 estimates, July 2016 and United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, custom data acquired via website.
Notes: Projections were made by calculating the HIV incidence rate (infections per uninfected adolescent) and determining the annual rate of reduction (ARR) of the incidence rate between 2010 and 2015 and applying that to the projected uninfected population of adolescents in 2016-2020.

FIGURE 3 Trends and projections in AIDS-related deaths in adolescents aged 10-19

Estimated number of AIDS-related deaths among adolescents (aged 10-19), 2010-2015 with 2016-2020 projections and ALL IN! targets, 25 ALL IN core countries



Source: UNICEF analysis of UNAIDS 2016 estimates, July 2016.
Notes: Projections were made by calculating the HIV incidence rate (infections per uninfected adolescent) and determining the annual rate of reduction (ARR) of the incidence rate between 2010 and 2015 and applying that to the projected uninfected population of adolescents in 2016-2020.

has identified bottlenecks undermining the performance of testing and treatment programmes for adolescent populations. Through these assessments and programme experience across partners in the ALL IN initiative, a clear understanding has emerged for corrective actions that includes the following:

1. Design and implement more efficient and effective strategies for HIV testing that target adolescents at high risk of exposure, and enable these adolescents, their families and caregivers to recognize their risk of exposure, enhance literacy on HTC and ART, and thus increase active demand for testing among families affected by HIV.
2. Ensure the implementation of provider-initiated testing and counseling to reduce missed opportunities for testing and linkage to care among adolescents at facilities for chronic illness.
3. Scale up targeted family-based care to identify undiagnosed adolescents and link them to care.
4. Improve the legal and policy environment, including factors such as laws on consent to access services, to ensure that adolescents are not excluded from or denied access to HIV testing services and therefore timely access to life-saving treatment.
5. Improve service quality to enhance acceptability and provide holistic care that addresses the needs of adolescents living with HIV, thus achieving better retention and transition among adolescents in care.
6. Address gender inequalities and gender-based violence to prevent HIV among adolescent girls and young women and mitigate its impact.
7. Empower and engage young women and adolescent girls as agents of change to participate in the design, implementation and monitoring of the HIV responses.

Stigma and discrimination remain significant barriers to inclusion, access to prevention, treatment, care and support among adolescents living with HIV, adolescent girls and young women, and adolescent key populations (adolescents who sell sex, adolescents who inject drugs, transgender adolescents and gay and bisexual adolescent males). Adolescents engaged in the ALL IN initiative, as well as country-level and network representatives, note how stigma and discrimination by health workers impacts on access and acceptability of HIV prevention services which should play a critical role in supporting risk reduction in adolescent key populations. Stigma and discrimination based on attitudes around gender remain widespread and deter adolescent girls and young women from accessing services and upholding their sexual and reproductive rights.

UNAIDS and the Global Network of People Living with HIV, the International Community of Women Living with HIV and the International Planned Parenthood Federation have developed a Stigma Index to help communities, including those living with HIV, to understand the experiences of PLHIV with stigma and discrimination, and to inform advocacy and formulate plans to end this. Over 50 countries have used this tool to assess stigma and discrimination from the perspective of people living with HIV. Some of them included adolescents among their respondents and thus provide important insight into the impact of stigma and discrimination on adolescents living with HIV. For example, in Zimbabwe, one out of every three adolescents living with HIV aged 15-19 feared being gossiped about, and adolescents were more likely than any other age group among PLHIV to feel ashamed of their infection, blame others for it, feel suicidal and exclude themselves from social gatherings with other adolescents.[3] Results in Malawi showed high levels of self-stigma among young people living with HIV. However, they also showed that young people living with HIV aged 15-24 were more likely than other age groups to have been denied sexual and reproductive health services from ages 15-19 and to have had to change their place of residence.[4] A 2015 report from Vietnam noted that much more effort was still needed to end stigma and ensure access to care and support for all at risk and affected by HIV. However, this report also showed that self-stigmatization and experiences of community and social stigma and discrimination had decreased significantly since the previous assessment in 2011.[5] This report urged continued action in the form of community outreach, support groups, community education on rights and the involvement of people living with HIV, to continue to reduce and work towards the elimination of stigma and discrimination.

3 Zimbabwe Stigma Index Research Report, December 2014
4 Malawi, The People Living with HIV Stigma Index, 2012
5 Viet Nam Stigma Index, 2015

3. STATUS OF THE GLOBAL RESPONSE

HIV testing and prevention

Ensuring better targeting of interventions towards adolescents at greatest risk of HIV infection and using more efficient strategies to identify adolescents living with HIV is critical to accelerating the progress in reducing new HIV infections and AIDS-related illnesses and death. HIV testing is a critical part of the cascade of interventions for HIV prevention and treatment. As shown in Figure 4, data on HIV testing in sexually active adolescents reveals a varied picture of progress to ensure that it is accessible and being demanded by adolescents at greater risk of infection. Between 2010 and 2014, 14 of the 25 ALL IN lead countries completed a Demographic and Health Survey that captured data on HIV testing among sexually active adolescents. Across these 14 priority countries, the proportion of sexually active adolescents who had tested for HIV in the 12 months prior ranged from 6.5 per cent among adolescent girls aged 15-19 in DRC and Nigeria to 64.6 per cent in girls in Kenya, and from 2.4 per cent among adolescent boys aged 15-19 in DRC to 40.1 per cent in boys in Kenya.[6]

TABLE 1

Current status of condom use in adolescents aged 15-19 at high risk of HIV infection

Region	% of adolescents (aged 15-19) with multiple partners who used a condom at last sex, 2010-2015*	
	Female	Male
South Asia	32	44
Eastern and Southern Africa	29	44
West and Central Africa	33	44
Middle East and North Africa	–	–
South Asia	–	–
East Asia and the Pacific	–	–
Latin America and Caribbean	–	–
CEE/CIS	–	–
Least developed countries	–	–
Low- and middle-income countries	–	–
World	–	–

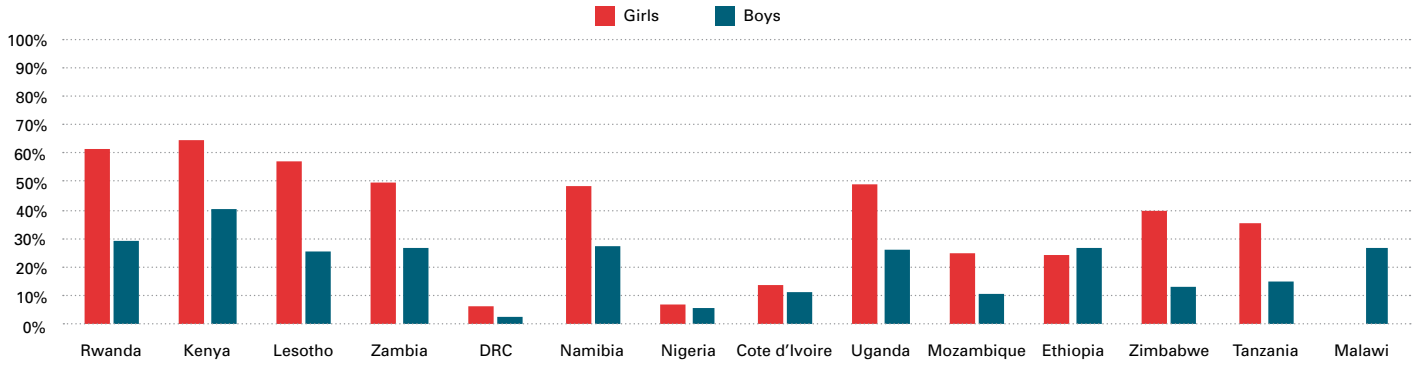
Source: UNICEF global databases 2016 based on DHS, MICS and other nationally representative surveys.

Advancing from advocacy to programme impact requires time, sustained political leadership, programme effort and financing. The low levels of testing among adolescent populations at higher risk of exposure to HIV underscores the urgent need to focus on quality and investment in adolescent HIV programmes.

There is another indicator that provides a measure of effective reach and risk-reducing behavior among adolescents at high risk of HIV infection: unprotected sex among adolescents with multiple sexual partners. From the three geographic regions where data is available to generate reasonably reliable estimates, only about one third of adolescent girls and four out of ten adolescent boys at high risk of exposure to HIV report consistent condom use. Furthermore, data on this indicator, as with many other indicators, remains unavailable for adolescents in other regions and this continues to limit advocacy, prioritization of adolescents, planning, and effective resource mobilization and allocation.

FIGURE 4 HIV testing in sexually active adolescents in selected countries

Percentage of sexually active adolescents 15-19 who had sexual intercourse in the 12 months preceding the survey who had an HIV test in the 12 months preceding the survey and know the results



Source: DHS Program Statcompiler November 2016

6 DHS Program Statcompiler - http://www.statcompiler.com/en/ accessed on 29 November 2016

To deliver better results, adolescent programmes must strengthen the data to inform the design of strategies that aim to find the adolescents at greatest risk and, linking them to and retaining them in the care of effective HIV prevention and treatment programmes, as well as programmes that address their broader health, protection and care needs. Adolescent HIV prevention programmes must do better at considered the influence of gender in shaping the specific needs of adolescent girls and boys in the response for HIV. Adolescent girls and young women must have the knowledge, agency and power to protect themselves against HIV, and for this, they need safe and enabling environments.

Efforts have been made over the past two years to engage adolescents in local advocacy and mobilization efforts, identify the locations and adolescent populations with the highest HIV burden, determine the bottlenecks limiting effective delivery of key interventions, and define with partners priority actions and innovative approaches to reach the most vulnerable adolescents. This work has formed an invaluable foundation for accelerated response for adolescents.

HIV treatment in adolescents

Significant improvement has been made in age-disaggregated reporting on treatment coverage in adolescents over the last two years. At least 67 countries have now provided data on the proportion of adolescents (aged 10-19) living with HIV that has been reached with ART *(Figure 5)*. However, the median ART coverage in adolescents across these countries is only 20 per cent, indicating once more the gap between the 90-90-90 target in adolescents and current programme performance. Global scale-up and quality improvements in ART for pregnant mothers (currently at 77 per cent) and paediatric ART (0-14 years, currently at 49 per cent)[7] will lead to an increasing number of children who live with HIV transitioning into adolescence on ART. For older adolescents living with HIV who are undiagnosed and not in care, a rapid shift to smarter targeting will provide them with critical, potentially life-saving opportunities for immediate diagnosis and linkage to care[8] – for example, through family-based care and provider-initiated testing and counseling (PITC), supported through better community and family engagement, to build treatment literacy and support for HIV testing. Operational research to inform the models for these approaches will play an important role in informing programme improvement. Another significant aspect of the ALL IN initiative includes ending all forms of violence and discrimination against women and girls, such as gender-based, sexual, domestic and intimate partner violence as these can have serious and long-lasting impacts on the health and well-being of women and girls throughout the life cycle and increase their vulnerability to HIV.

Cross-sectoral investments – Girls' education and teenage pregnancy

An important part of the ALL IN initiative is its emphasis on the importance of investing in the whole adolescent. The ALL IN framework clearly indicates that achievement of the goal of ending the AIDS epidemic in adolescents and the three related targets is dependent on there being sufficient attention to reducing vulnerability in adolescents, and not just immediate risk of HIV infection or illness. Investment in health systems that ensure access to sexual and reproductive health for adolescents is equally critical, laying the foundation for effective care over the long term and – when well-integrated with HIV services and appropriate links to community for support – engaging adolescents, including those that are hardest to reach, and providing more efficient care and support.[9] Similarly, the benefits of education and particularly girls' education are clear and well documented.[10] They include individual empowerment, protection and health, with these benefits extending to family, community and nation.[11]

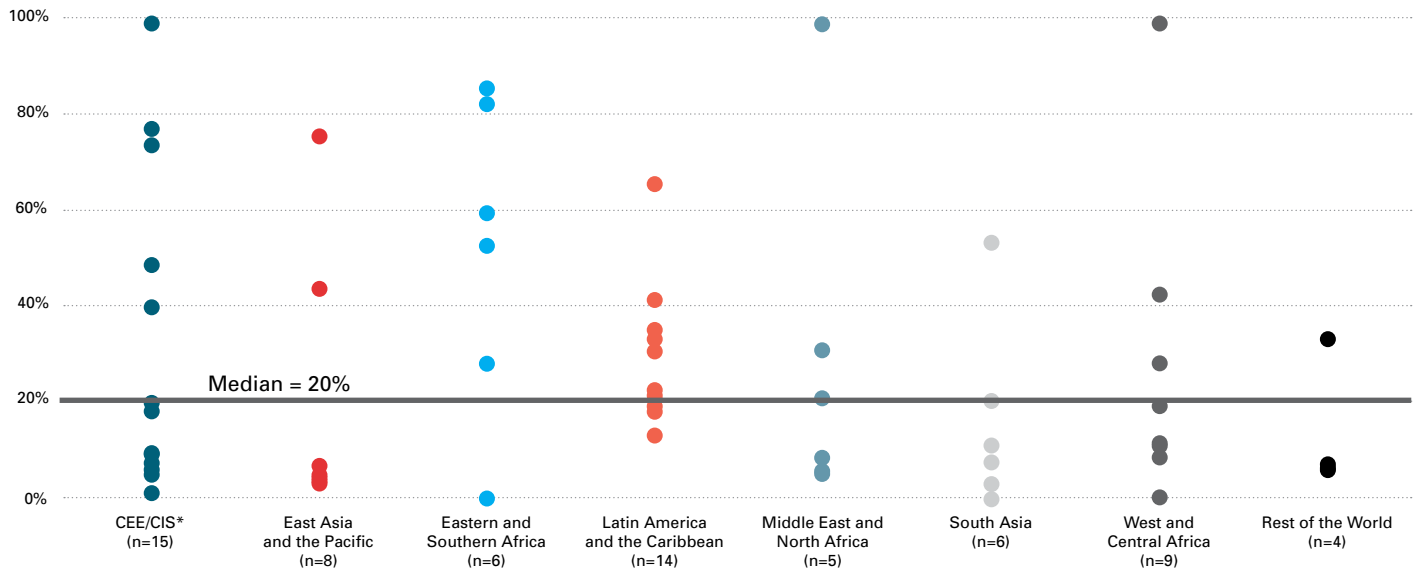
Figure 6 shows the current status of teenage pregnancy and relates it to completion of secondary school by girls in 23 of the 25 ALL IN lead countries. In the majority of these countries (20 of the 23), more than 1 in 10 girls will fall pregnant and give birth before the age of 18. In general, the proportion giving birth before the age of 18 falls with rising secondary school completion.

Through this assessment exercise, the ALL IN initiative is helping countries keep a close eye on progress through effective programmes across multiple sectors, to create an environment in which the adolescent, especially those most vulnerable to and living with HIV, can survive and thrive.

7 UNAIDS/UNICEF/WHO Global AIDS Response Progress Reporting and UNAIDS 2015 HIV and AIDS estimates, June 2016
8 WHO, HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policy-makers and managers, 2013
9 WHO, HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policy-makers and managers. December 2013
10 Hargreaves J et al., Systematic review exploring time trends in the association between educational attainment and risk of HIV infection in sub-Saharan Africa. AIDS 2008 Jan 30;22(3):403-14
11 UNICEF, State of the World's Children 2016: A Fair Chance for Every Child. June 2016

FIGURE 5 Coverage of antiretroviral therapy in adolescents aged 10-19 in 67 countries (2015)

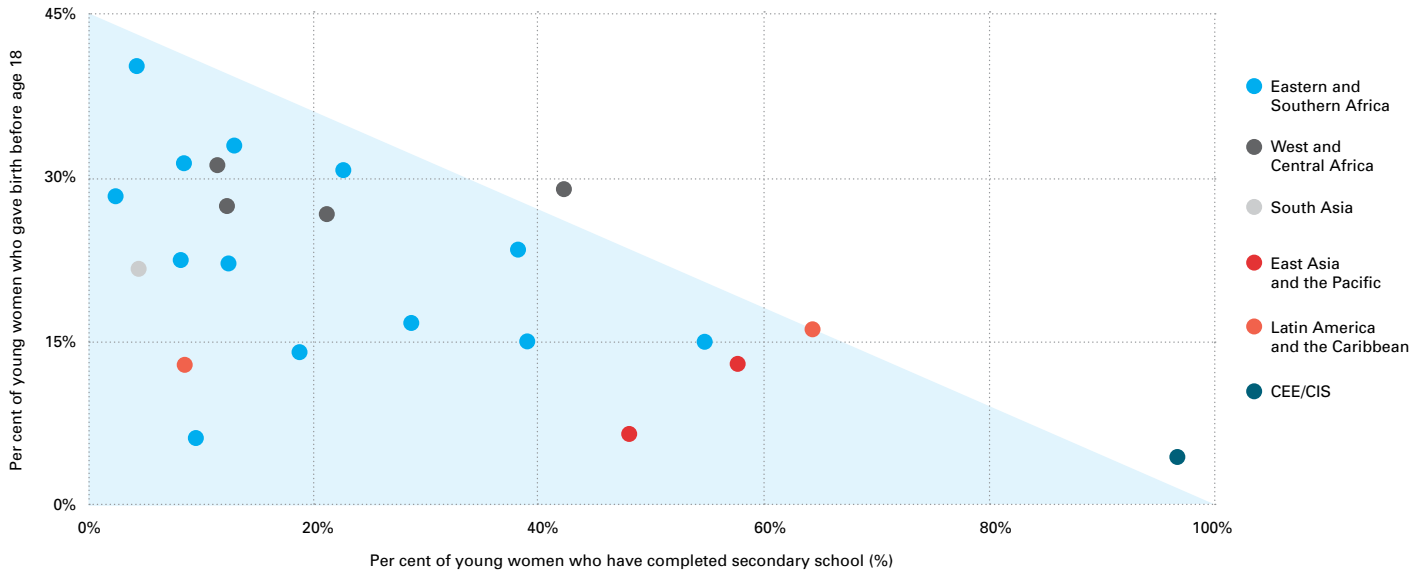
Percentage of adolescents (aged 10-19) living with HIV who are receiving ART, 67 countries reporting by UNICEF Region, 2015



Source: UNAIDS/UNICEF/WHO 2015 Global AIDS Response Progress Reporting and UNAIDS 2016 HIV and AIDS estimates, June 2016.
Note: Global reporting of ART numbers by 5-year age group began in 2014 and not all countries are yet able to report ART numbers disaggregated to this level of age specificity. As a result, the values above represent the 67 countries that were able to report adolescent ART data for 2015 (either full-year or first 6 months). These 67 countries account for 16% of all adolescents (aged 10-19) living with HIV globally in 2015.
* CEE/CIS = Central and Eastern Europe and the Commonwealth of Independent States

FIGURE 6 Secondary school completion and teenage pregnancy

Per cent of young women who have completed secondary school vs. per cent of young women who gave birth before age 18, 23 of 25 ALL IN countries, by UNICEF Region, 2009-2014



Source: UNICEF global databases 2016 based on DHS, MICS and other nationally representative surveys.
Note: Botswana and Iran are not represented due to lack of data availability

4. HIGHLIGHT OF STRATEGIC CONTRIBUTIONS FROM ALL IN (2015-2016)

Support of global and country action for adolescents has been coordinated through four workstreams and highlights of the results from these are summarized below.

Workstream 1: Engage, mobilize and support adolescents as leaders and agents of social change.

In 2016, the ALL IN partnership's workstream 1 on engaging, mobilizing and supporting adolescents as leaders and agents of social change focused efforts on three main areas:

1. Support adolescent participation in the HIV response.
2. Review and reform age of consent laws that pose obstacles for adolescents to access HIV and sexual and reproductive health services.
3. Foster a social movement to address stigma, discrimination, harmful gender norms, adolescents' access to social protection, and adolescents' empowerment.

As part of **focus area 1 on supporting adolescent participation in the HIV response**, this workstream developed an adolescent engagement guide to provide advice to programme designers, implementers, policy and decision makers on how to meaningfully engage adolescents in the AIDS response and broader health programming. It also demonstrates why adolescents and youth are critical in efforts to end the AIDS epidemic by 2030. This new resource highlights what steps should be taken to implement programmes and policies that improve adolescent health outcomes (including for HIV) at the national, regional and global levels.

To further strengthen adolescent participation, UNFPA in coordination with the Secretary-General's Envoy on Youth, UNICEF, UNESCO, UNDP, PBSO, universities, youth-led networks and other partners supported preparations for the establishment of a Global Commission on Adolescents by the UN Secretary-General. The Commission will be launched in March 2017 to serve a term of 18 months, until September 2018. The Commission will focus on six priorities:

1. Advocacy for increased national investments in adolescents
2. Supporting national efforts to prioritize adolescents
3. Reviewing progress made and making recommendations for priority actions to be taken to promote the human rights and development priorities of adolescents
4. Identifying opportunities and fostering partnerships
5. Providing a platform for mutual accountability
6. Harmonizing efforts of global initiatives

Multiple high-level events held in 2016 provided an opportunity for adolescent and youth-led advocacy, and UNFPA and partners supported events and participation of adolescents and youth within these platforms. These included:

- Side event in May 2016 with member states to advocate for CSE and SRHR as part of preparation for High Level Meeting (HLM) on HIV.
- Youth HLM pre-meeting in NYC.
- Special session on SRHR with young key populations in the main programme of IAC 2016 in Durban.
- Pre-conference at the IAC 2016 focusing on CSE, sexual and reproductive health laws and policies, among other topics.
- The Youth Pavilion that reached out to delegates and initiated over 2,000 conversations online, reaching some 1.2 million young people during the week of the conference.
- Global meeting to update international guidance on CSE.
- Meeting with the Secretary General's Envoy on Youth on 'Measuring the State of Youth in the SDGs: Tracking global indicators relevant to youth development and wellbeing'.

Regarding **focus area 2, focusing on the review and reform of policy and legal barriers**, this workstream developed and validated a comprehensive set of studies, analyses and tools for advocates and policy makers. This included 3 key complementary analyses.

1. A comprehensive analysis of laws and policies affecting ASRHR, supported by UNFPA in collaboration with the University of Pretoria, aimed at harmonizing legislation in 23 countries. It was completed and validated by key stakeholders for adoption by SADC and EAC and the development of a road map for adoption of the Legal Framework by the RECs by 2017.

2. In collaboration with the Southern African AIDS Trust (SAT) and with support from law firms in the Thompson Reuters Network, UNICEF supported a legal review of consent laws and policies in 22 countries, as well as a review of ethical, social and cultural (ESC) barriers in 11 countries, to understand the context behind them. The focus of the review was on legislation and practice in relation to: sexual activity, contraception, antiretroviral therapy (ART), post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), abortion, antenatal care (ANC), the vaccine for the human papillomavirus (HPV) and cervical cancer screening and treatment, and HIV testing. The ESC review used three frames of reference to understand the context for the legal provisions and general practice around consent for adolescents: a) contradictions between ethics (what ought be done based on universal human rights standards) and morality (what people generally think should be done based on individual values and beliefs); b) social factors (the way communities organize themselves and acquire identity); and c) cultural factors (both modern and traditional customs, traditions, practices, representation, expressions and values). Some of the key findings from the reviews are as follows:

   a. Most countries have set the age of consent to sex at 16 years, although in some the age is higher for girls and for sex between males. There are a number of exceptions to the legal age of consent in many countries – for example, if the underage person and their sexual partner are married. This presents a major challenge to the goal of ending child marriage and sexual exploitation.

   b. Most countries do not stipulate specific ages of consent for individual HIV and sexual and reproductive health services, including ART, PEP and contraception. In the absence of specific guidance, in most cases, the age of consent to these services is taken to be the same as the age of consent to medical treatment (ranging from 12 to 18 years, with 16 years being the most common age).

   c. The age of consent to HIV testing varies across countries but is mostly between 16 and 18 years *(Table 2)*.

   The findings from this review and complementary work by UNDP, UNFPA, UNAIDS and the PACT will now be used to raise awareness among adolescents and partners of contradictions and gaps identified in laws and policies, focusing actions to eliminate these structural barriers.

3. The PACT has led the development of an Age of Consent Advocacy Pack for youth advocates, which was piloted in Zimbabwe. UNFPA, the UNAIDS Secretariat and UN Women contributed to ending child marriage in several countries in Africa. UNFPA also launched campaigns to end child marriage in Ethiopia, Malawi, Mozambique, Zambia and Zimbabwe. In Malawi, UN Women worked with traditional leaders to ban early marriages, resulting in the adoption of the Marriage, Divorce and Family Relations Bill and increasing the marriage age from 15 to 18 years. In January 2016, Zimbabwe's Constitutional Court outlawed child marriages.

Focus area 3 strived to foster a social movement to address stigma, discrimination and harmful gender norms. As part of this workstream, UNFPA jointly with USAID and FHI360 led the dissemination of young key population technical briefs.[12,13,14,15] To provide the opportunity for youth-led advocacy and effective communication and knowledge sharing between youth advocates and other stakeholders working in CSE, the web platform *CSE Advocacy Hub* was developed and launched (on December 2) with a leadership of young people and support from UNFPA, as well as IPPF and UNESCO.

12 WHO, HIV and Young Transgender People, 2015
13 WHO, HIV and Young People Who Inject Drugs, 2015
14 WHO, HIV and Young People Who Sell Sex, 2015
15 WHO, HIV and Young Men Who Have Sex With Men, 2015

TABLE 2

Legal age and discretionary provisions on age of consent to HIV testing in 22 countries

Country	Age of consent to access HIV testing without parental consent	Provider discretion stated clearly in policy
Botswana	16	Yes
Brazil	Contradictory Guidance	N/A
Canada	Varies by province	Varies by province
Cote d'Ivoire	16	No
England	16	Yes
France	18	Yes if the health of the patient is in danger
India	12	Yes for anyone under the age of 18
Indonesia	18	No
Jamaica	16	No
Kenya	18	Yes
Malawi	13	Yes
Morocco	N/A	N/A
Nigeria	None	N/A
South	12	Yes
Swaziland	12	Yes
Sweden	18	Yes
Tanzania	16	No
Thailand	None	N/A
Ukraine	14	No
Vietnam	16	No
Zambia	16	Yes in the case of adolescents who are pregnant, married or in parenting roles
Zimbabwe	16	Yes

Source: SAT, UNICEF, Arnold & Porter LLP, Thompson Reuters Foundation, Age of Consent: Legal Review Summary, 2016

UNFPA's *Comprehensive Sexuality Education (CSE) for Out of School Young People Regional Resource Package* has been finalized in East and Southern Africa (ESA). In two days of ESA Commitment High-Level Events during July 2016, the 2015 ESA Commitment Progress Report, co-authored by UNESCO, UNFPA and UNAIDS, was launched and reaffirmed the ESA Commitment with a 2020 roadmap to speed up delivery of quality CSE and SRH services to young people in ESA.

Through formal partnership agreements with IPPF (on behalf of the PACT) and the World YWCA, UNESCO has supported young people's advocacy on CSE, young people's SRH and gender equality – including in high-level dialogues and at key international events in 2016 (CSW 60, Women Deliver, Durban IAC, ESA Commitment Progress Meeting) – as well as the implementation of SRH and CSE initiatives, designed and managed by young people in select countries.

UNESCO is also leading the process of reviewing and updating the 2009 UN International Technical Guidance on Sexuality Education to ensure that the evidence is up to date and that content reflects the contemporary needs of learners. A technical consultation, involving stakeholders from diverse sectors contributing to young people's SRH and wellbeing, including youth advocates, was convened by UNESCO in Paris in October 2016 to discuss the findings and agree on the nature and extent of the revisions to the existing guidance document. This will be published in 2017.

In addition, ILO has led efforts to advance young women's economic empowerment and target hard-to-reach populations along transport corridors and vulnerable communities in ESA, with the aim of reducing vulnerability to the HIV epidemic. Results of this approach were analyzed in the 2016 publication *Educated Empowered Inspired* -

Transforming lives through the response to HIV and AIDS in East and Southern Africa[16]. In Tanzania, a strategic partnership was built between ILO, UN Joint Program on Youth Employment, UNICEF and SAUTI-DREAMS to target vulnerable adolescent girls and young women in several districts. As part of it, the ILO has supported activities aimed at empowering young people aged 15-24 using its *Start and Improve Your Business and Women's Entrepreneurship Development* programmes. The ILO also set up a revolving fund to support trained youth with income generating activities and create employment opportunities.

In 2015-2016, UN Women advocated for the empowerment and meaningful engagement of young women and adolescent girls, including those living with HIV, in global and regional decision-making fora. UN Women contributed to the ALL IN Global Consultation on Adolescents' Engagement and the Asia and Pacific Youth LEAD's NewGen Leadership Programme to ensure that both gender equality aspects and adolescent girls' engagement and representation in the HIV response were addressed. In Malawi, Kenya and Uganda, UN Women partnered with IPPF to support empowerment and engagement of young women and adolescent girls, to mitigate risk and impact of HIV. In 2015, the 'Engagement + Empowerment = Equality' programme mobilized more than 1,000 young women and girl advocates, including those living with HIV, to voice their concerns at local, regional and national levels. Additionally, UN Women successfully advocated for gender-transformative national HIV strategies that highlight the HIV-specific needs of adolescent girls and young women, and engaged young advocates in planning and decision-making processes in Kenya, Mozambique, Uganda and Cambodia.

UNFPA and IPPF are working in partnership to develop evidence-based programmes on HIV and sexual and reproductive health and rights for young key populations. In 2015, they conducted a series of focus group discussions (FGD) among this group and, in 2016, developed a document to shape the implementation of national action plans in eight countries and assist their development in others.

In 2017, the ALL IN Workstream 1 will prioritize efforts to develop and roll out national, youth-led, advocacy roadmaps to reform laws and policies that pose obstacles to adolescents' access to HIV and SRH services. It will encourage review and reform of key policy issues, and support youth networks and other organizations to challenge stigma, discrimination and harmful gender norms that affect adolescents' access to services. Workstream 1 will also support the engagement of adolescent girls and young women, including those living with HIV, in the local and national HIV responses and global foras, and strengthen cross-level partnerships with national, regional and global stakeholders to advance political commitment and action towards key policy issues, including age of consent, comprehensive sexuality education, access to youth friendly services, gender equality and discrimination.

Workstream 2: Sharpen adolescent-specific elements of national AIDS programmes by improving data collection and analysis, and use this to drive programming and results.

This workstream focuses on strengthening the generation and use of data on adolescents. This will result in improved, more targeted programme planning, and boost operational evidence around effective reach, service delivery and retention of adolescents.

Data-driven programming: Over the last year, in partnership with UNAIDS and others, UNICEF has led the design of tools and guidance to support countries which undertake comprehensive assessments, in a bid to strengthen national responses to HIV in adolescents. These analytical tools help countries to identify equity and performance gaps that limit the impact of investments in adolescent programming, as well as the adolescents at greatest risk of infection, illness and death – such as those excluded from services and areas with poor service performance. In addition, the tools can also help to define bottlenecks that contribute to ineffective HIV prevention, treatment, and care.

UNICEF and partners have worked to implement comprehensive assessments using these tools in 25 countries to date. In each country, UNICEF has worked alongside the government to convene representatives from multiple sectors accountable for programmes serving adolescents, along with implementing partners, civil society and adolescent and youth networks, to provide, review and analyze data to inform recommendations for national programme improvement.

16 Educated Empowered Inspired - Transforming lives through the response to HIV and AIDS in East and Southern Africa, 2016, ILO: http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_456923.pdf

In all countries, this process has helped to reinvigorate national and sub-national coordination mechanisms for adolescent health and wellbeing, including HIV response, and to improve visibility and engagement with political leadership on adolescents by focusing on specific strategic gaps, accountabilities and opportunities. It has provided a critical first look for governments and partners at the value of systematic collection, consolidation, joint review and monitoring of age-disaggregated data, and translation of these findings into context-specific programme plans to improve the wellbeing of adolescents.

Strengthening operational evidence: While these assessments have contributed to improved use of strategic information, increased investment towards adolescent results through work led by ALL IN partners continues to strengthen operational evidence around implementation.

1. In 2015, at the 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention, UNICEF and partners organized technical meetings on PrEP among adolescents, both to consider the clinical, ethical and operational issues associated with implementing oral PrEP among sexually active older adolescents aged 15-19 and to inform the preparation of PrEP demonstration projects for older adolescents. Since then, UNICEF has worked with UNITAID and three countries (Brazil, South Africa and Thailand) to initiate demonstration projects that will introduce PrEP for adolescents as part of a multi-component HIV prevention package targeted specifically at adolescents at substantial risk of exposure to HIV. The findings from this five-year project will inform national policy development and strengthen global implementation guidelines for PrEP, as well as programme guidelines for targeting and programming with adolescents.

2. In Kenya, the World Bank supported more than 70 programmes across regions to increase retention in and quality of secondary education. These included the Quality Improvement Program in Malawi, the Tanzania Secondary Education Development Program, the Uganda Post-primary Education Program and the Mozambique Education Sector Support Program. By keeping vulnerable children and adolescents in school, these programmes have provided a platform for the delivery of CSE, SRH and other education to build life skills, support healthy lifestyles (including good nutrition), and delay early marriage and childbearing.

3. In the East Asia and Pacific region, countries are starting to roll out PrEP and increase research on programming with key populations. As with many plans, adolescents were not integrated within the demonstration sites for PrEP or other interventions, in large part due to legal age restrictions on service to these age groups, but the Government of Thailand and partners have worked over the last two years to ensure that age will not be a barrier to access for vulnerable adolescents. Thailand has now lowered the age of consent for access to HIV testing and services and is thus already moving forward to pioneer the roll-out of PrEP for adolescent MSM in four sites across the country, with support from UNICEF and the Thai Red Cross. The Asia-Pacific IATT on young key populations provides support to countries in creating demand and raising awareness of PrEP among young key populations. To do this, a series of webinars on the science and experience of users on PrEP has been scheduled and broadcast in partnership with Youth LEAD and Youth Voices Count using Facebook Live. An adolescent-friendly information package on PrEP will be developed and distributed to countries in 2017.

4. Through the VCT@WORK initiative in Kenya, the ILO was able to reach adolescents and young people. In 2015, 865 males and 1,072 females aged 15-19 were tested, and 4,560 males and 6,694 females aged 20-24 were tested – 22 tested positive and were referred to care. Linkage to care was ensured through partnerships with National AIDS STI Control Program (NASCOP) and National AIDS Control Council, as well as through services provided by organizations linked to the Ministry of Health including AIDS Healthcare Foundation, USAID APHIA plus, and LVCT Health And Highway Community Human Resource Centre.

5. In 2016, through the Boda Boda Testing initiative, 57 males and 70 females below the age of 15 were reached. Of the 2,386 males and 702 females aged 15-24 who were tested, 19 tested positive and were referred for care, support and treatment. The Boda Boda Testing initiative is the result of a partnership between AIDS Health Foundation in Kenya, UNAIDS, ILO and COTU (K), the National Workers' Organization in Kenya, and SWHAP (Swedish Workplace HIV/AIDS Programme). It is rolled out in coordination with the Nairobi City County through an innovative Health Promotion/HIV and Road Safety Integrated Campaign dubbed 'Dandia na Mpango; G'Jue'.

6. In northern Malawi, the ILO trained 200 youth as peer educators on HIV and AIDS issues. Two girls among them created a group to address the many challenges they face in terms of access to appropriate information and services. The 'Girl Empowerment Society (GES)' targets young women and girls aged aged 15-29 with the aim of empowering them and advocating for their rights and protection, making them less vulnerable. The group has created a partnership with juvenile court systems, local health departments, social services and district education centers to ensure the rights of girls are protected. It has also developed initiatives to advocate for HIV testing among the youths and education for young girls to reduce the rate of girls dropping out of school, as well as encouraging those out of school to engage in economic activities. ILO trained 120 girls in entrepreneurship skills to enable them build their own businesses and generate income, in an attempt to reduce the level of their vulnerability.

In addition, multiple investments have contributed towards improved use and evidence around m-Health[17] tools and the integration of technology.

1. In Swaziland, the World Bank supports the government in conducting the Sitakhela Likusasa impact evaluation on the effectiveness of incentives to reduce HIV infection among adolescent girls and young women aged 15-22 who are in school or have dropped out. The evaluation includes over 4,000 females across urban and rural areas of Swaziland and seeks to strengthen the evidence around the effectiveness of incentives targeted at young females in areas of consistently high HIV transmission. It has a specific focus on the role of school attendance and assesses the pathways of protective behaviours in young females. Final results will be available in 2018. Young people and men diagnosed with HIV have shown comparatively low linkage to care rates in South Africa. The World Bank is supporting the South Africa National Department of Health as it conducts a randomized controlled trial in inner-city Johannesburg that will evaluate a smartphone application designed to send viral load and CD4 count results from the laboratory directly to the client. The hypothesis is that if clients receive personalized information (such as laboratory results, tailored information and appointment reminders) via their phone, it can support their linkage to and retention in HIV care. The impact of the app is measured by linkage to care rates six months after the baseline CD4 count, indicated by the existence of routine viral load or CD4 data in the laboratory database. The trial may also demonstrate how an app can be operationalized within existing data systems across the laboratory, health facilities and the HIV treatment program. Final results will be available in 2017.

2. In collaboration with the Praekelt Foundation, UNICEF has worked with the Government of Nigeria and partners to guide enhancements in national use of m-health applications to identify reach, link and retain vulnerable adolescents in care. A pilot experience working with the National Call Center for HIV and Related Diseases in Nigeria was used to develop a blueprint for integration of m-health applications in national systems for HIV outreach, empowerment and data gathering. The center aims to offer easy access to information on HIV and broader health issues. Through operator-assisted voice calls, the center currently responds to 46,000 calls a year. The proposed upgrades recommended through the blueprint would immediately expand the reach of the center to 53 million people, 11 million of whom would be adolescents. Further upgrades also proposed in the blueprint provided as a result of this initial system review and consultation would expand the reach to 110 million people, doubling the number of adolescents reached to 23 million and accelerating improvements in knowledge, demand and linkage to services.

3. UNFPA organized the first Hack for Youth Hackathon in Uganda, bringing together young people, innovators, engineers and UN staff from 17 countries to design m-Health solutions to address young people's expressed SRH needs and challenges.

4. A Memorandum of Understanding (MOU) was signed between the ILO and Oasis Websoft, a software-development house in Ghana, to use the web application Bisa to reach young people with health-related information, including information on HIV and AIDS. Under the MOU, the Bisa application will be used to target young people in Ghana and provide the necessary health information at the click of a button, including options for accessing HIV counseling and testing services, treatment for STDs and HIV-related illnesses.

17 WHO acknowledges that mHealth is a component of eHealth which itself is the use of information and communication technologies (ICT) for health. The WHO Global Observatory for eHealth describes mHealth as "medical and public health practice supported by mobile devices (mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices). (WHO, mHealth New horizons for health through mobile technologies, 2011)

5. Youth Voices Count[18], in partnership with the multi-country South Asia Global Fund HIV Programme, developed the first ever animated video on youth-friendly health services which is now available with subtitles in 7 languages. The video discusses the challenges that young people face in accessing existing health services and what could be done to overcome them. The trailer has been viewed over 23,000 times and the full video over 14,000 times.

Workstream 3: Foster innovation in approaches that improve the reach of services for adolescents and increase the impact of prevention, treatment and care programmes.

ALL IN partners focused on three areas to drive innovation and bring to scale those models which work to address adolescents and HIV:

1. Community accountability and monitoring by adolescents on services for prevention and treatment.
2. Platforms for innovation.
3. Strengthening family support for adolescents, including girls, young key populations and adolescents living with HIV, and improving scientific knowledge base.

Over the last two years, substantial progress has been made in driving some key innovations to improve the life of adolescents. The key advances sought to design, build and document innovative approaches which:

1. Engaged adolescents
2. Were built around an expressed need of adolescents
3. Promoted new and creative ways of communication between adolescents and the public health practitioners who aim to support them

Some key examples highlighted by partners in the three areas are listed below.

Community accountability/monitoring – examples

U-Report is a social messaging tool that encourages adolescents and young people around the world to speak out on issues that affect them. Today, it has over 2.4 million registered users and is live in over 25 countries. In June 2016, U-Report conducted a poll in over 16 countries to better determine adolescent and young people's fears around HIV testing, and their preferences on testing services including self-testing. These results were presented by UNICEF's Executive Director Anthony Lake in Durban on July 18 at the AIDS 2016 Conference. Two out of three of the over 75,000 adolescents and young people polled said that "fear of an HIV positive test" is their biggest barrier to getting tested.

ACT!2015 is a collaboration for social transformation in the AIDS response, led by the PACT – a coalition of youth organizations of more than one million young people – and UNAIDS. Executed from September 2013 to December 2017, this partnership has produced tools on how to work with adolescents and youth. It has also driven efforts to engage youth in planning and facilitated the design of a mobile app called *TuneMe*, a youth engagement platform which helps young people to access sexual and reproductive health information.

Lessons learned:

1. Young people are avid users of social media. Creative social media channels can be a gateway to significant numbers of young people and adolescents, and provide a great resource for polling.
2. The validity and reliability of data gathered through social media must be considered when it is analyzed and applied. Working with adolescents and young people themselves to validate data can be an effective way of improving data use, as well as by engaging them in the design and planning of programmes.
3. Data should not only be 'pulled' from young people, but rather 'pushed and pulled'. Community accountability requires the engagement of adults with young people.

18 Youth Voices Count: https://www.youtube.com/watch?v=KxrXePpiOVc

Platforms for innovation – examples

Safeguard Youth Project (SYP) in ESA embarked on a project that documented health and educational facilities, gaining insight into the HMIS and EMIS, developing demographic inventories, and GPS mapping of HIV and teenage pregnancy prevalence hotspots. Seven out of the eight countries implementing SYP now have maps available to identify hotspots, clinics and the geographical concentration of young population and schools in order to make sound programmatic decisions.

In 2016, the Global Fund hosted, with the support of UN technical partners, implementation workshops for countries to better understand the evidence-based response, and have intra-country dialogues on how to best address the implementation challenges in scaling up programs for adolescents and youth. The Global Fund is also working with partners like Youth Lead and Women 4 Global Fund to make accessible the PACT/UNAIDS/Global Fund tool 'Making the money work for young people: A participation tool for the Global Fund to Fight AIDS, Tuberculosis and Malaria'[19].

Shuga is a creative MTV collaboration with African governments and local media, currently televised by 125 broadcasters globally, reaching nearly 80 per cent of all countries in Africa. This initiative tested nearly 50,000 young people in four months through MTV Shuga.

UNFPA, with UNESCO and IPPF, launched the Comprehensive Sexuality Education (CSE) Advocacy Hub[20]. Youth leaders have strongly voiced both a desire and enthusiasm for a safe online communication platform for advocates working in the field of CSE to share information and advice. During 2016, the Hub has been developed and tested, and it will continue to be managed by young activists in partnership with international civil society organizations with a user base of all CSE advocates and experts.

Lessons learned:

1. Innovation is required to respond to expressed needs outlined in the ALL IN assessments (and other data sets) and better linkages with the assessments could improve the quest for innovation.
2. Music and entertainment are effective in driving engagement of adolescent in youth, but programmes must apply a rigorous design and evaluation methodology to promote effective responses.
3. Programmes like PEPFAR DREAMS offer an opportunity to drive innovation linked to the expressed needs of children by funding innovative channels.
4. Social movements must ensure that adolescent and youth voices can be heard in all their diversity, and that support is provided to ensure that the most marginalized have access to high-level platforms.

Potential areas of future collaboration

1. Development of a social and community accountability mechanism to reinforce broad community engagement around adolescent priorities in ALL IN.
2. Follow up with Baylor on including adolescents and HIV in the next Hackathon[21].
3. Better linkages with workstreams 1 and 2 to a) use data to inform new programme innovations and b) scale up innovative ways of getting adolescents to access, analyze and use data.

Workstream 4: Advocate and communicate at the global, regional and country level to generate political will to invest in adolescent HIV and mobilize resources.

In 2016, this workstream focused on advocating to increase political will to strengthen global and national investment in the response to HIV.

Among the key achievements of advocacy efforts in 2015 and 2016 were the following:

1. Establishment of the **Adolescent and Youth Constituency** as part of the Partnership for Maternal, Newborn and Child Health, linked to the Secretary General's Every Women, Every Child initiative.

19 http://www.unaids.org/sites/default/files/media_asset/JC2661_part2_en.pdf
20 http://advocates4cse.com/
21 https://www.bcm.edu/global-initiatives/innovation-center/hack-a-thon and https://youtu.be/ygCiRLaU37w

2. Launch of **Start Free, Stay Free, AIDS Free.**
3. Visibility of adolescents, particularly from key populations, at the **2016 UN General Assembly Special Session on Drugs** in April 2016.
4. Visibility of adolescents at the **High-Level Meeting on Ending AIDS** in June 2016.
5. Visibility of adolescents throughout the **International AIDS Society Conference** in July 2016.
6. Release of a series of global reports around World AIDS Day, focused on the second decade (including UNICEF's ***7th Stocktaking Report: For Every Child, End AIDS*** and UNAIDS' ***Get on the Fast Track – the Lifecycle Approach to HIV***.
7. High-level launch of ALL IN to #EndAdolescentAIDS in multiple countries.

ALL IN has been catalytic in forging a global alliance around adolescents and HIV/AIDS. ALL IN has also been instrumental in increasing donor attention and commitment to prevention, care and support for adolescents and HIV/AIDS, most notably through PEPFAR's DREAMS initiative (summarized in Box 1) and the Global Fund's increased attention, commitment and resource tools to support investments for adolescents.

But the greatest advocacy achievement of ALL IN was the launch of the Start Free, Stay Free, AIDS Free global agenda in 2016, modelled to a large degree on the Global Plan towards the Elimination of New Infections Among Children By 2015 and Keeping Their Mothers Alive.

Launched at the High-Level Meeting on Ending AIDS, this effort builds on the successes of the past five years, while setting an ambitious new framework to end AIDS in children, adolescents and young women once and for all. The partnership aims to make stronger linkages across a life cycle approach and supports the Fast Track with a focus on children and adolescents. Start Free, Stay Free, AIDS Free provides a roadmap for the urgent work ahead, elevating and amplifying key initiatives that are already accelerating progress for children, adolescents and young women. These include the DREAMS partnership, the Accelerating Children's HIV/AIDS Treatment (ACT) initiative, ALL IN and many others. ***Adolescents are now prioritized in a way they have never been in the global AIDS response***.

Throughout the 15 years of the Millennium Development Goals (MDGs), the marginalization of young people from the global conversation had inhibited their contribution to practical and programmatic efforts to meet the needs of young people and adapt services to their unique needs. At the start of the Sustainable Development Goal (SDG) era, a different path is needed – one that integrates young people fully into the work of the global development community and gives them a voice to match their stake in the coming years.

The **Global Strategy for Women's Children's and Adolescents' Health** (the Global Strategy) requires that youth and adolescent health needs are fully embraced and addressed. Best practice in health clearly points to meaningful stakeholder participation as vital to success. In anticipation of this shift, the Partnership's Board Chair requested that young people who had been working with the Partnership on an adolescent health strategy develop options for stronger integration into the Partnership,

BOX 1

PEPFAR's DREAMS Initiative

DREAMS is an ambitious US$ 385 million partnership to reduce HIV infections among adolescent girls and young women in 10 sub-Saharan African countries. PEPFAR is partnering with the Bill and Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences and ViiV Healthcare to help girls develop into Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women. PEPFAR has reached over 1 million adolescent girls and young women with critical comprehensive HIV prevention interventions through the DREAMS partnership. Adolescent girls and young women are participating in interventions to learn their HIV status, and ultimately prevent HIV infection through programmes including education and social support to keep them in school. DREAMS is creating a ripple effect – the government of South Africa created She Conquers, a national campaign that will take DREAMS beyond the four PEPFAR-supported districts. Swaziland is joining forces with Global Fund and the National Emergency Response Council on HIV/AIDS (NERCHA), resulting in close to national coverage for adolescent girls and young women.

including the proposal to develop a new (eighth) constituency. Options for integration, and finally a recommendation for the Board, were developed through extensive consultation with more than 40 young leaders already engaged in the work of the Partnership. The young people proposed to mainstream adolescent and youth engagement across existing Partnership constituencies and to create a new **Adolescent and Youth (A&Y) constituency** to add a defined and formal voice to Partnership deliberations and efforts. In 2016, this A&Y constituency has begun to influence decision-making and direction-setting for addressing the SRMNCAH issues that affect them most.

Multiple high-level events afforded partners the opportunity to draw attention to the issue of adolescents and HIV/AIDS in 2016. Among the most significant were:

- The **United Nations General Assembly Special Session on Drugs**
- The **High-Level Meeting (HLM) on Ending AIDS** held in June 2016 and the Youth HLM pre-meeting in New York.
- The **International AIDS Society Conference** in Durban, South Africa in July 2016 and numerous adolescent-related sessions, side events, satellites and forums hosted by myriad partners.
    - Specifically, the pre-conference at the IAC 2016, focusing on CSE and sexual and reproductive health laws and policies, among other topics.
    - The Youth Pavilion that reached out to delegates and initiated over 2,000 conversations online, reaching some 1.2 million young people during the week of the conference.
    - The Innovation Satellite which brought together partners investing in new ways of addressing prevention, including PrEP.
    - A young ambassador (Siyanda) toured the region and prepared compilation video, blogs, vlogs and interviews. She also led part of the innovation session, live-tweeted from Durban and interacted with Children's Radio Foundation reporters who were present at the conference and broadcasting live radio.

In the run up to the **United Nations General Assembly Special Session (UNGASS) on the World Drug Problem** in April 2016, UNAIDS released the report *'Do no harm: health, human rights and people who use drugs'*. WHO, UNDP, UNICEF and others also released similar reports. The impact of drugs upon the lives of children and adolescents was acknowledged at the UN General Assembly Special Session on Drugs (UNGASS) 2016, *Achieving the 2019 Goals: A Better Tomorrow for the World's Youth.* The Special Session represented a significant opportunity to understand and address the ways in which drugs affect children and adolescents in particular, an issue that has been largely overlooked to date in much of the debate and documentation on drugs. It also represented an opportunity to prioritize health, human rights and safety in global drug policy. The health benefits of harm reduction have been well-documented since the last Special Session in 1998 and influenced the policy discussion at the UNGASS. Additionally, there was also an increasing recognition of the need for a public health and human rights approach to drug policy, the importance of a recovery-oriented continuum of care, and alternatives to criminalization and incarceration of adolescents.

The **UN High-Level Meeting (HLM) on Ending AIDS**, held in New York in June 2016, came at a pivotal moment – when the SDGs are being translated into concrete plans, systems and strategies for implementation. It constituted an important milestone in implementing the UNAIDS 2016-21 Strategy and for member states to commit to concrete targets on HIV at the highest intergovernmental level. The HLM has helped stimulate global leadership to help catalyze and commit resources to achieve the Fast Track targets and identify actions to achieve SDG Target 3.3. ALL IN-related advocacy centered on featuring adolescents in the formal HLM program, supporting the deliberations on 'Fast Track for Children and Adolescent Treatment', participating in the official side event on 'Delivering an AIDS-free Generation', providing input to the Zambian mission for the inclusion of adolescents in the declaration, and facilitating relevant NGO/CSO discussions and input to the declaration process.

On World AIDS Day (1 December 2016), UNICEF released ***For Every Child, End AIDS: Seventh Stocktaking Report on Children and AIDS***. The report called for dramatic improvements in prevention, treatment and care for children, adolescents and women. It highlighted the dangers of decreasing attention and funding for HIV/AIDS, urging policy-makers to act swiftly and boldly in order to end AIDS – a leading cause of death for adolescents and one of the major human rights issues of our time. The report used new data analysis to justify why investments in adolescent prevention must not only be maintained but need to increase, in light of a dramatic growth in the adolescent population that means new HIV infections will rise unless the world acts now.

- In 2010, there were about 200 million young Africans aged 15-24, and that number could rise to more than 450 million by 2050.
- Since Africa is one of the regions most heavily impacted by HIV, the number of adolescents newly infected is projected to increase in coming decades, even if the current rate of progress is maintained.

UNAIDS' ***Get on the Fast Track – the lifecycle approach to HIV*** report also used data-driven advocacy to make the case for continued investments in adolescent treatment and care. It noted that, globally, 1.8 million adolescents aged 10-19 were living with HIV in 2015, a 28 per cent increase from 2005, and in urgent need of treatment and better support to ensure adherence and successful transition, given that most of these are adolescents living with vertically acquired HIV.

5. ADOLESCENT AND YOUTH PERSPECTIVE ON ALL IN PROGRESS

As a part of this reporting exercise, UNICEF and UNAIDS reached out to adolescents and youth through global ALL IN partners and those in all 25 lead countries, inviting their perspectives on ALL IN, its major contributions to adolescent HIV programming and, in particular, the main ways they have been involved since its launch in 2015. A total of 133 adolescents and youth responded to the English and French language surveys. Respondents were almost evenly split between male and female (68 male and 60 female) and included 2 transgender respondents. A total of 38 adolescents aged 10-19 participated in the survey, while 93 respondents were aged 20 years old or older.

FIGURE 7 Adolescent and youth perspectives: Ways in which adolescents and young people have been involved in the HIV and Adolescents response

Some of the respondents also served as members of national and sub-national steering groups on ASRH. The survey feedback revealed that the key areas of engagement of adolescents in ALL IN over the last two years have been advocacy, training, support to referral and social mobilization. Specifically, youth and adolescents have been involved in drawing attention to the equity gaps in the HIV response among adolescents at national and sub-national levels, with feedback indicating that this has been done with a focus on issues such as awareness creation on HIV transmission, HIV testing, ASRH, quality of adolescent-friendly health services, stigma reduction and adherence support to ALHIV who are on treatment.

The feedback also provided some insight to the key strategies used by adolescents and youth to carry out their roles in support of the ALL IN agenda. These included peer education, the use of music, dance and drama (as edutainment), community dialogue, participation in webinars, conferences, workshops and campaigns.

While some respondents noted that the ALL IN agenda is helping to foster better coordination and focus on adolescents, as well as providing a platform for adolescents to raise their voices, others pointed out that there is still a need to improve the engagement of adolescents and young people since they themselves have either not been involved or are yet to see results from ALL IN. Some of these views are as follows.

Concerns about the ALL IN agenda as expressed by adolescent and youth respondents:

- "Thus far, I don't think there has been any significant change. So, yes, we now have updated figures and, yes, we have set out goals and plans that will make a difference, but I think that until those goals have been achieved, we really cannot highlight any change." *Adolescent male aged 15-19, Jamaica*
- "Meaningful changes have not yet appeared in Ukraine, because of the lack of attention from the government." *Adolescent male aged 15-19, Ukraine*
- "As the ALL IN initiative is still so new, lots of people are yet to learn about it and it's a bit too early to speak about its impact on our lives." *Adolescent female aged 15-19, Cameroon*

Positive perception of adolescents and young people about the ALL IN agenda:

- "For the first time in Uganda, adolescent health has become a priority." *Adolescent male aged 15-19, Uganda*
- "We have felt a change in efforts to involve us." *Adolescent female aged 15-19, Haiti*
- "The Ministry of Education has actually reached out to us more to be involved." *Adolescent female aged 10-14, Cote d'Ivoire*
- "The increased attention and community sensitization around HIV is going to make it easier for us adolescents to go out and ask for an HIV test." *Adolescent female aged 15-19, Chad*

PART 2: COUNTRY SUMMARIES

This part of the report presents country profiles featuring data summaries drawn from global databases, as well as narrative summaries of lessons learned in the four areas of work supported through ALL IN during the period 2015-2016. Specifically, each country narrative describes the following lessons:

a. **Social change and adolescent engagement:** Results related to meaningful adolescent participation in decision-making, review of policies and access laws to services, and support for adolescent-led social movements to address HIV risk and vulnerability, including stigma, discrimination and harmful gender norms.

b. **Programme scale-up and acceleration:** The application of findings from country assessments to upscale HIV response among adolescents, including partnerships and leveraging of resources.

c. **Innovation:** Results associated with the use of online and mobile technology, social incentives and new programming tools to improve access, utilization and quality of HIV interventions for adolescents, including improving community monitoring and accountability systems.

d. **Advocacy and communication:** Results associated with the outcome of advocacy efforts, including political commitment, public awareness and optimization of resource allocation such as resource gap mapping and expenditure tracking to inform investments in HIV among adolescents.

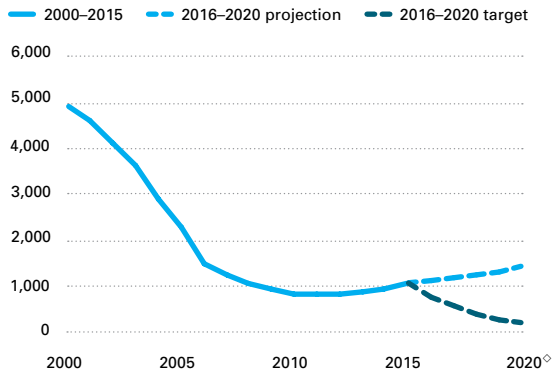
Data notes: Sources and explanatory notes for the country data profiles are indicated on the profiles by letters (sources) and symbols (explanatory notes). The full sources and explanatory notes are detailed on page 199.

CENTRAL & EASTERN EUROPE AND THE COMMONWEALTH OF INDEPENDENT STATES

COUNTRY I **UKRAINE**

ADOLESCENT HIV TRENDS

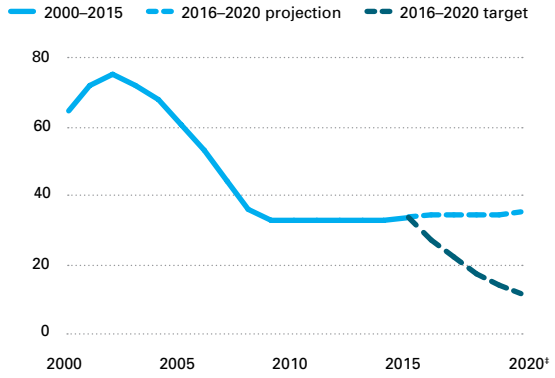
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

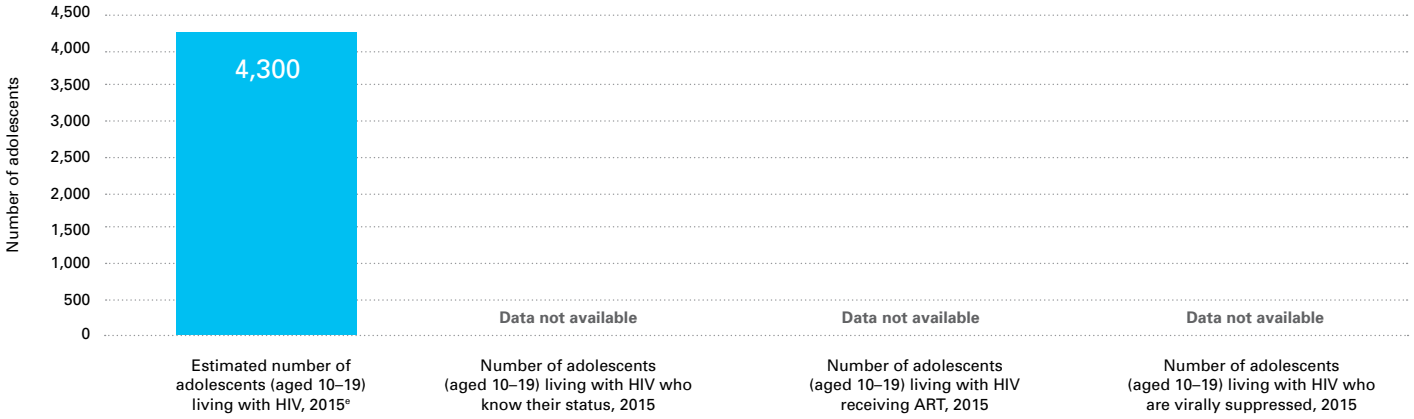
AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	44,800,000	24,100,000	20,800,000
	Estimated population of adolescents (aged 10–19), 2015[c]	4,000,000	1,900,000	2,000,000
	% of total population that is adolescents (aged 10–19), 2015[d]	8.8%	8.0%	9.8%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	490,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[h]	–	4.4 (2012)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.1%	0.1%	0.1%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.1%	0.3%	0.0%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	0.3%	0.5%	0.2%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	4,300	3,200	1,100
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	1,100	<1,000	<100
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<100	<100	<100
Policy	Age of consent for HIV testing[f]	14	14	14

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15-19) with comprehensive, correct knowledge of HIV	38.9 (2007) [i]	33.2 (2007) [i]	42.6 (2012) [h]	36.6 (2012) [h]
% of adolescents (aged 15-19) reporting multiple sexual partners in the last 12 months	1.5 (2007) [i]	8.0 (2007) [i]	3.1 (2012) [h]	14.8 (2012) [h]
% of adolescents (aged 15-19) reporting multiple sexual partners who reported condom use at last sex	–	66.2 (2007) [i]	–	89.8 (2012) [h]
% of adolescents (aged 15-19) who were tested for HIV in the last 12 months received the results of the last test	7.7 (2007) [i]	5.0 (2007) [i]	6.9 (2012) [h]	9.9 (2012) [h]
% of adolescent boys (aged 15-19) who have been circumcised	–	–	–	–
% of adolescent girls (aged 15-19) who have ever experienced sexual violence	0.3 (2007) [i]	–	–	–
% of youth who have completed secondary school	–	–	96.8 (2012) [h]	96.9 (2012) [h]
% of young people (aged 20-24) married or in union by age 18	–	–	9.1 (2012) [h]	3.8 (2012) [h]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

ALL IN has provided a platform for dialogue and consensus-building among a number of key partners in Ukraine who have been working on issues of adolescent key populations and other adolescents most-at-risk of HIV infection. A number of consultative processes have been put in place with the support of representatives from the various government ministries (including health, youth and sports, social policy, education), the commissioner of the President of Ukraine for children's rights and various civil society organizations, academia, the youth sector and organizations of people living with HIV.

The meaningful participation of adolescents living with HIV has been supported through the work of Teenergizer!, a network of HIV positive adolescent activists who have been strong advocates for raising awareness and opening dialogue about HIV among adolescents in Ukraine and in the region. Teenergizer! has been actively developing leadership skills among HIV positive adolescents and facilitating their participation in public events and policy dialogue, as well as through social media channels.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

A key policy change required in addressing adolescent key populations is a move towards stronger recognition of the realities and contexts of adolescent risky behaviours. Policies and practices in service provision need to move from the current 'don't ask, don't tell' policy – which avoids asking adolescents their age when providing services – towards a more open policy of supporting adolescents at risk with appropriate services regardless of age.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

The access by adolescent key populations to HIV prevention, care and support services has been extremely low. Age is one of the key barriers for accessing services, including those provided through civil society organizations.

The ALL IN assessment findings indicated that:

- Of those who received services for needle and syringe exchange, less than 1 per cent were aged 14-19 and about 5 per cent were aged 20-24.
- Among young people who sell sex, approximately 3 per cent were adolescents aged 14-19 and 25 per cent were aged 20-24.
- Among men who have sex with men and receive HIV services, less than 2 per cent were aged 14-19 and about 20 per cent were aged 20-24.
- Population size estimates for adolescent key populations indicate important increases, with an estimated 15,000 adolescent IDUs in 2014 and 21,700 adolescent IDUs in 2015.[22]
- There is a lack of HIV risk-awareness among adolescents overall, including among marginalized adolescents (e.g. from vocational schools that generally cater to poorer segments of the population). This lack of risk-awareness has been identified as an obstacle to seeking HIV testing by adolescents.

The first and second phases of the ALL IN assessments identified that one of the key challenges in Ukraine is the exclusion of issues related to marginalized and most-at-risk/vulnerable adolescents from the **political agenda**. Adolescent key populations and other vulnerable adolescents who are at highest risk of HIV infection are often seen as 'anti-social' and therefore not perceived as a political or funding priority for the country.

22 UNICEF/UISR, 2016 Booklet on MARA: estimates and dynamics

The lack of financial support from the government for programmes focused on prevention, care and support among vulnerable adolescents from key populations is a key obstacle to programming. This coincides with the exiting and severe reduction in funds from many other international donors who were supporting these programmes in the past.

Coordination and management mechanisms for addressing issues related to most-at-risk adolescents are weak or non-existent, risking further discontinuation of activities and programmes previously agreed among key stakeholders. The process of decentralization and restructuring of central and local authorities has contributed to this. There has been rather poor monitoring of compliance with the existing laws and policies, and programmes and policy reforms have not benefited from the information, knowledge and evidence generated through pilot interventions.

Consultative processes have been weak, with a lack of systematic discussion about prevention of HIV among adolescent key populations at the national and regional levels. Furthermore, in many regions, there has been poor collaboration and consultation between partners from government, civil society and the media. In particular, a missing component is the lack of dialogue with adolescents that would provide an opportunity for programmes to be informed by the opinions and views of adolescents about their needs and services.

Legal and policy obstacles to programming include the discrepancies between different policies and guidance, as well as the lack of knowledge among service providers of the existing laws and policies. Often, there are discrepancies about the minimum age for HIV testing and counseling, as well as differing policies relating to access by adolescent key populations to existing harm reduction services, including needle exchange and condoms. Service providers often do not follow existing guidance but rather conform to local practice, which influences the quality of services for adolescents, particularly those from marginalized key populations who are often already perceived as being 'problematic' and 'undeserving' of care.

Overall, high levels of stigma in society towards most-at-risk adolescents, as well as towards adolescents living with HIV, continues to represent one of the most important barriers to programming.

For adolescents living with HIV, a key finding is the lack of access to optimized ARV treatment regimens which would result in simplified regimens and easier uptake of medications, thereby increasing adherence to treatment.

Progress in implementation of priority actions identified through assessments

As a result of the ALL IN assessments, the **advocacy and awareness** of service gaps for adolescent key populations has increased. Programming for adolescent key populations also increased, with the most occurring in service coverage for 18 and 19 year olds.

Efforts to increase **access and uptake of HIV testing** have been promoted as part of the ALL IN activities. While overall increases in the last 2 years of at-risk adolescents accessing HTC services and receiving their results were modest (up by 5 per cent), they increased by 200 per cent among adolescents living and working on the streets, and by 44 per cent among adolescents injecting drugs. The percentage of those who had a HIV test and received their results during the past year increased from 30 to 70 per cent in the 5 service delivery models that were implemented.

Among those tested for HIV, 0.9 per cent of adolescents and young at-risk populations obtained a positive HIV test result.[23]

An important area of work has also been on increasing the **knowledge and capacity of service providers** on how to effectively work with adolescents living with HIV. Ukraine has piloted a series of training seminars and materials on psychosocial support and communication with HIV positive adolescents, not only to improve their care but also as a strategy to reduce stigma and discrimination.

Impact of the assessments on the use of strategic information on adolescents

A strategic information system to guide the expansion of services for most-at-risk adolescent key populations will be built with civil society partners. While not straightforward (with such difficult to reach populations), monitoring

23 UNICEF/UISR, 2016 MARA Case Studies: http://www.unicef.org/ukraine/ukr/media_10621.html).

access to quality services through U-Report and other means will be expanded as part of strengthening knowledge management. To help create and sustain an enabling environment for interventions with such a highly vulnerable population, UNICEF will help design and promote strategies to combat negative attitudes in society and among service providers on MARA, breaking down stereotypes and pre-conceived attitudes.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

An innovative online application featuring a virtual-reality sexual encounter between two adolescents was developed as part of efforts to promote safer sex and HIV testing among adolescents in Ukraine. This innovation has generated curiosity and motivated more than 100,000 adolescents to seek information on HIV and/or a HIV test.

Through participatory engagement with adolescents, Ukraine developed a highly innovative application for mobile phones, designed to increase adherence to ARV treatment among adolescents living with HIV. The highly creative app, developed by HIV positive adolescents, is currently being tested and will be available to any adolescent who may need support.

Adolescents living with HIV have also been involved in the youth committee that is shaping U-Report in Ukraine. U-Report currently engages with more than 25 000 U-Reporters, of which 50 per cent are aged 14-19. About a quarter of questions asked through the U-Report platform have a direct connection to issues of HIV, including aspects related to knowledge, stigma, tolerance and gender issues.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

Advocacy focused on the integration of issues of adolescents, including most-at-risk adolescents from key populations within national AIDS response programme planning for 2018-2022.

Successful advocacy also included testing and treatment, including optimization of treatment regimens, to move towards fixed dose combination treatment as recommended by WHO.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. **Context matters**: HIV programmes need to understand and be nested in the realities of adolescents' lives. Working with adolescents, particularly those who are most vulnerable to HIV and/or are living with HIV, requires an understanding of their context and overall situation and requires addressing the multiple deprivations, rights violations and traumatic experiences that many of them have been subjected to.
2. **Age matters**: Removing age-related barriers to service provision, access and uptake is critical for ensuring effective HIV prevention, care and support for adolescents.
3. **Voice matters**: Working with adolescents as partners in co-creating change is critical for ensuring that programmes are able to adequately address their needs and priorities.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. **Adolescents will need to be placed higher on the government agenda**, with predictable financing of adolescent-focused HIV prevention, testing, treatment and care initiatives, including HIV testing. In 2017, all sectors supporting ALL IN work will focus on vulnerable adolescent key populations and be strengthened through

the establishment of a coordination body that will ensure that the issues of at-risk adolescents are adequately featured in the National AIDS Response programme 2019-2022 and supported by adequate financing.

2. **HIV testing among adolescents** will be further scaled up through youth-friendly health services, as well as more systematic risk-awareness raising, counseling and testing among adolescents. A key area of improvement is access to HIV testing supplies in youth-friendly health services.
3. **A focus on the ongoing conflict**: The current political and economic situation risks reversing the gains achieved in the HIV response in Ukraine, including for most-at-risk adolescents. The conflict, internal displacement and overall difficult economic situation is resulting in increased vulnerabilities to HIV. There are numerous reports indicating increases in transactional sex, drug and alcohol use, drug trade and gender-based violence (GBV). Large population movements require additional efforts and outreach strategies to ensure that IDPs affected by HIV are able to access quality services, including uninterrupted treatment, care and support.

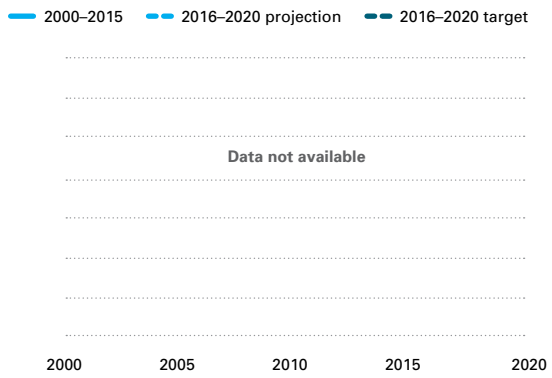
EAST ASIA AND THE PACIFIC


AIDS
TIDZBOY
DANNY

COUNTRY I **CHINA**

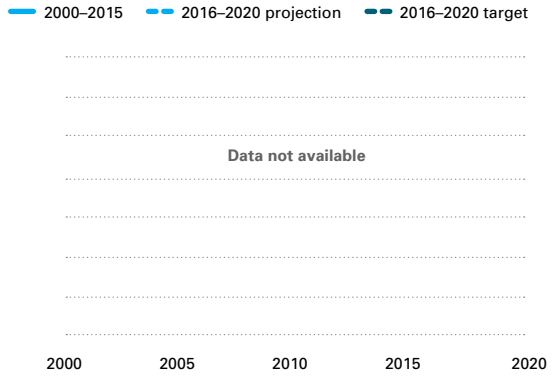
ADOLESCENT HIV TRENDS

New HIV infections among adolescents (aged 15–19), 2000–2020



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

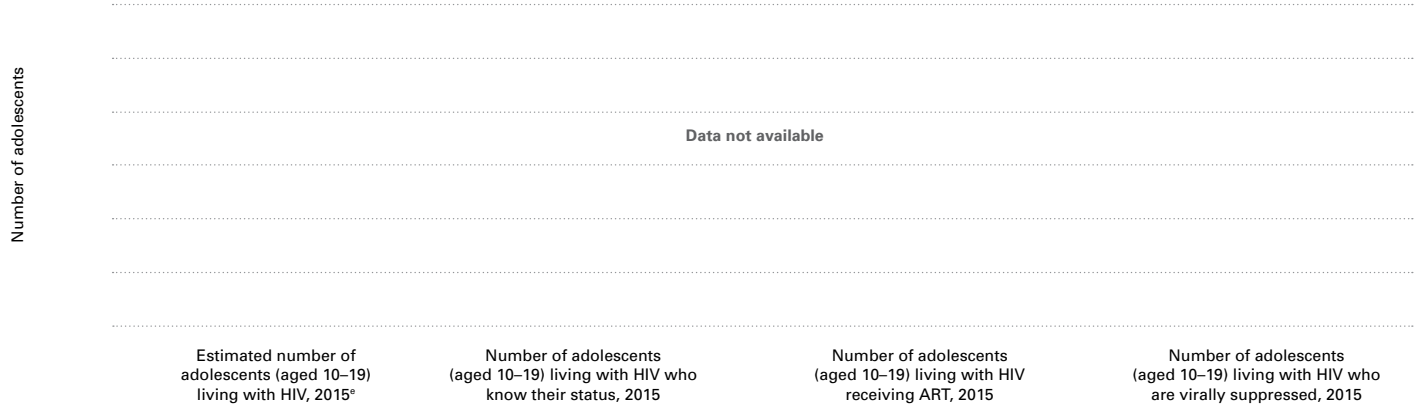
AIDS-related deaths among adolescents (aged 10–19), 2000–2020



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	1,376,000,000	667,100,000	709,000,000
	Estimated population of adolescents (aged 10–19), 2015[c]	154,200,000	71,900,000	82,300,000
	% of total population that is adolescents (aged 10–19), 2015[d]	11.2%	10.8%	11.6%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	16,900,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent	–	–	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015	–	–	–
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015	–	–	–
	Estimated HIV prevalence among youth (aged 20–24), 2015	–	–	–
	Estimated number of adolescents (aged 10–19) living with HIV, 2015	–	–	–
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015	–	–	–
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015	–	–	–
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15-19) with comprehensive, correct knowledge of HIV	–	–	–	–
% of adolescents (aged 15-19) reporting multiple sexual partners in the last 12 months	–	–	–	–
% of adolescents (aged 15-19) reporting multiple sexual partners who reported condom use at last sex	–	–	–	–
% of adolescents (aged 15-19) who were tested for HIV in the last 12 months received the results of the last test	–	–	–	–
% of adolescent boys (aged 15-19) who have been circumcised	–	–	–	–
% of adolescent girls (aged 15-19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	–	–	–	–
% of young people (aged 20-24) married or in union by age 18	–	–	–	–

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in programme planning and implementation

In collaboration with UNAIDS and other UN agencies, UNICEF is leading the development of a five-year work plan with government and civil society partners to address HIV prevention, treatment and care for adolescents at greatest risk of infection and those living with HIV. This includes actions to address service gaps, capacity needs, management, legal, policy and social barriers that most affect the response to HIV in adolescents.

Adolescent engagement has been systematically built into the work plan, with major activities to promote safer sex and demand for services linked to key dates and events.

1. Around 'Chinese Valentine's Day' in 2016, the China Centre for Health Education and partner agencies collaborated to mobilize community and youth networks online and offline, gathering views from over 5,700 young people on community action to support condom promotion and safer sex.
2. Rural summer volunteering programmes were set up to engage students in reaching out to peers in rural areas, providing safe sex education to adolescents from migrant households.
3. Over 30,000 adolescents and youth around China used games and participatory community activities to teach condom use and dispel myths about HIV. This culminated in a national-level gathering of youth representatives in August 2016 where they shared findings from the community with media and partner agencies, calling for greater engagement and support to adolescents in the AIDS response.
4. UNICEF is supporting youth networks and community-based partners to promote HIV testing among adolescent and youth at high risk of HIV. Lessons from this targeted outreach and partnership will inform further implementation and scale-up.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

UNICEF and UNAIDS kicked off ALL IN in China through a high-level Red Ribbon Forum that brought national and provincial government and community partners together in Beijing in April 2016. This national meeting was an opportunity to highlight the 'hidden epidemic' among adolescents globally, in Asia-Pacific and in China, and partners jointly identified key barriers to effective programming with adolescents. Among gaps noted were age of consent to testing and treatment, lack of clear policy briefs to guide comprehensive action by line ministries, and lack of service guidelines for programme delivery for adolescents.

UNICEF will support the government coordinating body SCAWCO and partners to conduct further policy consultation on adolescents, particularly focusing on adolescent key populations. In addition, UNESCO has taken the lead on preparing the next Red Ribbon Forum on school-based CSE.

B. PROGRAMME SCALE-UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

A rapid assessment of the adolescent epidemic and response is underway to identify programme and data gaps in older adolescents (aged 15-19) and this is set to be completed in 2017.

In the meantime, partners are supporting local evidence generation around service delivery, as well as the development of guidelines to improve quality of outreach and support.

1. In partnership with the China Association for STI/AIDS Prevention and Control (CASAPC), the technical advisory body of the Prime Minister's Social Organization Fund and National Student Fund, UNICEF is supporting demonstration projects with local government and community organizations from four cities (Chengdu,

Guangzhou, Nanjing and Tianjin), focusing on HIV prevention, promotion of testing and counseling, and access to quality treatment and care for adolescents.

2. CASAPC, the Gates Foundation, SCAWCO and UNICEF have trained youth leaders and school administrators from the National Student Fund, CDCs and community-based organizations on adolescent-friendly health services.
3. UNICEF is working with the treatment department of NCAIDS and the China CDC to develop guidelines on psychosocial support of adolescents living with HIV.
4. UNAIDS and UNICEF are supporting an evaluation of the AIDS Prevention and Education Project for China's Youth (APEPCY), a model for provision of CSE to adolescents. The evaluation report will serve as the baseline document for the next Red Ribbon Forum on comprehensive sexual education and will inform further strengthening of sexuality education within the national education system.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

With UNAIDS' technical support, Blued, the most popular MSM dating application in China, has used its reach to promote HIV testing and improve literacy and demand for other services among adolescents and young people.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

UNICEF, UNAIDS and UNFPA supported NCAIDS to hold a technical consultation with civil society partners and youth representatives to define an advocacy and communication strategy for ALL IN. Two key platforms will be used to drive advocacy, adolescent, youth and community engagement, and education on the epidemic in adolescents. They will also be used to highlight challenges and priorities in the response.

1. A Chinese language ALL IN online platform, hosted by the National Centre for the Prevention and Control of STD/AIDS of China CDC.
2. An ALL IN video series, featuring eight profiles of adolescents living with HIV, youth peer educators, health workers, young migrant girls and celebrities, has been produced and launched on Youku (a leading video website based in China). Promoted through social media, it is being used to raise awareness and engage social dialogue.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. Data collection among adolescents is still sensitive and poses a significant challenge to planning.
2. The Ministry of Education has not been fully engaged, which is a significant gap to date.
3. In a country the size of China, partnership is key to achieving scale and sustainability of an effective adolescent response. There is strong political will to support adolescent health and development, including HIV response.
4. Mobile technology can make sexual networks more 'hidden', but it is also an opportunity to develop more targeted programmes and to support outreach at a larger scale.
5. Adolescents themselves must participate in all stages of programming to ensure the programme is properly designed, delivered and measured.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

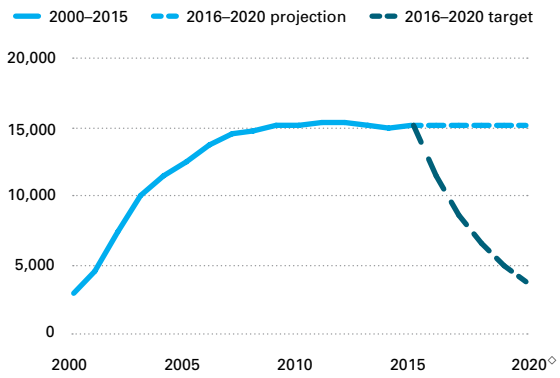
Partners have identified five priorities for the upcoming year:

1. Strengthen partnerships in the education sector and expand outreach through the education sector, targeting older adolescents where higher risk behavior is clearly indicated.
2. Strengthen collaboration with community-based organizations (CBOs) to improve social norm change, outreach and support for vulnerable adolescents.
3. Support government to improve disaggregated reporting of data to guide programming and explore innovative data collection channels, broadening the reach of current survey platforms and data resources.
4. Review and amend laws and policies that may propagate stigma and discrimination or prevent adolescents' independent access to services.
5. Strengthen capacity of local health workers and CBOs to ensure that the adolescent agenda is mainstreamed and addressed.

COUNTRY I **INDONESIA**

ADOLESCENT HIV TRENDS

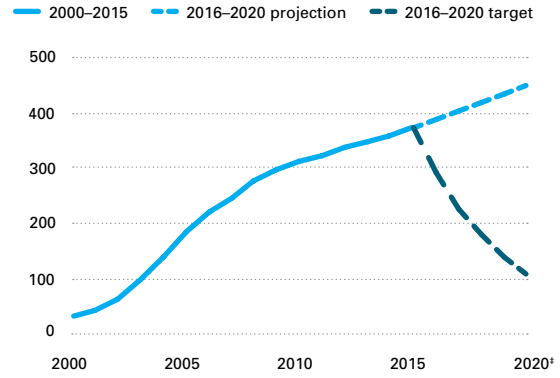
New HIV infections among adolescents (aged 15–19), 2000–2020[◇a∞]



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

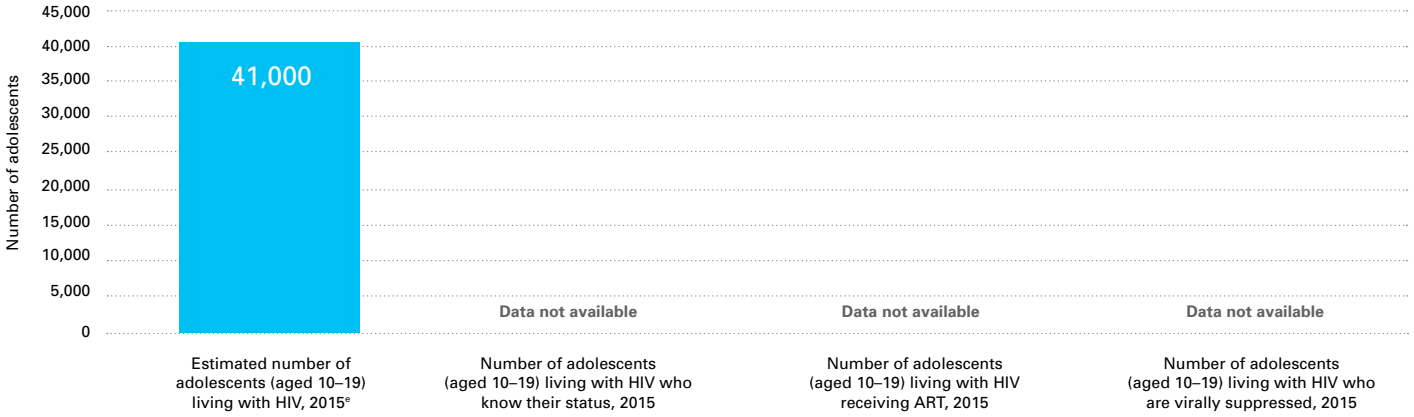
AIDS-related deaths among adolescents (aged 10–19), 2000–2020[‡b∞]



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	257,600,000	127,900,000	129,700,000
	Estimated population of adolescents (aged 10–19), 2015[c]	46,500,000	22,600,000	23,900,000
	% of total population that is adolescents (aged 10–19), 2015[d]	18.0%	17.7%	18.4%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	5,100,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[j]	–	6.5 (2012)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.0%	0.0%	0.0%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.2%	0.2%	0.1%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	0.7%	0.7%	0.7%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	41,000	25,000	16,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	15,000	8,600	6,600
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<500	<500	<200
Policy	Age of consent for HIV testing[f]	18	18	18

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15-19) with comprehensive, correct knowledge of HIV	5.7 (2007) [k]	2.1 (2007) [k]	9.4 (2012) [j]	4.0 (2012) [j]
% of adolescents (aged 15-19) reporting multiple sexual partners in the last 12 months	–	–	–	–
% of adolescents (aged 15-19) reporting multiple sexual partners who reported condom use at last sex	–	–	–	–
% of adolescents (aged 15-19) who were tested for HIV in the last 12 months received the results of the last test	–	–	–	–
% of adolescent boys (aged 15-19) who have been circumcised	–	–	–	–
% of adolescent girls (aged 15-19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	–	–	48.1 (2012) [j]	52.0 (2012) [j]
% of young people (aged 20-24) married or in union by age 18	–	–	13.6 (2012) [j]	5.3 (2012) [j]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the service delivery to adolescent key populations

Since 2015, UNICEF and UNAIDS have been supporting the implementation of a model for effective engagement and HIV service delivery for adolescent and young key populations, with funding from the Global Fund. This is the source of funding for much of the HIV work supported by non-governmental organizations (NGOs) in Indonesia.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms has been undertaken.

UNICEF is working with the Indonesian Network of Young Key Population (Fokus Muda) to implement a demonstration project called LOLIPOP (Linkages of Quality Services for Young Key Populations) that will now expand from the initial location (Bandung City) to three further sites (Surabaya, Denpasar, and West Jakarta), with additional resources mobilized from the Global Fund to strengthen service delivery to adolescent key populations. In Bandung, to address the barrier created through the legal requirement for parental consent, agreement has been secured for health services to provide testing to adolescents younger than 18 years, based on consent provided by an NGO serving in the role of a guardian.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

A baseline study, secondary data analysis and a review process have been conducted in Bandung.

The key findings from the baseline study and review process were:

1. High reported sex among young key populations
2. Low levels and inconsistent condom use among male partners of young key populations
3. Low ART coverage and poor retention among adolescents and young people
4. A predominantly online strategy for outreach only reached young MSM and not other adolescent and young key populations
5. Low treatment literacy

Key findings from the secondary data analysis on adolescents and young key populations in Bandung include:

1. Low HIV comprehensive knowledge
2. Low condom use
3. Low HIV testing
4. Treatment data not easily available

Furthermore, based on this assessment, it is now widely acknowledged that information on adolescents is lacking, despite its availability in IBBS and the routine data.

Progress in implementation of priority actions identified through assessments

Health services and outreach workers in Bandung, West Jakarta, Surabaya, and Denpasar were trained to make services more sensitive and responsive to the needs of adolescents and young key populations.

To strengthen and build on the success of outreach to adolescents and young MSM, both online and offline outreach strategies and tools have been developed by the Indonesian Network of Young Key Population (YKP) to support treatment literacy efforts, demand creation and support for adolescents and young key populations.

Impact of the assessments on the use of strategic information on adolescents

A data analysis workshop is planned for early 2017 to build capacity for routine data analysis on adolescents and HIV. Participants will include representatives from district and provincial levels and from the national health office.

The data analysis efforts in Papua and West Papua have been used to guide the development of the adolescents strategy.

UNAIDS provided technical assistance to the Ministry of Health in collaboration with UNICEF to provide HIV projection data among young people (aged 15-24) using Spectrum. The information has been used together with findings from the assessment for better planning.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

Online platforms have been widely employed, amid increasing use of the internet and mobile phone. A preliminary evaluation of these has found the following:

1. Social media. There has been a clear growing trend in the use of this for adolescents and young people, who respond well to graphics and animations and less enthusiastically to compound or complex messages or Twitter.
2. Online counseling. While this has increased in use, adolescents and young people report frequent and lengthy delays as they await responses. Users find online counselors much better able to address general queries than health and psychosocial problems.
3. SMS-based referral. This has not yielded any referral cases. It is thought this could be because users have preferred sites for various services instead of those recommended via SMS.

UNAIDS and other UN partners supported the Indonesia AIDS Coalition to develop the iMonitor+ website to provide users with information about testing sites and treatment provision, as well as other health services. Details on the site include facilities at the lowest sub-national level.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

1. Prioritization of adolescents and young key populations in all relevant policy and strategy development.
2. Resource mobilization for programming for adolescents and young key populations, including through the Global Fund, to sustain ongoing initiatives in three priority implementation areas (Surabaya, Denpasar, and West Jakarta).
3. Ensure that the national initiative for strengthening adolescent-friendly health services fully integrates considerations for adolescent and young key populations as it rolls out.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

There is a need for strengthening age and sex disaggregated data on adolescents and YKP through secondary data or in-depth analysis.

There is also a need to develop a comprehensive framework for adolescents and YKP programming through better linkages among available services and key stakeholders (health, education, child protection).

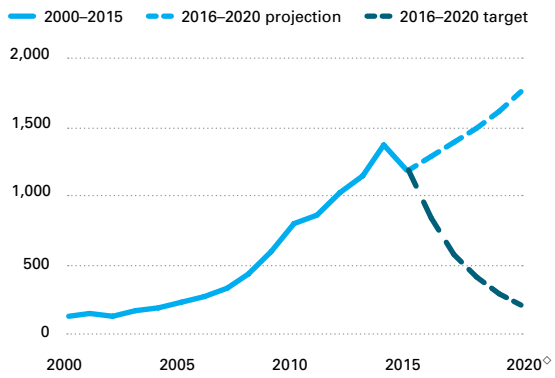
F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. Strengthen age and sex disaggregated data on adolescents and YKP through secondary data and in-depth analysis.
2. Develop a comprehensive framework for adolescents and YKP programming for each priority sub-national area.

COUNTRY I **PHILIPPINES**

ADOLESCENT HIV TRENDS

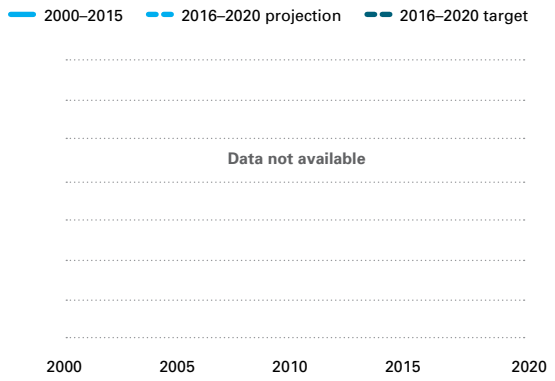
New HIV infections among adolescents (aged 15–19), 2000–2020[◇a∞]



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

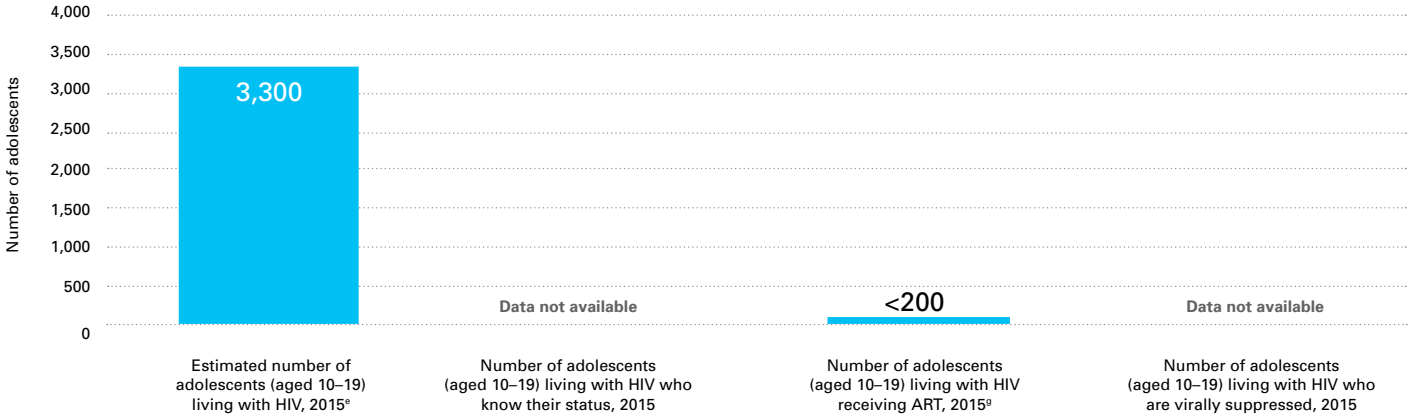
AIDS-related deaths among adolescents (aged 10–19), 2000–2020[λb∞]



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	100,700,000	49,900,000	50,800,000
	Estimated population of adolescents (aged 10–19), 2015[c]	20,400,000	9,800,000	10,600,000
	% of total population that is adolescents (aged 10–19), 2015[d]	20.2%	19.7%	20.8%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	2,300,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent	–	–	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.0%	0.0%	0.0%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.0%	0.0%	0.1%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	0.0%	0.0%	0.0%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	3,300	<500	2,900
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	1,200	<200	1,000
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<100	<100	<100
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15-19) with comprehensive, correct knowledge of HIV	18.7 (2008) [l]	–	–	–
% of adolescents (aged 15-19) reporting multiple sexual partners in the last 12 months	–	3.0 (2003) [m]	–	–
% of adolescents (aged 15-19) reporting multiple sexual partners who reported condom use at last sex	–	34.0 (2003) [m]	–	–
% of adolescents (aged 15-19) who were tested for HIV in the last 12 months received the results of the last test	0.1 (2008) [l]	–	<0.1 (2013) [n]	–
% of adolescent boys (aged 15-19) who have been circumcised	–	–	–	–
% of adolescent girls (aged 15-19) who have ever experienced sexual violence	5.1 (2008) [l]	– [l]	4.4 (2013) [n]	–
% of youth who have completed secondary school	–	–	–	–
% of young people (aged 20-24) married or in union by age 18	–	–	15.0 (2013) [n]	–

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision-making

As early as 2008, the Philippines set up mechanisms to ensure meaningful youth engagement in the HIV response, conceived through the first National Young People's Planning Forum (NYPPF). More than 50 adolescents and young people gathered to provide recommendations for the Operational Plan of the then 4th Philippines AIDS Medium Term Plan. This aims to ensure that young people's perspectives are adequately integrated into the national AIDS response and public policy decisions. Since then, NYPPF has become the vehicle to institutionalize young people's participation, especially in defining national AIDS response strategies such as:

1. Multi-sectoral engagement and capacity building
2. Meaningful and ethical participation of young people
3. Child protection
4. Coordination
5. Harmonization
6. Establishing indicators for monitoring progress and structure for youth participation

The National Committee for Children and Young People on HIV (NCCYPHIV) is composed mainly of youth leaders and advocates, representing various organizations across the country. The Committee reflects the Government of the Philippines' commitments and obligations for children's civil rights and civic engagements. As a State Party to the UN Convention on the Rights of the Child, the Committee pursues the continued and sustained "ethical participation of children and young people in development concerns affecting their welfare."

In 2013, the NCCYPHIV obtained funds to implement the ACT!2015 project and support the formation of the Philippines ACT!2015 Alliance. While it appears NCCYPHIV builds on ACT!2015, it opens the door for a new generation of adolescent and youth leaders from non-HIV-focused youth organizations to become part of a consultative and recommendatory body.

To date, the Philippines ACT!2015 Alliance is actively working with the Commission on the Welfare of Children and the Philippine National AIDS Council in convening adolescents and young people, as well as leading the design and development of the youth consultation to develop the 6th AIDS Medium Term Plan 2017-2022.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

The challenge of providing adolescent reproductive health services has been compounded by the decisions of the Supreme Court on the constitutionality of Republic Act 10354 or the Responsible Parenthood Reproductive Health Law. Based on a decision in April 2014, government clinics can provide sexual and reproductive health services (specifically FP Methods) to adolescents below the age 18 only if they are accompanied by a parent or guardian. This was anchored on the primary right of parents over a child, which is enshrined in the Constitution. It is this 'primary right' that is now being extended to cover other RH services, e.g. HIV testing. Given that most adolescents would not want their parents to know about their sexual activities, this provision in the RP-RH law is clearly a barrier to accessing health services. In response, policy discussions have been held among stakeholders, which have highlighted the role of non-government clinics in providing services to adolescents under 18. Likewise, Republic Act 8504, known as the National AIDS Prevention and Control Law, requires that young people below the age of 18 who wish to undergo HIV testing should have the written consent of their parent or guardian.

Through the pro-active lobbying of CSO partners and with technical guidance from UNICEF and UNAIDS, DSWD issued a paper on the AIDS Bill, which proposed lowering the age of HIV testing to 15 without the need for parental consent. In support of proposals like these from civil society and government to amend the law, young people are being prepared to engage in policy advocacy to ensure that new laws will facilitate access to services, especially in UNICEF-supported demonstration sites. Progress has been made in high burden cities such as Zamboanga and Iloilo, where regulation related to SRH and HIV is undergoing review. Memorandum of Agreements (MoAs) with

local government units have also been secured to improve access to life-saving information and quality of services for adolescents at risk of HIV and pregnancy. Recently, the local government of Quezon City was the first to amend its local HIV ordinance to address these needs, only requiring written parental consent from an individual taking a HIV test if the person is below 15 years of age. The amended ordinance was based on government, CSO and UN-endorsed provisions, and specifies conditions under which the HIV testing shall be made available to a minor requesting the services.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

In October 2015, member organizations of the NYPPF, NCCYPHIV, and Philippines ACT!2015 Alliance were brought together by government agencies to plan a national strategy for adoption of the ALL IN agenda. Subsequently, in 2016, the Department of Health, local government units, UNICEF and UNAIDS, Save the Children, other UN agencies, civil society, youth organizations, and key adolescent populations collaborated to undertake a comprehensive adolescent-focused assessment.

A framework to enhance YKP interventions was developed with partners such as UNICEF, UNAIDS, STC, and other youth advocacy groups, beginning in January 2016. The primary action was to call a stakeholders meeting – engaging them to facilitate broader buy-in from local stakeholders, develop partnerships to aid the assessment, and establish a commitment to utilize the data from the assessment to plan for appropriate YKAP interventions in their city.

In the assessment phase, four methods were used to gather data:

1. A descriptive analysis conducted in late 2015, leading to development of an advocacy briefer specifically for YKAP to raise awareness of the increasing problem among youth.
2. In-depth, disaggregated analysis of IHBSS data to better understand the factors contributing to increasing HIV cases among young people in the country, specifically finding answers to the following questions:
    a. What was putting adolescents at risk so early? Were the risk factors different in each city?
    b. Was there a pattern among sub-groups, such as those in high school, college or those not in schools?
    c. Was the male-identifying sub-group more or less at risk as the female-identifying group?
    d. What are the things already being done in each city and the intervention gaps on HIV information dissemination, condom distribution, HIV testing, and treatment?
3. Key informant interviews among young MSM, including 60 respondents in each city around sites known to have hotspots.
4. A youth-friendly focus group workshop.

To keep activities fun and engaging, a slam book was used as a tool to effectively collect qualitative data from young people. Such books are popular in the Philippines, encouraging young people to note down personal information and help them socialize. In this case, the books helped gather personal information on perceptions and practices related to relationships and sexual behavior, with a view to understanding HIV risk.

Findings:

1. Only 1 in every 5 young MSM in Quezon City and Cebu answered the five basic HIV questions correctly. Their most common sources of information were television and friends.
2. The assessment clearly showed that there is untapped potential in the form of schools. Although 7 out of 10 young MSM were in school, few got HIV information from the classroom, even though HIV is part of the Grade 8 Health curriculum. Among the reasons for this were:

   a. No formal training on HIV is currently on offer to teachers
   b. School textbooks have outdated information on HIV
   c. Some teachers were not comfortable discussing the topic, which led to them skipping the lesson altogether or referencing it very briefly
3. Data from previous IHBSS showed that condom use is generally low in the country. While every round of the IHBSS shows a 2-3 per cent increase, it remains low at only 48 per cent among young MSM. Around half of young MSM did not use a condom in Queszon City and in Cebu, citing unavailability of condoms as their primary reason for having unprotected anal sex. This reason was provided most frequently by young MSM in high school. However, aside from making condoms available, data shows that there is also a need to increase proper condom use skills among young MSM since none of the workshop participants demonstrated correctly, despite their knowledge that condoms protect against HIV.
4. Case reporting data from these two cities suggests that 67 per cent of PLHIV aged 20 and above have been diagnosed, compared with only 2 per cent of adolescents aged 15-17. In the Philippines, people below the age of 18 need parental consent to be tested for HIV. However, although people aged 18-19 can be tested voluntarily, HIV diagnosis in this age group is just 19 per cent. The primary reason for not getting tested in Cebu was a lack of time, while young MSM in Quezon City feel no need to get tested.
5. Overlooking young PLHIV in the first step of HIV diagnosis, as well as in education on HIV testing and treatment, also leads to low demand and treatment coverage. In fact, ART literacy is only around 2 per cent among young MSM.

Progress in implementation of priority actions identified through assessments

Key assessment findings were presented to stakeholders, facilitating buy-in and commitment to YKAP interventions. The second phase used the assessment findings per city as a reference to develop evidence-based strategies for YKAP interventions. Priority actions that were identified and are now being implemented include:

1. In Quezon City, a comprehensive prevention strategy among YKAP was pilot tested, with the aim of increasing knowledge, access to testing and condoms. This includes integrating better quality HIV discussions in school through Grade 8 health classes, using the supplementary reference material in four pilot schools. The reference material was developed through the Division of City Schools, Quezon City Health Department, Department of Health, UN agencies, and other civil society and youth groups.
2. Science and MAPEH teachers, including guidance counselors, were trained in using these reference materials and oriented on the basic topics of HIV and AIDS, since the assessment indicated a need to address uneasiness around discussing such topics.
3. High school teachers were also oriented in conducting risk assessment using a standardized self-administered questionnaire, conducting referrals for counseling and providing information on where to access condoms and free HIV tests.

Impact of the assessments on the use of strategic information on adolescents

Using strategic information, the Quezon City Health Department lobbied for an accelerated HIV response in Quezon City. Through three social hygiene clinics and three sundown clinics in strategic locations in the city, and with support from partners and the community, Quezon City is improving HIV testing, targeting adolescents and young MSM.

In Cebu City, the City Health Office is now providing HIV education to parents during Parent and Teachers Association (PTA) assemblies, emphasizing the issue of consent for HIV testing in adolescents. Lessons learned have paved the way for service delivery networks that link at-risk youth in schools with communities and health service providers.

In other areas supported by UNICEF, where the integrated SRH and HIV service delivery for adolescents is already being modeled (Iloilo and Zamboanga cities), promising results are emerging.

1. In 2016 alone, the number of adolescents accessing services in IP facilities or activities at community level has risen from an average of 3 adolescent clients to 83 clients per month. This includes 40 adolescents accessing HIV

testing, 22 pregnant teenagers visiting antenatal care services, 18 adolescents receiving medical treatment, and 3 adolescents accepting family planning counselling and commodities.

2. UNICEF and DOH-Epidemiology Bureau (DOH-EB) are collaborating to build on their experience with assessments to develop a video-based toolkit. This will make it easier for cities requiring technical assistance to understand the processes entailed in conducting the same exercise, as well as the resources and preparations required.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

The use of slam books is being expanded, not only to collect qualitative data but also to improve demand and linkage to services, as well as monitoring those received by adolescents.

The YKP brief developed through the DOH-Epidemiology Bureau and UNICEF has been shared through social media, and an improved communication strategy for adolescents and key populations is being developed. This will integrate infographics to summarize findings from the assessment and incorporate multiple mobile and social media tools to reach adolescents and young key populations.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

Partnerships, including the engagement and collaboration of young people in the assessment and national adaptation of the ALL IN agenda, have been critical to progress made to date. Some important steps taken in the form of advocacy or as a result of advocacy include:

1. The local health board of Quezon City has approved use and funded the printing of revised HIV Reference materials for Grade 8 students in 47 high schools over the next school year. This move reflects greater local government awareness of unique programme considerations, as well as accountability for outcomes in adolescents and young key populations.
2. HIV is now clearly integrated within the comprehensive Adolescent Health and Development Programme (AHDP) of the Department of Health. An M&E plan is being developed, based on the AHDP Manual of Operations, to ensure that indicators for adolescent health, including HIV, will be monitored through social hygiene clinics and become a priority to be reported on regularly by the regional adolescent health coordinators.
3. These efforts have resulted in increased investment in joint capacity building around adolescent-friendly health services (AFHS) by social hygiene clinic staff, school guidance counselors, health teachers, doctors and nurses. Training on AFHS has been facilitated using a video-based toolkit on practical adolescent health service delivery called 'ADEPT'.
4. Further financial and technical support on quality of services for adolescents has been successfully planned with the Department of Health and is scheduled to be provided by the UNICEF regional office in 2017 in support of nurses involved in the care of adolescents living with HIV.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

Lessons learned from ALL IN strengthen the evidence that engagement with young people and multi-sectoral stakeholders, along with broad representation during assessments and planning, are essential components of evidence-based programing. Specific lessons include:

On building partnerships, understanding the need to involve the local government in all processes is the best

assurance of their ownership of the program. Likewise, engaging young people and other stakeholders makes the task easier and more productive. Youth-focused organizations, including non-government agencies, can be important allies when working with a diverse range of young people.

On the methodologies, identifying good practices and bottlenecks, as well as validating the results of existing findings and data, informs future plans. Innovation is also welcome, especially that which targets participation by those most affected.

On the planning, the following are recommendations to consider:

1. Form a core group that discuss the findings and their possible implications
2. Engage youth in planning to ensure age-appropriate interventions
3. Invite decision-makers from different sectors as participants
4. Present key assessment findings to stakeholders in order to facilitate buy-in and commitment to YKAP interventions
5. Use the Force Field Analysis as an effective planning tool
6. Maximize existing opportunities for YKAP interventions (e.g. school, local communities, NGOs)
7. Facilitate the collaboration of different stakeholders towards unified YKAP interventions

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

Modest progress has been made towards implementing recommendations from the assessment.

On the corrective actions to address bottlenecks and data gaps. The new administration puts a premium on restoring security and order nationwide, and the President has vowed to impose a national curfew for minors and a crackdown on illegal drugs. This has affected the planned IHBSS, with difficulties anticipated in meeting the required number of minors to participate in surveillance at night. In addition, these activities at night pose a threat to the security of teams undertaking surveys, potentially affecting the quality of results.

LGUs are not yet fully utilizing the recent IHBSS data. In response, DOH-EB and UNICEF are developing video-based technical guidance on bottleneck analysis and strategic planning for LGUs, CSOs and youth groups. This will encourage in-depth data gathering and on-site testing at priority sites.

On the capacity building and demand generation. Upstream work includes endorsement of the HIV Reference Manual for Teachers by the Department of Education, as part of the nationwide implementation of CSE. The manual could potentially benefit around 2 million Grade 8 students[24], assessing their knowledge and increasing awareness of basic HIV topics. To ensure success, harmonizing teacher training on HIV is crucial, as is building their capacity to conduct basic sexual risk assessments, integrate prevention and protection to HIV lessons, and refer to adolescent-friendly health facilities. Likewise, support to build the capacities of health care providers, social workers, teachers and guidance counselors using the e-learning toolkit ADEPT will be continuously leveraged to national agencies and local government unit. Downstream work includes the assistance of UNICEF and other stakeholders on the different models of Service Delivery Network for Adolescents, as well as a conduct of review to inform strategies that strengthen linkages from school to community.

On the advocacy. Evidence generated through initiatives such as in-depth bottleneck analysis and community and school-based interventions for adolescent key populations will be used both for legislative advocacy and programmatic review. New partnerships will be established to support a network of youth leaders and advocates on SRH and HIV, encouraging innovation and participation in legislative discussions that work towards amending AIDS and RPRH law.

24 Estimates based on the Policy Note of the Philippine Institute for Development Studies, 2015

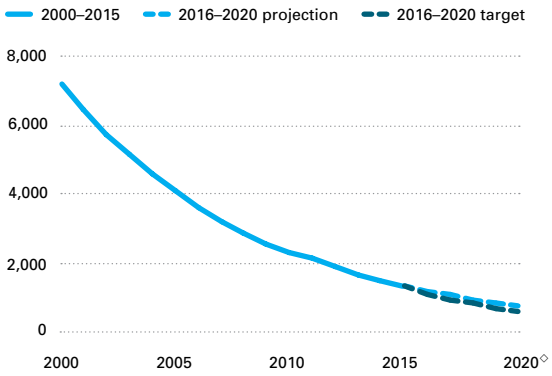
Lessons learned as a result of engaging young people in ALL IN indicate that the priority is removing barriers to HIV testing and improving access to SRH services, especially for minors.

Phase 4 (Evaluation) of ALL IN will be conducted by the last quarter of next year in order to evaluate the effectiveness of the strategies implemented.

COUNTRY I **THAILAND**

ADOLESCENT HIV TRENDS

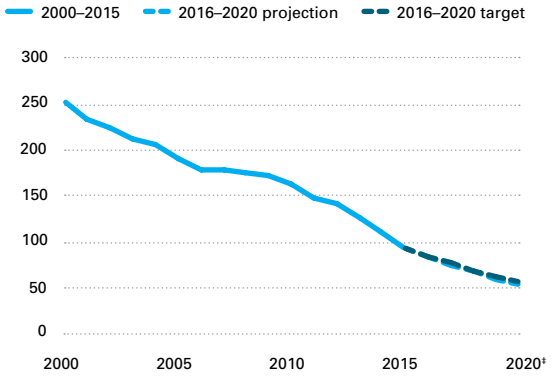
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

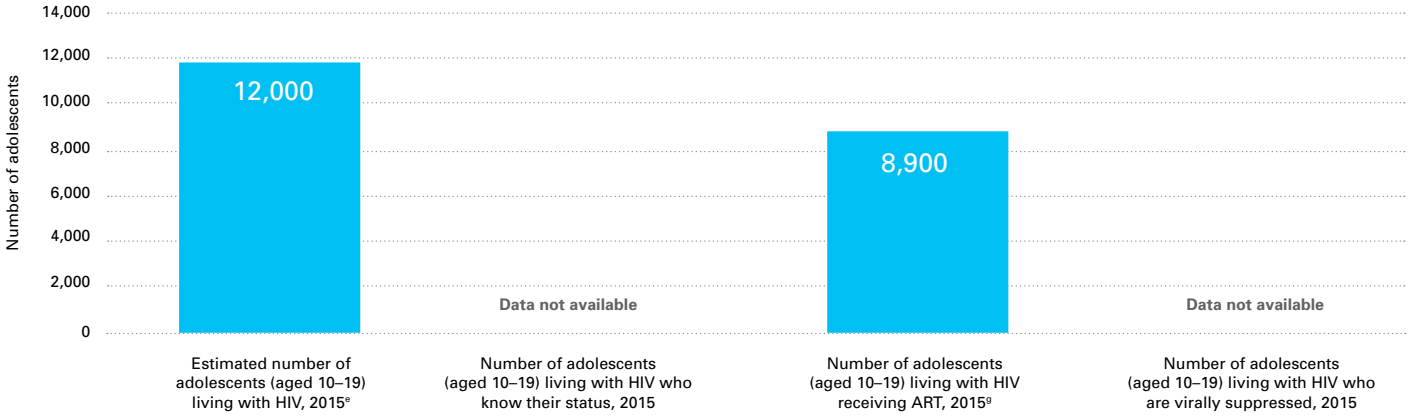
AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	68,000,000	34,500,000	33,500,000
	Estimated population of adolescents (aged 10–19), 2015[c]	8,600,000	4,200,000	4,400,000
	% of total population that is adolescents (aged 10–19), 2015[d]	12.7%	12.3%	13.0%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	750,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[o]	–	13.0 (2012)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.1%	0.1%	0.1%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.2%	0.2%	0.2%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	0.5%	0.4%	0.5%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	12,000	6,000	5,800
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	1,300	<1,000	<1,000
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<100	<100	<100
Policy	Age of consent for HIV testing[f]	None	None	None

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15-19) with comprehensive, correct knowledge of HIV	46.0 (2007) [p]	–	56.9 (2012) [o]	–
% of adolescents (aged 15-19) reporting multiple sexual partners in the last 12 months				
% of adolescents (aged 15-19) reporting multiple sexual partners who reported condom use at last sex	–	–	–	–
% of adolescents (aged 15-19) who were tested for HIV in the last 12 months received the results of the last test	–	–	7.1 (2012) [o]	–
% of adolescent boys (aged 15-19) who have been circumcised	–	–	–	–
% of adolescent girls (aged 15-19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	–	–	57.7 (2012) [o]	51.7 (2012) [o]
% of young people (aged 20-24) married or in union by age 18	–	–	22.1 (2012) [o]	–

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

In Thailand, UNICEF works with an adolescent reference group, existing adolescent networks and online platforms such as I-Used (developed through NGO partnership) and 'U-Report'. In 2016, UNICEF Thailand worked with adolescents through these mechanisms to support development of a proposal for PrEP introduction for adolescents, development of the country programme of cooperation (CPD 2017-21), an adolescent situation analysis and a review of the CSE implementation plan.

A national partnership is in place to support empowerment of a network of adolescents and youth living with HIV/AIDS.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

1. UN agencies and partners are members of a national strategy development sub-committee. Through this, evidence has been generated with analysis of data on HIV prevalence and related risk factors. The evidence was used to promote the adolescent component in the National Strategy Plan and further the End AIDS Plan 2030.
2. Thailand passed a new act for prevention of adolescent pregnancy through a multi-sectoral approach to SRH. As sub-committee members, UNICEF and UNFPA have used evidence generated through a 2015 analysis of teenage pregnancy to influence the national policy and strategy for prevention of teenage pregnancy.
3. UNICEF is providing technical and financial assistance to the Ministry of Public Health to adapt and strengthen results-based planning on adolescent health, using an Adolescent Country Tracker tool to monitor levels of adolescent health (SRH, HIV and mental health) and wellbeing.
4. The Bureau of Reproductive Health in the Ministry of Public Health has partnered with UNICEF to develop a web-based surveillance system and database to track and communicate about teenage pregnancy.
5. UNICEF is working with the Biomedical Subcommittee to incorporate PrEP for older adolescents in the national service package.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

Following the UNICEF EAPRO Data Analysis Workshop in May 2015 and subsequent discussions, UNICEF Thailand partnered with the Department of Disease Control in the second quarter of 2016, completing a rapid assessment of available data on adolescents and young key populations. They will now work with the National AIDS Management Committee and UNAIDS to consolidate data for older adolescents.

Thailand is facing a concentrated HIV epidemic among young key populations, which are at higher risk of HIV exposure. Particular effort needs to be invested in reaching younger MSM, especially those who have moved to the capital from outside Bangkok.

There are indications that the highest risk of acquiring HIV is associated with young people's participation in MSM parties involving alcohol and recreational drugs. Detailed findings have been consolidated into a brief overview entitled 'HIV prevalence and related risk, knowledge, testing and treatment among young key populations (aged 15 to 24) in Thailand' which summarizes existing gaps, as well as opportunities for strengthening the data in the national response.

In addition to supporting the assessment, UNAIDS has assisted partners to better understand the HIV epidemic in Bangkok, using a simple and less expensive method to estimate HIV incidence among young MSM.[25] This method

25 Osmond's algorithm for behavioural imputation published in 1994. This has now been tested and validated for use in Thailand.

has been implemented using IBBS data collected among YMSM under the age of 21 in Bangkok from 2003-2014. Results reveal that HIV incidence among YMSM in IBBS is high, increasing from 4.1 in 2003 to 7.6 per 100 person-years (PY) in 2014.

Progress in implementation of priority actions identified through assessments

UNICEF Thailand has secured funding for a demonstration project aimed at enabling the scale up of PrEP and linkage to testing among sexually active older adolescents. In addition to providing comprehensive and targeted HIV prevention support, the learning from this project will feed into global knowledge on HIV prevention. It will be implemented in collaboration with UNAIDS, WHO, technical and academic agencies, community-based organizations, and other local and provincial agencies such as public health facilities.

To address the lack of age disaggregated estimates for the MSM population, UNICEF and UNAIDS will support the Ministry of Public Health and CSO stakeholders in completing a mapping of MSM/YMSM in 2016-17.

Impact of the assessments on the use of strategic information on adolescents

New evidence on HIV incidence has informed the development of the National AIDS Strategy 2017-2030 and Bangkok AIDS Strategy 2017-2030. Both now feature specific strategic approaches and interventions for young people and adolescents, including MSM - males who have sex with males; TG - trans gender men; MSW - male sex worker.

Tailored interventions targeting YMSM have been included in the 2017 Bangkok Operational Plan to End AIDS.

Following rapid assessment in March and April 2016, a further in-depth assessment of data on adolescents and HIV is being planned in 2017.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

A demonstration project is being implemented in partnership with national NGOs with the aim of promoting online access to information and service linkages. UNICEF is also in the process of scaling up U-Report (using the rapid-pro platform) to empower, as well as engage, adolescents and youth in social monitoring and advocacy.

UNAIDS has supported the partnership of SWING (MSW CBO) and Bangkok Metropolitan Administration (BMA) in adopting iMonitor+, an application that works as a participatory real-time tool to give a voice to communities of key populations. Currently, the use of iMonitor+ in Bangkok is managed by BMA. The implementation of iMonitor+ was also expanded to Payao.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

1. Age disaggregated data for tracking results
2. Policy advocacy including PrEP for older adolescents in the national service package for HIV prevention
3. Expanding the reach and scaling up of innovative interventions effectively engaging YMSM
4. Maintaining inclusive platforms for policy dialogue and action planning

As a result of joint advocacy, Bangkok Metropolitan Administration supported the establishment of an inclusive platform to bring together all key actors involved in the response to the HIV epidemic among MSM/YMSM. This work resulted in strengthened partnerships, improved coordination, and preparation and endorsement of a unified action plan that consolidates the efforts of government, CSO and communities in Bangkok.

UN agencies (UNICEF, UNAIDS, UNFPA, WHO and UNESCO) are working closely with community-based organizations, youth and PLHIV networks to advance the agenda of adolescent sexual health.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

- Participation of adolescents, especially ALHIV, remains a challenge due to confidentiality, anonymity and identity.
- Adolescence is an important age group which needs focused investment. It continues to be a challenge in this high middle income, concentrated epidemic setting.
- Declining financial resources available from partner agencies present another challenge in sustaining programme efforts and leveraging existing gains made by the country.
- Evidence for action is critical, serving as a catalyst to accelerate responses for adolescents and young key populations.
- Mega cities should receive priority attention in the context of ALL IN.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

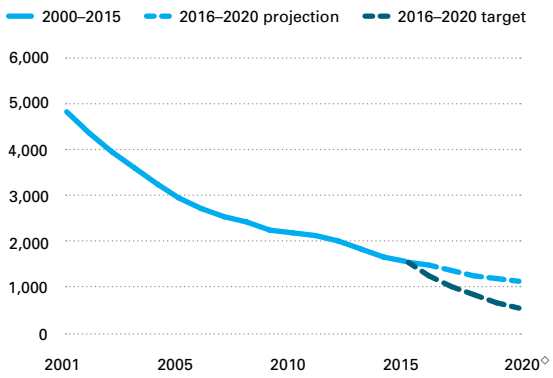
1. In-depth analysis of available data on adolescents and HIV.
2. Demonstration and scale-up of a HIV prevention package, including development strategies to support early access to SRH, HIV testing and prevention such as PrEP.
3. Improved adolescent participation.
4. Advocating for innovative interventions that are tailored to reach and meet the specific needs of young MSM in priority provinces.
5. Development of an MSM investment case, with particular emphasis on young MSM.
6. Paying particular attention to young key populations in e-learning modules on reducing stigma and discrimination (currently under development).

EASTERN AND SOUTHERN AFRICA

COUNTRY I **BOTSWANA**

ADOLESCENT HIV TRENDS

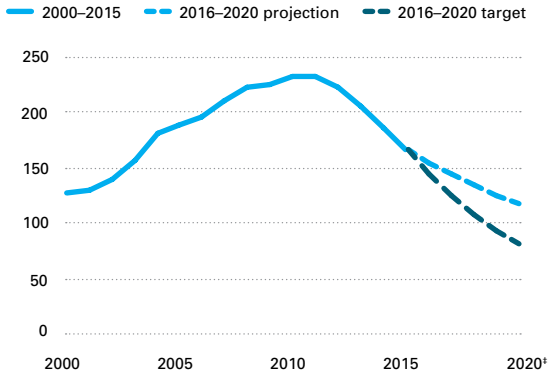
New HIV infections among adolescents (aged 15–19), 2000–2020[◇a∞]



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

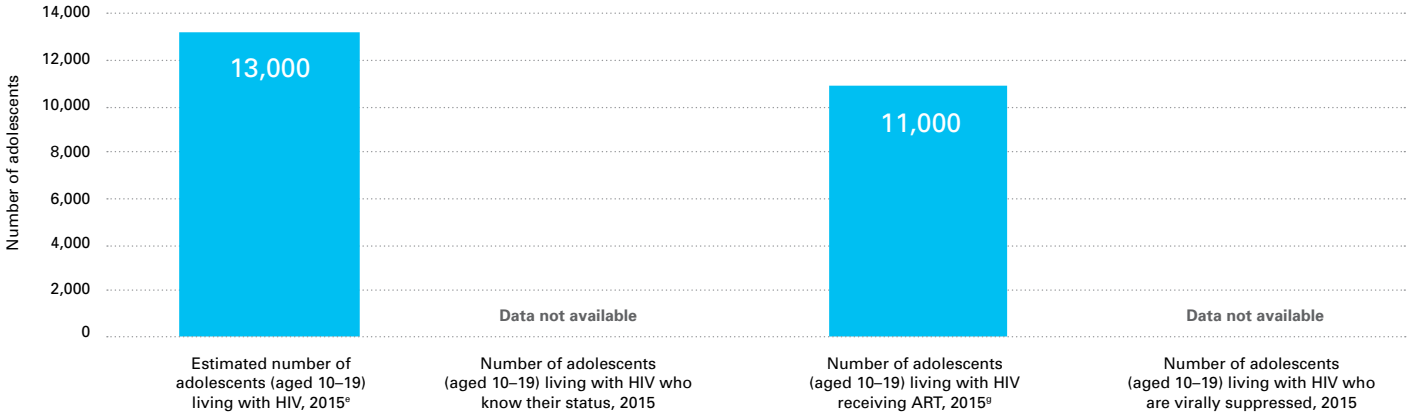
AIDS-related deaths among adolescents (aged 10–19), 2000–2020[‡b∞]



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	2,300,000	1,100,000	1,100,000
	Estimated population of adolescents (aged 10–19), 2015[c]	440,000	220,000	220,000
	% of total population that is adolescents (aged 10–19), 2015[d]	19.5%	19.3%	19.6%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	55,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent	–	–	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	1.9%	1.9%	2.0%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	4.1%	5.6%	2.6%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	9.0%	13.1%	4.9%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	13,000	8,200	5,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	1,600	1,300	<500
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<200	<100	<100
Policy	Age of consent for HIV testing[f]	16	16	16

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	–	–	–	–
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	2.4 (2008) [q]	1.1 (2008) [q]	–	–
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	–	–	–	–
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	–	–	–	–
% of adolescent boys (aged 15–19) who have been circumcised	–	5.7 (2008) [q]	–	–
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	–	–	–	–
% of young people (aged 20–24) married or in union by age 18	–	–	–	–

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

Adolescents participated in both the rapid analysis and in-depth analysis phase of the country assessments, and were engaged in the development of the National Programming Framework for Adolescents and Young Adults in Botswana 2016-2020.

Key outputs:

- Two consultation meetings with adolescents and ALHIV were conducted prior to the ALL IN national validation meeting.
- Active participation of adolescents in the phase one validation meeting, including co-chairing sessions with UN and government partners.
- Qualitative survey and focus group discussions with adolescents were conducted as part of the phase two district level in-depth analysis.
- Continued adolescent participation in the ALL IN thematic working groups and validation exercises.
- Strong adolescent input and participation in development of the National Programming Framework for Adolescents and Young Adults in Botswana 2016-2020.

Through all these processes, adolescents provided their perspectives, helped to identify bottlenecks to improve service delivery, and made recommendations on how they can be further engaged, as well as the role they can play in preventing new infections. Adolescents participating in the stakeholder analysis of the enabling environment gave favourable ratings to the areas of adolescent programme coordination, legislation, resource allocation and mobilization, but extremely poor ratings to the areas of adolescent consultation and participation.

Additionally, adolescents continue to be engaged through specific implementation efforts of CSOs and other youth-focused organisations. The challenge remains in moving particpation and engagement into policies and programmes, and finding substantive ways for adolescents to be more involved in how information, support and services for adolescents are delivered.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

Nationally, there have been significant efforts to improve policies and laws governing access to HIV and SRH services for adolescents in Botswana. These include:

- The UNFPA and UNAIDS HIV and SRH linkages project provides a number of integrated services, including SRH (e.g. family planning, safe motherhood and cervical cancer screening) and HIV (e.g. testing and counseling) services.
- Launch of 'Treat All' (Test and Treat) as the national testing and treatment strategy in 2016. Adolescents and key populations are priorities for the programme.
- National Programming Framework for Adolescents and Young Adults in Botswana 2016-2020.
- The MoH/UNAIDS Investment Case, with strong support from UN, highlighted adolescents and youth as the number one priority for HIV prevention.
- Public health law defines that adolescents aged 16 years and above do not need parental or guardian consent for HIV testing.

Additional policy and programming progress has been demonstrated in:

- Reduction of age of consent to HTC from 18 to 16 years.
- Youth-friendly services that have improved the uptake of services.
- Appropriate age-specific BCC messages and use of social media/SMS for referrals.

- Livelihood activities to reduce vulnerability to transactional sex, such as women empowerment grants (MLHA/GeAD), youth economic empowerment initiatives, entrepreneurship coaching, life skill training, and 'Tweende' (funded by Barclays Bank and implemented by PCI with UNAIDS technical support) for adolescent and youth financial training.
- Teen pregnancy guidelines and promotion of girls education to address school drop-outs.
- Re-organization of youth departments and officers in all ministries.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

1. More adolescent girls are living with HIV than boys aged 10-19 (6,100 vs 5,100). There has been a significant increase in incidence among young adults, particularly young women within the 20-24 age group. The HIV prevalence in young women aged 20-24 is three times as high as prevalence in young men.
2. Possible drivers of HIV risk in young women include:
   a. Decreasing condom use among sexually active young people aged 15-24 from 78.4 per cent in 2008 to 65.2 per cent in 2013.
   b. Low levels of comprehensive knowledge on HIV and SRH, which are reflected in high STI prevalence and teenage pregnancy.
   c. Transactional sex with older men.
3. The coverage of ART in adolescents aged 10-19 is very high at 90 per cent, contrasting sharply with less than 50 per cent coverage in young adults. This indicates challenges in adherence and retention of patients to ART during transition to adulthood, as well as HIV testing and counseling in young adults and behaviorally infected adolescents.
4. Mechanisms for programming on adolescents are currently weak. Government departments and youth agencies work in silos, risking duplication and unequal distribution or disconnected interventions. For instance, condoms programmes are not necessarily linked to family planning or sexual and reproductive health services.
5. Contradictory legal and policy provisions on consent to sex, HTC and health services hamper access to services by adolescents. For example, adolescents under the age of 16 may access contraceptive services and commodities, but not HTC without parental consent. Sex work and same-sex relationships are illegal practices in Botswana.
6. Critical interventions that require strengthening include:
   a) HIV testing and counseling
   b) ART linkages for behaviorally-infected adolescents, and retention and transition from adolescence to adulthood
   c) Comprehensive sexuality education
   d) Condom use for HIV and STI prevention, as well as family planning

An additional four interventions were highlighted during the country assessment and are mostly related to prevention interventions. These include:

1. Prevention of teenage pregnancy
2. Prevention of gender-based violence (GBV)
3. Safe male medical circumcision
4. Prevention of substance abuse (particularly alcohol)

Botswana is on track to exceed the international targets for coverage on treatment. However, it is not on track to achieve the 2020 target for reductions in new infections. The target for reduction in new HIV infections set for 2020 in the ALL IN strategic framework is 75 per cent. If the level of investment in prevention and treatment programmes stays steady, and declines in new HIV infections maintain the average rate seen in the last five years, new HIV infections in adolescents will likely have declined by 63 per cent from the 2010 baseline level by the year 2020. This figure falls short of the global ALL IN 2020 target.

Adolescent policy and programme environment

- Fragmentation of adolescent programming, with government departments working in silos and not necessarily familiar with adolescent issues. There is an urgent need to better understand the adolescent situation and to address legislation relating to homosexuality, sex work and age of consent that hamper access to services.
- There is a need to standardize an M&E system, instead of adopting donor-driven systems.
- There is a need for consistency in the definition of adolescents, as well as provision of youth-friendly health facilities and life-skills programmes for out-of-school children.
- There is a need to strengthen the engagement of youth in decision-making processes.
- Efforts for resource mobilization are focused on the HIV/AIDS response in general, neglecting broader issues that are critical for adolescent health and development.
- There was no uniform understanding among technical partners on the current policy on age of consent for HIV testing, counseling and SRH in adolescents (including contraceptive access). Better communication and clarification are required for policy makers, service providers, adolescents and the community at large.

Findings from consultations with adolescents and young people, as well as adolescents living with HIV (ALHIV)

Two consultation meetings with adolescents and ALHIV enrolled in the Baylor programme were conducted prior to a national country stakeholders meeting to validate the findings of the ALL IN phase one assessment. Adolescents and youth from districts outside Gaborone were present at the stakeholders meeting.

- Youth participation is either limited or non-existent in national development processes, including in planning of HIV/AIDS and health programmes.
- There is an urgent need to establish more interactive peer-driven SRH services.
- Adolescents that have attended school showed some awareness about HIV or SRH education.
- It was noted ALHIV showed more awareness and participation in HIV/AIDS service delivery, but not in decision-making and planning, which suggested a low coverage of HIV prevention services.
- Main issues expressed by adolescents included lack of an adult role model, transactional sex, stigma and discrimination (against ALHIV), and no health-seeking behaviour among adolescents.

Progress in implementation of priority actions identified through assessments

Since 2015, ALL IN has been utilized as an umbrella strategy by the National Aids Cooridinating Agency for assessing, analyzing and operationalizing adolescent and HIV programming. This has provided an opportunity for expanding stakeholder engagement and facilitating more comprehensive analysis and planning. It is a work in progress, but seen as an opportunity to more purposefully and strategically bring the broad spectrum of stakeholders together to better address adolescents and HIV issues, programming, services and participation.

At district level, following bottleneck analysis conducted in 2015 and 2016, action has been taken to improve data collection and analysis, but also to review adolescent service delivery strategies. Findings from the bottleneck analysis will be incorporated into existing district plans. This will ensure that the in-depth analysis processes for data collection, adolescent engagement and bottlenecks continue and that strategies are integrated into formal planning and reporting processes – reducing duplication and parallel planning processes.

Impact of the assessments on the use of strategic information on adolescents

Through the consultative rapid assessment, data was gathered, verified and analyzed from a wide range of surveys, administrative data and research. Data was discussed to determine its relevance and reliability, often acknowledging

that findings were not representative nationwide. However, it did provide important information, especially for behavioral factors affecting adolescents and key populations. This was the first time in Botswana that a wide range of data on adolescents was presented together, allowing a more complete picture of progress and challenges in the area of supply, demand, quality and enabling environment.

Data collection, both quantitative and qualitative, in four strategically selected districts (Ghanzi, Central Boteti, Selibe Pikwe and Good Hope) highlighted the importance of reliable and timely data. Similar to the experience at the national level, it was found that different indicators, data sources and strategic information had never been compiled, discussed or analyzed at district level. While there were many data gaps and issues with data quality, there was considerable data collected at facility and district level, providing important insights into the situation of adolescents and HIV. Districts have acknowledged deficiencies in data and strategic information, but also realized there is a lot of data and information available that could be better utilized to inform planning and monitor issues of supply, demand, quality and enabling environment.

The development of a National Programming Framework for Adolescents and Young Adults in Botswana 2016-2020 has provided the impetus to continue to more regularly collect, monitor, analyze and report a range of strategic information, including broadly sharing, discussing and applying new strategic information as it emerges.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

Innovation and the use of technology has been underutilized in Botswana, with major inhibitors including cost, technical capacity and sustainability. Wise-Up, a multimedia campaign established by UNICEF and the National Aids Coordinating Agency in 2011 that has continued to support outreach and communication around the ALL IN in agenda, has reached out to adolescents and young people with facts on HIV in a way that is both engaging and age appropriate – split into three target groups (ages 10-14, 15-19, and 20-24). In addition to use of SMS, adolescents were engaged through Facebook and local level adolescent-focused activities, including drama, sports, discussions and peer support. Technical issues with providers for the SMS platform caused considerable interruptions to the technology portion of the campaign. Wise-Up has continued under Global Fund support, with efforts made to address the key technological bottlenecks experienced and to provide a wider range of ways for adolescents to engage, interact and contribute to the discussion on a broad range of issues – including service delivery, behavior and the role they can play in preventing new HIV infections.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

Advocacy priorities have focused on raising awareness of the unique challenges and opportunities facing adolescents and the fight against HIV. This has been accomplished through high-level consultations will political leaders, traditional leadership structures such as the Ntlo ya Dikgosi (House of Chiefs), and stakeholders. Use of traditional media, such as print, radio and television, shows that investments in prevention and specifically focusing on adolescents provides a good return, and is the clearest strategy for halting the HIV epidemic. A mix of data, evidence and personal experiences have been used to stimulate public dialogue.

Results include:

1. High-level support and buy-in to the National Programming Framework for Adolescents and Young Adults in Botswana 2016-2021.
2. Commitment to more robust analysis and specific programming for adolescents in the National Strategic Framework III for HIV covering the period 2018-2023.
3. Reprogramming of grants by the Global Fund to support programming for adolescent girls and young women.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

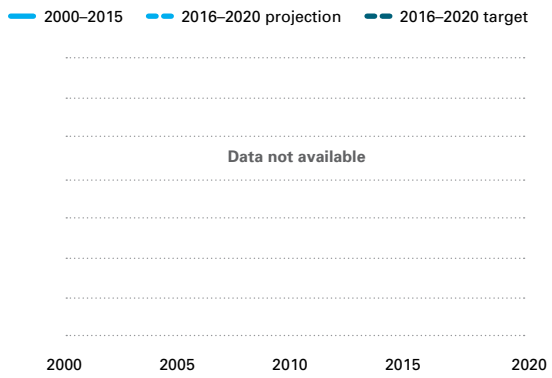
1. The time is right for a focus on adolescents. It is crucial to improve coordination, planning, financing, monitoring and evaluation of adolescent HIV programming. The data shows this and there are high levels of interest and commitment to change the course we have been on.
2. Evidence is still lacking in many areas. Data availability at the sub-national level and specifically on adolescents is often not available from existing surveys. There is very little data on key population groups. Additionally, there is little evidence on what works and what doesn't work in adolescent programming in Botswana. However, there is still important data that can be analysed and used to support improved adolescent programing.
3. Maintaining momentum and interest of stakeholders, especially adolescents themselves, is essential. More creative ways for networking, information sharing and engagement are needed to maintain interest and commitment.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. Operationalize the National Programming Framework for Adolescents and Young Adults in Botswana 2016-2021, and use it as a means for expanding partnerships and strengthening adolescent engagement and contributions.
2. Work with district health teams, as well as adolescents, to include strategies and activities that address identified bottlenecks in existing district HIV plans.
3. Improve information sharing amongst stakeholders, with an emphasis on evidence of what programming strategies are successful and provide good returns on investment.
4. Continued advocacy and use of evidence to increase investment in prevention and in quality adolescent programing.

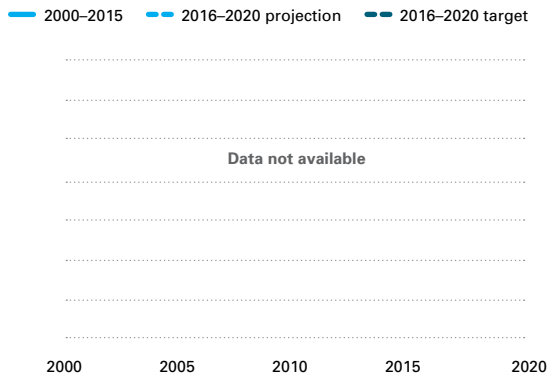
ADOLESCENT HIV TRENDS

New HIV infections among adolescents (aged 15–19), 2000–2020



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

AIDS-related deaths among adolescents (aged 10–19), 2000–2020



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	99,400,000	49,800,000	49,600,000
	Estimated population of adolescents (aged 10–19), 2015[c]	24,700,000	12,200,000	12,500,000
	% of total population that is adolescents (aged 10–19), 2015[d]	24.9%	24.6%	25.2%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	3,100,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[r]	–	22.2 (2011)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015	–	–	–
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015	–	–	–
	Estimated HIV prevalence among youth (aged 20–24), 2015	–	–	–
	Estimated number of adolescents (aged 10–19) living with HIV, 2015	–	–	–
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015	–	–	–
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015	–	–	–
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS

ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	21.1 (2005) [s]	32.1 (2005) [s]	24.0 (2011) [r]	31.8 (2011) [r]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	0.1 (2005) [s]	0.2 (2005) [s]	0.3 (2011) [r]	0.5 (2011) [r]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	–	–	–	–
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	2.4 (2005) [s]	1.5 (2005) [s]	18.8 (2011) [r]	16.5 (2011) [r]
% of adolescent boys (aged 15–19) who have been circumcised	–	86.7 (2005) [s]	–	87.6 (2011) [r]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	–	–	12.4 (2011) [r]	12.8 (2011) [r]
% of young people (aged 20–24) married or in union by age 18	–	–	41.0 (2011) [r]	7.3 (2011) [r]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

There have been early discussions in Federal HIV/AIDS Prevention and Control Office (FHAPCO) to launch the ALL IN platform in Ethiopia. There have also been a number of interventions related to adolescents led by the government (FHAPCO) or supported by development partners. Interventions have focused both on in-school (upper primary secondary and higher educational institutions) and out-of-school adolescents, especially those most at risk.

The major mechanisms of interventions are:

- Ensure the participation of young boys and girls aged 10-19 in the following activities, with special emphasis on the most at risk and vulnerable adolescents and young people:
  - Capacity building through life-skill training
  - Knowledge generation and information exchange forums, such as those for youth dialogues, peer education and school community conversations, mini medias
  - Establishing mechanisms through which adolescents can test their skill and capacity in negotiations for their own benefit, and also make life choices (such as Anti AIDS Clubs).
- Strengthen livelihood and economic support for vulnerable adolescents.

Following the regional WHO/UNICEF workshop 'Stepping up the pace for HIV/AIDS care and treatment among children and adolescents in the African Region', which was held in Uganda in September 2015, Ethiopia developed a national response road map for children and adolescents living with HIV. In this, the Government identified adolescents as a priority group that is most at risk in terms of HIV prevention. The National HIV Prevention advisory group, chaired by FHAPCO and its supporting partners (UNAIDS, UNICEF, WHO), also prioritized this group. The Ministry of Education joined the advisory group to strengthen the work related to HIV prevention in adolescents. The Ministry of Youth has been given responsibility for overall coordination of multi-sectoral programming for adolescents and youth. Previously, this was coordinated by the Ministry of Women, Children and Youth.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

1. Ethiopia has developed a draft comprehensive National Adolescent and Youth Health Strategy for 2016-2020 which has a strong focus on HIV and SRH. A successful achievement was including young adolescents aged 10-14, unlike the previous strategy which had only covered adolescents older than 15. In the new strategy, the age bands 10-14 and 15-24 are adopted for age-appropriate targeting and design of interventions. Younger adolescents aged 10-14 are mainly targeted for education and information provision, while youth aged 15-24 are targeted for the uptake of both preventive and curative health services.
2. The national HIV investment case (5-year National HIV strategy 2015-2020) emphasizes utilizing targeted interventions to achieve greatest impact. Priority groups of adolescents – those at greatest risk – will be targeted through a minimum package of interventions for prevention, with linkages to treatment, care and support.
3. Training materials on psychosocial support for adolescents living with HIV have been developed and training is being rolled out. This material is designed to build the capacity of healthcare workers to establish facility-based peer support groups for adolescents who have disclosed their HIV status and seek support for their experiences.
4. Communication for development materials which focus on disclosure and treatment adherence have also been prepared to guide improvements in quality.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

The ALL IN data assessments have not been conducted yet. Preparations are underway to conduct the phase 1 data assessment within the next 6 months under the leadership of FHAPCO.

Progress in implementation of priority actions identified through assessments

Although the country has not yet launched the ALL IN initiative, the following are some activities related to adolescents which are supported by development partners.

1. Scale-up of direct HIV/ SRH services such as youth-friendly services, voluntary counselling and testing for adolescents.
2. Community-based education sessions and outreach targeting of out-of-school youth. This includes social and behavioural change communication activities and support.
3. Livelihood and income generating services for adolescents and youth.

Impact of the assessments on the use of strategic information on adolescents

N/A

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

N/A

D. ADVOCACY AND COMMUNICATION:

Advocacy priorities and action taken on these priorities in 2015 and 2016

A focus on most at-risk adolescents, both in and out of school.

Reinforcing a human rights-based approach to adolescent and youth development programming, including HIV and SHR, particularly in urban hot spots (Woredas) identified through UNICEF and UNFPA analyses.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

There is an urgent need for evidence data to inform existing programmes and improve outcomes in adolescent HIV and wellbeing.

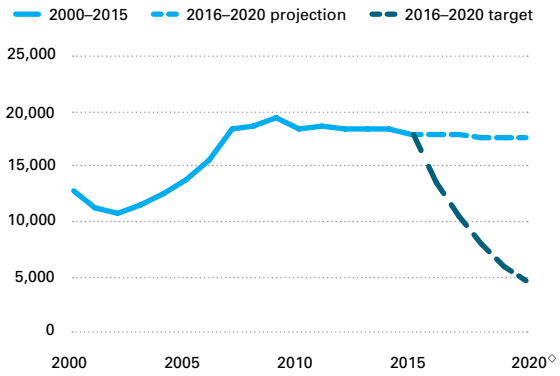
F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. Conduct ALL IN data assessments.

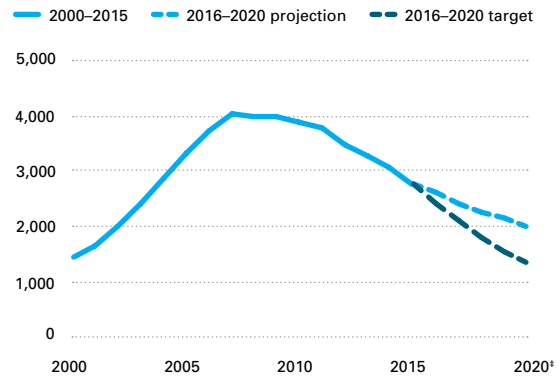
COUNTRY I **KENYA**

ADOLESCENT HIV TRENDS

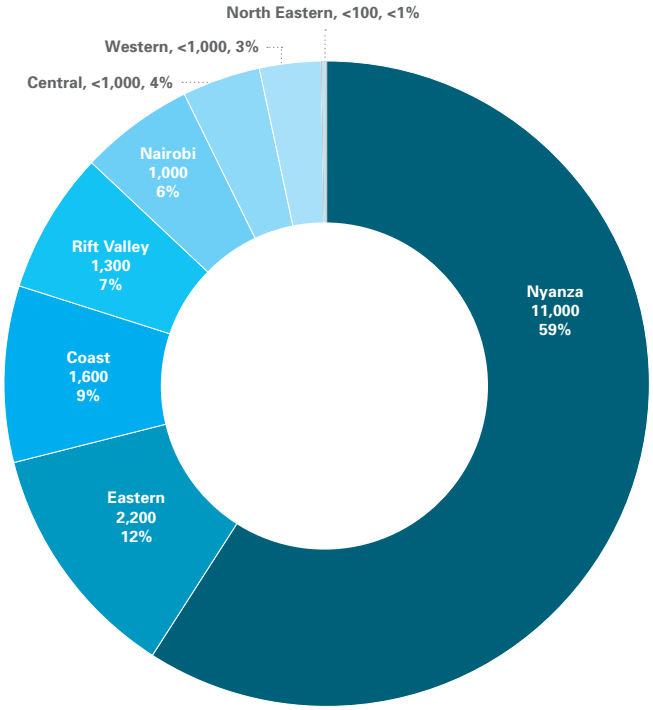
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015e



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015c	46,100,000	23,000,000	23,000,000
	Estimated population of adolescents (aged 10–19), 2015c	10,400,000	5,200,000	5,200,000
	% of total population that is adolescents (aged 10–19), 2015d	22.6%	22.5%	22.7%
	Estimated annual number of live births, 2010–2015 (annual average)c	1,500,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recentt	–	23.3 (2014)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015a	0.7%	0.7%	0.7%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015a	2.0%	2.5%	1.4%
	Estimated HIV prevalence among youth (aged 20–24), 2015a	4.2%	5.4%	3.0%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015e	130,000	79,000	55,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015e	18,000	13,000	5,100
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015e	2,800	1,300	1,500
Policy	Age of consent for HIV testingf	18	18	18

HIV TREATMENT FOR ADOLESCENTS

ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	41.9 (2009) [u]	51.2 (2009) [u]	51.7 (2014) [t]	57.7 (2014) [t]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	1.3 (2009) [u]	4.3 (2009) [u]	1.0 (2014) [t]	3.7 (2014) [t]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	–	69.1 (2009) [u]	26.1 (2014) [t]	64.1 (2014) [t]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	17.8 (2009) [u]	13.1 (2009) [u]	35.3 (2014) [t]	26.6 (2014) [t]
% of adolescent boys (aged 15–19) who have been circumcised	–	75.5 (2009) [u]	–	87.1 (2014) [t]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	11.3 (2009) [u]	–	6.5 (2014) [t]	–
% of youth who have completed secondary school	–	–	38.2 (2014) [t]	43.9 (2014) [t]
% of young people (aged 20–24) married or in union by age 18	–	–	22.9 (2014) [t]	2.5 (2014) [t]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

To ensure meaningful and genuine engagement in the HIV response, UNICEF Kenya, working with the National Empowerment Network of People Living with HIV, initiated the formation of the Sauti Skika, a network of adolescents living with HIV (ALHIV). Sauti Skika is a Swahili term meaning "voices be heard" or "amplified voices" and, true to that, the network is a mechanism to mobilize, educate and secure the meaningful engagement of at-risk, affected and infected adolescents (aged 10-19) with the aim of ensuring their active and meaningful engagement in the AIDS response. The formation and support to Sauti Skika since the launch of ALL IN in Kenya has ensured that adolescents and young people living with HIV have been visible and their voices enhanced at high-level (international, national and county) engagement in the HIV response. The network is recognized by the Government, UN Agencies, CSO's and other stakeholders who call on it to engage in various decision-making and partnership opportunities.

Overall milestones in terms of strengthening adolescent and youth engagement include:

1. UNICEF's support of their involvement in the development and implementation of Kenya's Fast-Track Plan to end HIV and AIDS amongst adolescents and young people.
2. Adolescent symposium at the county level.
3. Participation of adolescents and young people as panelists, speakers and delegates during the International Conference on AIDS and STIs in Africa (ICASA) in Zimbabwe in December 2015, the International AIDS Conference in Durban in July 2016, and in various sessions at the High-Level Meeting on HIV and AIDS in New York in June 2016.
4. Formal input into and participation of young people in the Kenya Delegation at the UN High-Level Meeting on HIV and AIDS in New York in June 2016.
5. Support for adolescents and young people from Kenya to participate as panelists in Stop AIDS Now (SAN) Meeting in South Africa in October 2015.

Furthermore, the design and implementation of a national anti-stigma campaign through football, dubbed Maisha County League, has targeted and involved young people.

Adolescents have also been involved in:

- Development of treatment literacy materials for ALHIV and their parents or guardians.
- Development of standards to guide ALHIV support networks.
- Guiding strategies to support adolescents living with HIV within learning institutions through their collaboration with the Ministries of Health and Education.

UN Women has partnered with IPPF to implement a pilot initiative "Empowerment + Engagement = Equality" to ensure inclusion of adolescent girls and young women as advocates in the All In assessments and the broader HIV response. More than 1,000 girls were mobilized across three priority countries (Kenya, Malawi and Uganda). The young advocates participated in multiple thematic working groups and some are now preparing to register as a formal self-help group to continue advocacy on gender equality and HIV at the national level.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

In September 2015, Kenya launched its national plan to fast-track HIV prevention and end AIDS in adolescents and young people. The coordination and monitoring of progress is overseen by a national steering committee reporting to the Minister of Health on a regular basis. Furthermore, following the launch of ALL IN,in Kenya, a specific adolescent sexual and reproductive health (SRH) policy was developed in 2015, supported by a national guideline for provision of adolescent and youth-friendly services. This policy aims to enhance the SRH status of adolescents in Kenya and to contribute towards realization of their full potential in national development through the following approaches:

- Promoting adolescents' SRHR.
- Contributing to increased access to ASRH, HIV information and age-appropriate sexual education.
- Contributing to reduction of STIs burden, including HPV and HIV, and improving appropriate response for infected adolescents.
- Addressing the special HIV and SRHR-related needs of marginalized and vulnerable adolescents.

Kenya also lowered the age of consent for HIV testing from 18 to 15. This is a great milestone that is expected to improve testing outputs as well as linkage to services at county and country level, contributing to Kenya's Fast-Track Plan to End HIV and AIDS among adolescents and young people.

Led by the Ministry of Health, with support from UNICEF, the country also released a report from a situation analysis of policy and health care for adolescent males who have sex with males, adolescent sex workers and adolescents using drugs. The report, from the assessment 'Most At Risk Adolescents: Invisible or Ignored', provided specific recommendations for programming aimed at Kenya's most at-risk adolescents, based on the WHO key populations guidelines for adaption at local level. Moving forward, essential health sector interventions will be integrated with strategies to create an enabling environment for service provision to adolescent key populations.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

Nationally, despite the decrease in the HIV infections in Kenya in recent years, more than 50 per cent of all new HIV infections in 2015 were between ages 15-24 (31 per cent in 2013).

Following the ALL IN global launch and Kenya's launch of its national Fast-Track Plan to end HIV and AIDS among adolescents and young people, several initiatives were launched to support government efforts to strengthen disaggregated data systems on the 10-19 age group as part of regular national health information systems.

1. At national level, the revision and training on new disaggregated Health Management Information Systems (HMIS) tools and strengthening of the DHIS2 on adolescent data were completed.
2. At sub-national level, six counties with high HIV burden – Nairobi, Mombasa, Turkana, Kisumu, Siaya and Homa Bay – were supported to comprehensively assess the situation of adolescents and young people and HIV. The assessments were undertaken through a close collaboration between the National AIDS and STI Control Programme (NASCOP), the National AIDS Council (NACC), Kenya National Bureau of Statistics (KNBS), and other government, non-government, UN and development partners, and county governments.
3. The globally developed Adolescent Assessment and Decision Makers (AADM) tool was adapted based on consultations with stakeholders at national and county level, resulting in a tailored tool – the 'Kenya Adolescent Assessment and Decision Makers' tool (KAADM). The KAADM uses internationally comparable indicators, draws data from government data sources and, where not available, uses agreed approximations.

The ALL IN assessments in Kenya provided a rapid overview of programme performance on HIV and other related interventions among adolescents aged 10-19, producing evidence-informed priorities of who, what and where to focus HIV programming among adolescents.

Preliminary findings from the assessments include the following:

1. In all counties, there seems to be almost equal HIV prevalence between boys and girls aged 10-14. However, HIV prevalence appears to be increasing with age, as in most counties. HIV prevalence in the age group 15-19 nearly doubles compared to 10-14.
2. Overall, adolescents begin engaging in sex at an early age (1 in every 5 by the time they are 15 years) with

reported low condom use.

3. HIV infection rates increase particularly among girls, with young women (aged 20-24) almost two times more vulnerable to HIV infection compared to young men of the same age.
4. In all six counties, the assessments suggest that the number of ALHIV represents on average 10 per cent of the total HIV positive population.
5. Overall, it was found that new infections among adolescents have decreased over the last 5 years. Numbers reduced steadily in Turkana, with a slight decrease between 2010 and 2015 in Nairobi and Mombasa, except for Kisumu, Siaya and Homabay, where there was an increase between 2014 and 2015. It is not immediately clear whether this rate of decline is similar in other age groups.
6. HIV-related deaths in adolescents appear to have reduced by between 14 per cent in Kisumu and 40 per cent in Nairobi over the last 5 years, which is below the global ALL IN targets of 65 per cent reduction in AIDS related deaths among adolescents by 2020.
7. There is very limited disaggregated data on adolescent key populations at national and county level. A rapid review of national programme data from NASCOP suggests that around 7 per cent of key populations reached with services by implementing partners are under the age of 19.
8. In almost all counties, preliminary findings suggest there is low HIV testing (less than 20 per cent) and low ART coverage (less than 25 per cent) among adolescent boys and girls. Viral suppression in adolescents is reportedly sub-optimal.
9. Across most counties, there is also a high number of young girls married and in union, and relatively low net secondary school attendance in most.

Some of the challenges faced during the assessments were that HIV estimates were generated previously at national level and epidemiological disaggregated HIV estimates at county level only became available in October 2016. Also, routine HIV service data for adolescent will only become available in January 2017 when the new MOH data tools will be applied. When adolescent disaggregated data was available for this assessment, this was not stored in one single data platform, but either being kept by local service providers or CSOs. Data on adolescent participation and decision-making was also not reliable. Demographic and Health Survey (DHS) and other household surveys had small sample sizes for young age groups that did not allow for sub-national adolescent disaggregated data analysis. Therefore, for some indicators, the only available data at county level was for the age band 15-49.

Following the county data assessments, the KAADM tool was updated with data from the National Bureau of Statistics in July 2016, including age-disaggregated data for age groups 15-19 and 20-24 in all counties and 2015 HIV estimates released by NACC in October 2016. The assessment is currently being validated and discussed with all stakeholders. Preliminary findings have already helped define priority actions, such as advocating for age and sex-disaggregated data collection, tools and surveys, and target-setting at county and national levels for adolescent HIV prevention, treatment and care.

Progress in implementation of priority actions identified through assessments

There has been marked progress in following through priority actions identified through the assessments.

In terms of data, the new HIV estimates and county profiles for Kenya that were launched in October 2016 included, for the first time age, disaggregated data for key indicators on number of adolescents living with HIV, new infections and AIDS-related deaths among adolescents at national level and all counties. New (age and sex-disaggregated) HMIS data collection tools on HIV have been developed and counties trained on their use in order to allow for regular routine HIV programme data on adolescents from January 2017 onwards.

Impact of the assessments on the use of strategic information on adolescents

The process of developing the country assessments involved obtaining NACC/NASCOP data on the number of ALHIV, new infections and AIDS-related deaths. Then, based on EPP Spectrum modelling, the ratio between male and female of the same age band 10-19 by region was calculated in order to obtain county sex-disaggregated data. The country now has new HIV data collection tools that have age and sex disaggregation.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

Kenya's mobile coverage is estimated at 89.2 per cent of the population and use of internet at 82.6 per cent, according to the communication authority of Kenya. The majority of users of social networking sites are young people aged 15-29. Given this high coverage of web and mobile-based platforms, different stakeholders in the HIV sector have over the last two years developed a package of age-appropriate messages for different online audiences. There are various efforts from government (NACC) and CSOs (LVCT Health's one2one platform, Dance4Life Kenya, ALL IN Kenya, NAYA Kenya, to name but a few), as well as radio, television, sports, music and art celebrities to disseminate messages on HIV and SRH among adolescents and young people. The efforts would need stronger coordination for possible monitoring of progress.

As part of the UN Women/IPPF initiative "Empowerment + Engagement = Equality" the young advocates set up WhatsApp groups to serve as safe spaces to meet, mobilize, provide peer support and discuss not only HIV but broader issues affecting gender equality.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

1. Meaningful and genuine engagement of adolescents in the HIV response. Efforts to date have led to a growing national network of ALHIV who are actively giving voice and face to the HIV response at community, county and national levels.
2. Age and sex-disaggregated data with adolescent-specific indicators for use in decision-making at various levels.
3. Targeting, resourcing and monitoring adolescent HIV programming, having seen the development and launch of county AIDS strategic plans with clear targets, strategies, resources and monitoring plans for specific HIV interventions for adolescents.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. Importance of working in partnership at national and sub-national levels – the national government has shown leadership and the counties ownership of the new data.
2. Close collaboration with the national HIV estimates working group and partnerships with MoH, Avenir Health, PEPFAR, National Bureau of Statistics.
3. Adolescent participation in the HIV response, coupled with enhanced evidence and advocacy, has contributed to increased visibility and priority-setting for adolescents in national and county plans and programmes.
4. Issues around adolescent and young key populations continue to be sensitive and deliberate programme outreach appears limited.
5. Age and sex disaggregated data has helped to plan targets and interventions for adolescents of different age bands, sex and locations.
6. Various other factors (such as school enrolment, drop out, exposure to child labour, poverty and economic hardships, sexual abuse and exploitation or harmful cultural practices) impact negatively on HIV prevention, treatment and care outcomes.

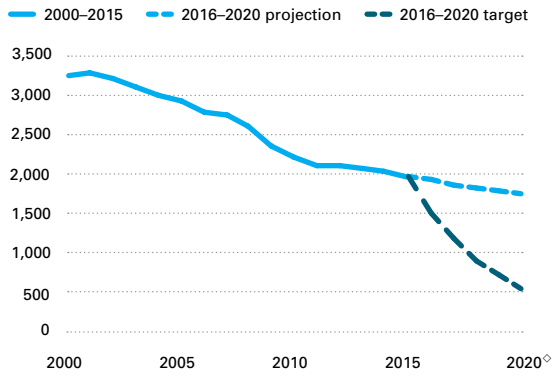
F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. Monitoring and reviewing progress against the Fast Track Plan to end HIV and AIDS in adolescents and young people, as well as 2016 county HIV profiles and adolescent data baselines.
2. Conduct special data reviews to generate deeper insights into ART enrolment and adherence challenges among adolescent boys and girls.
3. With 'KEN-PHIA' – Kenya's Next Population-based HIV Impact Assessment – there is an important opportunity to design the survey so that it can provide sub-national and age/sex disaggregated data.
4. Support to the MOH to conduct data quality reviews, geared towards improving the quality of adolescent data in HTS, care and treatment and viral suppression.
5. Strengthen school-based adolescent interventions, such as school health programmes, through partnership between the ministries of health and education.
6. Use the adolescent data assessment and explore a national assessment with the MOH.
7. Utilize the adolescent data assessments to inform the next GFATM and PPEFAR grant applications for Kenya.

COUNTRY I **LESOTHO**

ADOLESCENT HIV TRENDS

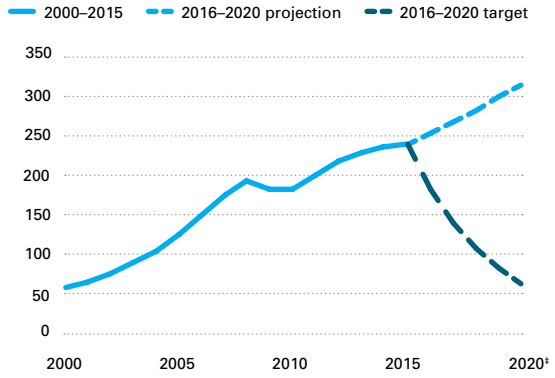
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	2,100,000	1,100,000	1,100,000
	Estimated population of adolescents (aged 10–19), 2015[c]	490,000	240,000	250,000
	% of total population that is adolescents (aged 10–19), 2015[d]	23.1%	22.6%	23.5%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	60,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[v]	–	13.9 (2014)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	1.9%	1.9%	1.9%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	3.1%	3.9%	2.3%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	10.3%	13.3%	7.3%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	12,000	7,200	5,200
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	2,000	1,400	<1,000
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<500	<200	<200
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS

ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	35.2 (2009) [w]	28.1 (2009) [w]	34.8 (2014) [v]	29.7 (2014) [v]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	2.1 (2009) [w]	13.4 (2009) [w]	2.9 (2014) [v]	15.3 (2014) [v]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	36.6 (2009) [w]	60.2 (2009) [w]	57.9 (2014) [v]	79.7 (2014) [v]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	33.1 (2009) [w]	11.8 (2009) [w]	40.5 (2014) [v]	24.9 (2014) [v]
% of adolescent boys (aged 15–19) who have been circumcised	–	26.8 (2009) [w]	–	–
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	18.8 (2009) [w]	13.7 (2009) [w]	–	–
% of young people (aged 20–24) married or in union by age 18	18.8 (2009) [w]	–	17.3 (2014) [v]	1.2 (2014) [v]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

There are a number of platforms that have been created for adolescents' engagement in the HIV response. In the health sector, there is a Young People's Technical Working Group, which was created following the ESA Ministerial Commitment on CSE and signed in 2013 by our governments at the ICASA conference. It includes adolescents and young people themselves, as well as organisations that work with them. There are also working groups recommended in the Adolescent Health Policy which require the inclusion of adolescents. At community level, there are Health Centre Committees, which typically should include the presence of young people. There is also a National Youth Council, which ideally should include adolescents and young people – however, the structure has not been working very effectively due to internal challenges.

The National AIDS Commission has just been re-established and, within it, there are plans to include coordination platforms for young people. The Global Fund CCM also ensured that young people inform the current proposal, which includes a chapter on adolescent girls and young women (AGYW.. Young people are also members of the Technical Working Group, overseeing implementation of the DREAMS initiative.

Main outputs delivered through these mechanisms include:

1. The AGYW chapter in the Global Fund.
2. The feedback report with recommendations from young people who attended the International AIDS Conference 2016.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

In Lesotho, the age of consent for HIV testing is 12 years old. The Child Protection and Welfare Act also provides access of SRH services to any child who needs it. There are no laws prohibiting access of services by key populations. However, even though sex work and MSM are still taboo, there are no laws that prohibit these groups from accessing services. Their main challenge lies in the discriminatory attitudes of service providers.

Most HIV and SRH related policies include adolescents as a special group that needs attention. The new Test and Treat guidelines, the HIV strategic plan and supporting documents include an adolescent section. Consequently, trends have shown an increasing number of adolescents who access HIV testing services (up from 33.1 per cent to 40.5 per cent among females, and from 11.8 per cent to 24.9 per cent among males in 2009 and 2014, respectively. and an increasing number of adolescents aged 15-19 who use condoms during premarital sex (from 62.3 per cent to 80.1 per cent among females, and from 62.5 per cent to 77.8 per cent among males in 2009 and 2014, respectively.. There are still challenges in terms of lack of data disaggregation of data on ART services.

In terms of sexual and reproductive health services, the Lesotho DHS 2014 provides some insight on adolescent access through the lens of ANC attendance and use of contraception. The LDHS 2014 shows an increased number of adolescent girls who utilize ANC services at least once, and those who deliver at facility level. The same study shows that around 70 per cent of sexually active unmarried adolescent girls aged 15-19use modern contraceptive methods.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

The bottlenecks identified here were informed by the ALL IN assessment and other studies, as well as reports developed with support from various partners in Lesotho including:

a. WHO Updated Situation Analysis (Sitan. for Adolescents and Young People's Health, 2015
b. ALL IN Assessment Report, 2016

c. Focus Group Discussions Report on the Bottleneck Analysis for ANC/PMTCT services, 2014

d. The Lesotho Demographic and Health Survey, 2014

The key findings are:

1. Improved HIV testing among adolescents (aged 15-19), but still very low (40 per cent among girls and 25 per cent among boys who tested and received results in the past 12 months).
2. Coverage for adolescent circumcision is very low at 30 per cent, even though adolescent boys constitute the majority of newly medically circumcised males.
3. Comprehensive knowledge among adolescents is low at 35 per cent among girls aged 15-19 and 30 per cent of boys of same age.
4. In Lesotho, 19 per cent of young women are married or in union by the age of 18.
5. Net secondary school attendance mostly favours girls (61 per cent. over boys (26 per cent).
6. Teenage pregnancy is at 19 per cent.
7. Condom use amongst unmarried, sexually active 15 to 19 year olds is around 80 per cent.
8. Males report first sex before 15 more than girls. Trends show girls reducing in numbers at age of first sex.

Major bottlenecks affecting service delivery for adolescents include the following:

1. Sharing of information related to adolescents among stakeholders or implementing partners was regarded to be a priority gap affecting performance within the delivery of services to adolescents.
2. Lack of information sharing and practical linkage across programme platforms within and between sectors leads to many missed opportunities to improve indicators overall. For example, no deliberate effort is made to link cash transfer programmes to other HIV risk reduction interventions.
3. Weak capacity of service providers to deliver adolescent-friendly services.
4. Many key facility-based services are not adolescent friendly, either because of the attitudes of providers, service house or lack of space for adolescents.
5. ART coverage for adolescents living with HIV is not known because of the way data is aggregated.
6. Stigma is still the main factor that prevents people from accessing HIV testing services and other services, including adherence support.
7. Family involvement and support can have huge positive implications on adolescents accessing or using services.
8. Incorporating sex and sexuality education in schools, especially church-owned schools, is still a challenge.
9. Influence of negative cultural norms, attitudes and practices.
10. Access to services by key populations is still difficult (e.g. adolescent sex workers, MSM., mainly due to the discriminatory attitudes of health workers and times of service delivery.
11. Running out of supplies at facility level, mainly HIV test kits, is a recurrent problem.
12. Lack of HIV testing counselors at district level (and other HR gaps). This has only recently been addressed through a recruitment exercise in 2016.

Progress in implementation of priority actions identified through assessments

Lesotho is still discussing next steps to consolidate the findings and recommendations of recent assessments mentioned above, including the ALL IN Assessment, in order to draw a comprehensive action plan which would then be assessed in the coming years.

Impact of the assessments on the use of strategic information on adolescents

Lesotho has already achieved the following:

1. Informed the Global Fund AGYW section, which is being implemented in 2016 through a local NGO and PACT.
2. Informed the Adolescent Health Strategy, which was completed last year. Following its completion, a training package was developed and has just been pre-tested, yet to be widely disseminated in 2017 and beyond, to service providers at all levels.
3. Informed the draft School Health Policy, which is complete, but yet to be approved by authorities in government.
4. Informed the revised comprehensive sexuality education curriculum for secondary schools, which is already being implemented.
5. Informed the new Test and Treat guidelines which were launched in April 2016.
6. Influenced the conceptualization of the DREAMS programme and ongoing implementation.
7. Ongoing advocacy to further disaggregate adolescent data in most programmes.
8. Formation of various working groups (DREAMS, Global Fund, Adolescent Health, etc.., with common members, thus strengthening coordination efforts in this area, especially across sectors.

Most of the data gaps identified in the country assessment had already been noted. What the assessment was really able to highlight was the lack of cross-fertilization or communication among programmes. This is now being addressed through various coordination platforms. Data improvement recommendations are being implemented within the MOH, in terms of collecting and reporting routine data at source (mainly health centers) in a disaggregated manner, but further advocacy efforts to expedite this process will be intensified.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

Mobile technologies have mainly been explored to create demand and partially monitor service utilization. Lesotho has used it to engage young people in driving blood donation, as well as HIV testing. The platform seemed to encourage young people to speak freely about their fears and views on issues that affect them. Ensuring continuity of use of the platform is a challenge since access to Wi-Fi is not easy, and data can be costly for adolescents and youth.

Lesotho also once used a free SMS service, which was very good at provoking discussion, but became expensive to maintain over the long term. The platform became costly to the host, even though it remained free for the user.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

ALL IN complements already existing partnerships and has become a very informative process to strengthen the implementation of partner interventions, as well as coordination among partners. It has also made it easier for partners in Lesotho to make the case for a wider approach to addressing HIV among young people beyond the health sector.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

Lesotho has not yet validated findings from the rapid phase of the ALL IN assessment, but the findings of the assessment have already been used to inform programming moving forward.

A lesson learned is that the ALL IN efforts must be government-led and country partners need to be involved from the very beginning of the process, not brought in at some later stage. In Lesotho, there was a difference in pace between the Government and the UN, due to the time taken to understand the whole concept.

Another lesson learned is that there should be a clear strategy on how to engage young people at different stages of the process, from data collection, validation, action planning, implementation and monitoring.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

These were informed by all the ministries, as part of TWG collective thinking, and some from the various sources mentioned above.

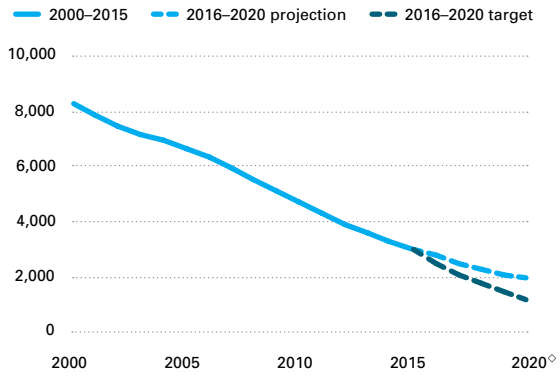
Key priorities moving forward:

1. Disaggregation of adolescent data at entering and collation points.
2. Strengthened coordination at national, district and community levels of adolescent-focused interventions.
3. Intensified advocacy for efficient spending in HIV prevention, especially among adolescents.
4. Advocacy for more spending in adolescent-friendly service delivery.
5. Increased efforts to enhance adolescent reach, riding on other platforms in other sectors (e.g. social protection, education, school health, employment, small business and culture..
6. Using online, mobile technology and other multimedia platforms to improve access, utilization and monitoring of HIV and SRH services among adolescents and young people.

COUNTRY I **MALAWI**

ADOLESCENT HIV TRENDS

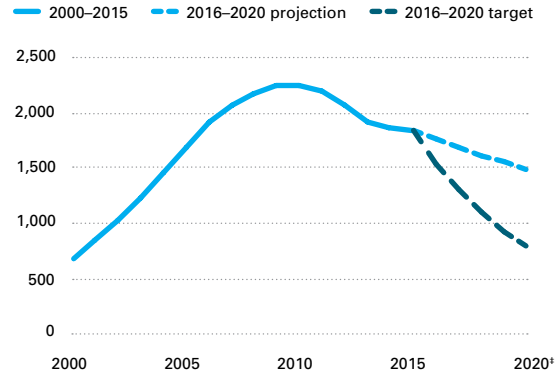
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	17,200,000	8,600,000	8,600,000
	Estimated population of adolescents (aged 10–19), 2015[c]	4,100,000	2,100,000	2,100,000
	% of total population that is adolescents (aged 10–19), 2015[d]	23.9%	23.8%	24.0%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	630,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[x]	–	31.3 (2014)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	1.4%	1.4%	1.4%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	1.7%	1.9%	1.4%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	3.5%	4.6%	2.3%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	62,000	33,000	29,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	3,000	2,300	<1,000
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	1,800	<1,000	<1,000
Policy	Age of consent for HIV testing[f]	13	13	13

HIV TREATMENT FOR ADOLESCENTS

ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	39.5 (2010) [y]	44.7 (2010) [y]	42.8 (2014) [x]	50.0 (2014) [x]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	0.7 (2010) [y]	4.9 (2010) [y]	1.2 (2014) [x]	7.1 (2014) [x]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	41.7 (2010) [y]	36.1 (2010) [y]	38.3 (2014) [x]	49.1 (2014) [x]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	44.1 (2010) [y]	21.0 (2010) [y]	32.2 (2014) [x]	24.8 (2014) [x]
% of adolescent boys (aged 15–19) who have been circumcised	–	21.7 (2010) [y]	–	30.5 (2014) [x]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	17.8 (2010) [y]	–	–	–
% of youth who have completed secondary school	–	–	8.5 (2014) [x]	14.8 (2014) [x]
% of young people (aged 20–24) married or in union by age 18	–	–	46.3 (2014) [x]	6.4 (2014) [x]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

UNICEF consolidated the national delivery and advocacy of comprehensive services (including HIV prevention) to adolescents and out-of-school youth by scaling up the Action 4 Adolescents and Youth platform (A4A&Y) to include new partners. These included all UN agencies (leveraging US$ 4.9 million), NGOs, companies from the private sector such as Standard Bank, and local initiatives. The expanded A4A&Y platform reached 20 districts and 200,000 adolescents in Malawi through the coordination of the Ministry of Labour, Youth and Manpower Development (MOLYMD) and the Ministry of Health.

When the UNICEF Malawi Country Office (MCO) and its implementing partner developed a project for adolescent MSM, MSM peer educators participated in the project design. Given the sensitivity of the topic, it was essential to have these adolescents and young people engaged from the very beginning. In addition, the MCO developed a training manual for service providers on adolescents, LGBTI and diversity. MSM peer educators played a key role in the development of the manual content, including identifying topics and providing scenarios for role-play.

The UNICEF MCO has been supporting outreach services to adolescents for several years. A new project that builds upon this work sees youth leaders being trained in SRH information and community mobilization, becoming responsible for demand creation through their youth networks and clubs. This active leadership by young people seeks to improve uptake services, as well as strengthen the engagement of young people in communities.

UN Women has partnered with IPPF to implement a pilot initiative "Empowerment + Engagement = Equality to ensure inclusion of adolescent girls and young women as advocates in the All In assessments and the broader HIV response. More than 1,000 girls were mobilized across three priority countries (Kenya, Malawi and Uganda). The young advocates worked with religious leaders, teachers and other community members to highlight and motivate for change to harmful gender norms. They also met with the First Lady of Malawi to present their perspectives and experiences with gender-based violence, child marriage, HIV-related stigma in schools and health care settings, and bottlenecks preventing girls from continuing education.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

In 2016, the UNICEF MCO supported the development of the National Roadmap for Pediatric/Adolescent HIV Prevention, Care and Treatment. This framework will guide the implementation of interventions aimed at reducing new pediatric and adolescent HIV infections, accelerating access to care and treatment.

Also in 2016, the MoH launched the revised HIV Prevention, Care and Treatment Guidelines (also known as Test and Treat) and the revised National HIV Testing Services Guidelines. The MCO was closely engaged in both documents, ensuring that both respond to the needs and reflect the best interests of children and adolescents.

Child marriage makes girls more vulnerable to becoming infected with HIV. UN Women has supported the work around ending the child marriage, particularly in sub-Saharan Africa. In Malawi, this contributed to the adoption of the Marriage, Divorce and Family Relations Bill that now increases minimum age at marriage from 15 to 18 years; and in development of by-laws and/or action plans by Paramount Chiefs to enforce the Bill.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

At present, the HMIS does not disaggregate data according to adolescents (disaggregation is 0-14, 15-24, 15+ depending upon the service). However, various studies have indicated that adolescent girls and young women do not access HIV and SRH services to same extent at older women. To address this gap in knowledge, the MCO undertook

a pediatric and adolescent data abstraction exercise in 8 districts. Data was collected in October 2016 and analysis is now underway. Notably, the MoH led the exercise, with full participation from district health officials, facility-level staff and collaboration from UNAIDS and WHO. The data will be used to highlight to policy makers, donors and implementing partners the need to address the specific needs of adolescent pregnant and lactating women. It will also be used to advocate for the inclusion of age and sex disaggregated data in future iterations of the HMIS.

Progress in implementation of priority actions identified through assessments

Social protection and HIV/SRH services: UNICEF MCO has been supporting outreach services to adolescents for several years. In 2016, UNICEF integrated these services with the Social Cash Transfer Programme, a national programme that distributes small sums of money to food-poor, labour-constrained households, the majority of which are affected by HIV. The outreach was conducted in 5 districts, in areas that have been targeted to receive cash transfers. A total of 14,291 adolescents and young people received HTC, and 40 per cent accessed family planning services.

Adolescents living with HIV: A new agreement was signed this year with Baylor College of Medicine to provide services to adolescents living with HIV, conduct clinical attachments, and work with caregivers and teachers on addressing stigma and providing support. Data on numbers reached will not be available until January 2017.

Adolescents, LGBTI and diversity: In 2014, the UNICEF-supported size estimation study on MSM found that half of adult MSM had their first sexual experience with another man while an adolescent. Based on this finding, the UNICEF MCO developed an adolescent MSM project that, trained hotline counselors, service providers and peer educators to address issues of sexuality and diversity. While the hotline is nationwide, the service providers and peer educators are located in areas where there are supportive social networks for MSM. Peer educators in 5 districts conducted outreach to adolescents, distributed 52,840 condoms and 47,240 lubricants. In addition, 148 adolescent males tested for HIV through this outreach, with a 13 per cent positivity rate, and 20 males were screened and treated for STIs.

Life skills education, in collaboration with UNFPA: Training of 82 secondary school teachers in life skills education has boosted levels of confidence in delivering the subject. It will also lead to an estimated 41,000 students being reached with information on CSE (1/500) and reduce the number of girls who drop out due to unwanted pregnancies.

UNFPA's CONDOMIZE! campaigns: These enabled young people to access 25,000 male condoms and accurate information. In three campaigns, 11,400 young people were reached with SRHR messages, with 160 testing for HIV and receiving their results. A further 210,000 young adults were reached with HIV and STI messaging, using UNAIDS' Protect the Goal campaign. Using this same campaign, as many as 150 soccer coaches and peer educators (both female and male) have been trained to deliver SRHR education. The aim is to improve the uptake of comprehensive and correct HIV messaging, as well as related HTS and SRHR services, among young adults in Malawi. The campaign also specifically promotes voluntary male medical circumcision (VMMC) and condom use in collaboration with locally-based partners.

Functional literacy groups: For 5,000 girls, including adolescent mothers, in 3 districts.

Sports festivals: Four sports festivals reached 8,000 adolescents, offering HIV and SRH information and services.

Impact of the assessments on the use of strategic information on adolescents

UNICEF made significant contributions to information provision and promotion of adolescent participation and services. UNICEF led the Joint UN Program on Youth in partnership with the Ministry of Labour, Youth and Manpower development (MLYMD), and launched the first ever situation analysis on Adolescents and Youth in 2016. This intensive and analytical report provided a baseline of the youth situation in education, employment, health (including HIV) and participation at a national and district level. As a result, the government of Malawi set up a committee of 5 concerned ministries to lead in addressing issues identified under the leadership of MOLYMD. Headed by UNICEF, a joint work plan for all UN agencies and the MOLYMD was produced for the first time, addressing key issues identified in the report.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

The joint A4A&Y initiative, led by UNFPA and with UNICEF collaboration, launched a mobile application for accessing SRH services.

As part of the UN Women/IPPF initiative "Empowerment + Engagement = Equality" the young advocates set up WhatsApp groups to serve as safe spaces to meet, mobilize, provide peer support and discuss not only HIV but broader issues affecting gender equality.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

The joint programme on girls' education engaged family members, communities and village leaders in advocating to keep girls in school.

UNICEF supported a visit by the UN Special Representative to highlight violence against children, giving issues of sexual violence and child marriage a stronger profile and strengthening advocacy to introduce and enforce relevant legislation.

E. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

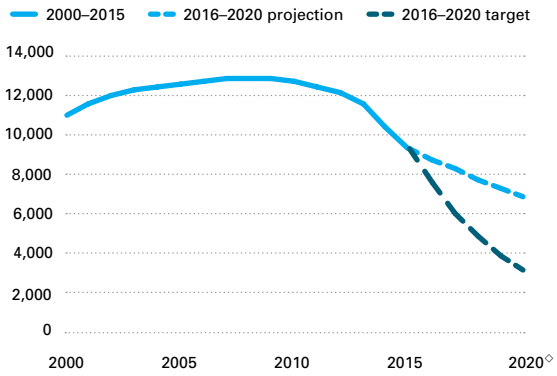
In addition to continuing implementation, the country team plans for three priorities:

1. Young adolescent health study: Building on findings from the Global Early Adolescent Study project, UNICEF MCO is supporting a longitudinal study on reducing sexual abuse and GBV, improving SRH outcomes, and empowering young adolescents (aged 10-14) to realize their rights. The study will include developing an evidence-informed, school-based intervention for young adolescents that is focused on developing more gender-equitable relationships and transforming harmful notions of masculinity and femininity.
2. Adolescent women's utilization of the PMTCT cascade: UNICEF MCO will support formative research on whether support from young mentor mothers benefits HTC, ART uptake, retention, and follow-up of HEI among adolescents. It will also link to growth monitoring, nutrition surveillance and early childhood development.
3. National PMTCT programme review: This will encompass maternal and neonatal health, child health, adolescent sexual and reproductive health, and PMTCT/ART. Importantly, the inclusion of ASRH recognizes the preliminary results of the data abstraction exercise.

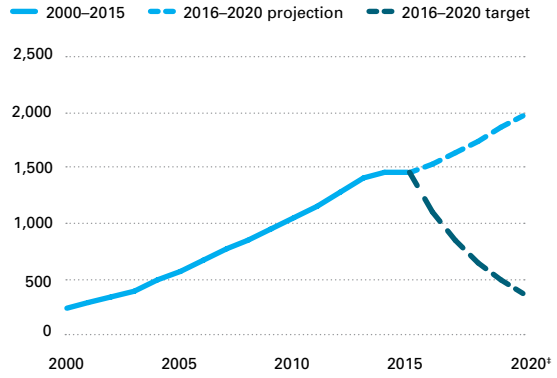
COUNTRY I **MOZAMBIQUE**

ADOLESCENT HIV TRENDS

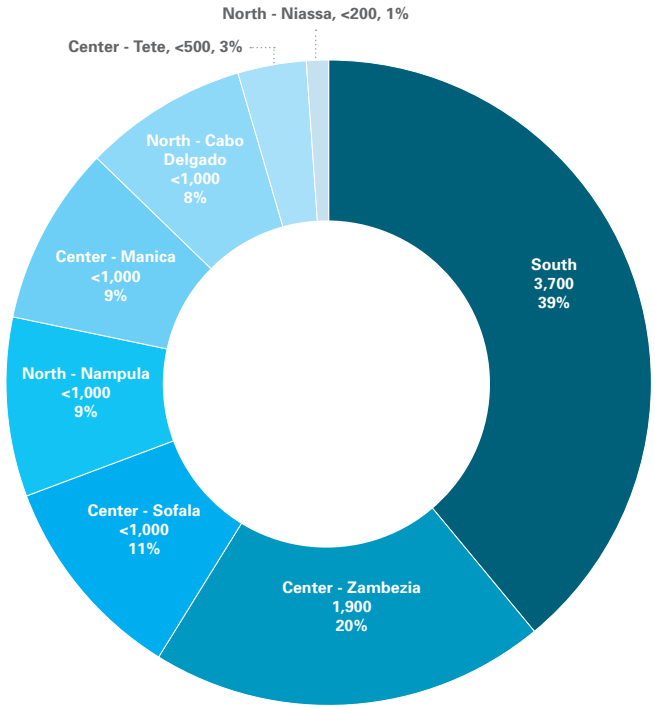
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015e



*Southern region disaggregated by province unavailable

BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015c	28,000,000	14,300,000	13,700,000
	Estimated population of adolescents (aged 10–19), 2015c	6,700,000	3,400,000	3,400,000
	% of total population that is adolescents (aged 10–19), 2015d	24.1%	23.5%	24.6%
	Estimated annual number of live births, 2010–2015 (annual average)c	1,000,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recentz	–	40.2 (2011)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015a	0.8%	0.8%	0.8%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015a	1.3%	1.6%	0.9%
	Estimated HIV prevalence among youth (aged 20–24), 2015a	5.0%	6.3%	3.7%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015e	68,000	39,000	29,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015e	9,400	6,300	3,000
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015e	1,400	<1,000	<1,000
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS

ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	37.2 (2009) [aa]	31.5 (2009) [aa]	27.4 (2011) [z]	48.5 (2011) [z]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	4.2 (2009) [aa]	10.3 (2009) [aa]	2.7 (2011) [z]	17.9 (2011) [z]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	33.1 (2009) [aa]	41.4 (2009) [aa]	42.5 (2011) [z]	43.5 (2011) [z]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	15.1 (2009) [aa]	5.6 (2009) [aa]	17.8 (2011) [z]	7.7 (2011) [z]
% of adolescent boys (aged 15–19) who have been circumcised	–	39.7 (2009) [aa]	–	36.2 (2011) [z]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	–	–	9.3 (2011) [z]	2.8 (2011) [z]
% of youth who have completed secondary school	–	–	4.3 (2011) [z]	7.5 (2011) [z]
% of young people (aged 20–24) married or in union by age 18	–	–	48.2 (2011) [z]	8.7 (2011) [z]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

Mozambique recognizes that adolescents and young people (aged 10-24) are a priority population for the HIV response in the country and has adopted the ALL IN platform as a means to guide operationalization of related components of the national HIV strategy (2015-2019). As a result, the Government of Mozambique has established a steering committee to coordinate all HIV interventions for adolescents and young adults. The committee is led by the NAC and consists of members from the mainline ministries (such as the Ministry of Health, Ministry of Education, and Ministry of Youth and Sports), other government sectors, bilateral and multilateral partners (notably, PEPFAR, UN, Global Fund primary recipients), civil society organizations, and importantly, members of adolescent and youth organizations. The Steering Committee is supported by a smaller technical work group on adolescents, similarly led by NAC.

Key outputs of the steering committee in 2015/2016:

1. Adolescents were actively engaged in the ALL IN rapid assessments. Consultations were conducted with adolescents representing all 11 provinces of the country, relevant government sectors, civil society and development cooperation partners. The final end product, the ALL IN report, was validated and circulated in December 2015.[26]
2. A national coordinating mechanism for adolescents has been established.
3. A schedule of activities for adolescents is being implemented by main partners. This joint schedule allows all partners to view current activities for adolescents and implementation locations, improving coordination and investments, and avoiding duplication of effort.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

1. The National HIV Strategy (2015-2019) is addressing, for the first time, adolescents and young people as a priority population.
2. The National HIV Law of 2014 supports the protection and provision of the rights of adolescents living with HIV, timely access to HIV testing services (establishing the age of consent at 11 years) and guaranteeing the right of adolescents to comprehensive sexuality education in schools. Implementation of programmes in line with these provisions is still inconsistent in some areas.
    a. The Government of Mozambique is still working on including comprehensive sexuality education in the primary and secondary school curriculum.
    b. Secondary school students now have access to condoms through schools counseling, professionals and vocational training centers.
    c. Girls can obtain access to contraception without parental consent through any health services. Although there is no clear policy on age of consent, it is clear that girls above the age of 15 will have access to contraceptives. However, for girls under 15, it depends on who is attending at the point of service delivery.

Challenges in the legal and policy environment:

1. The current national social protection system does not include cash transfers for adolescent girls and young women or PLWHIV.
2. There is no policy on retention of pregnant girls in school. Pregnant students are not allowed to attend school during the day and need to be transferred to the night shift.
3. No policies or laws addressing adolescent key populations are in place.

26 See: https://youtu.be/tF-m7Femq4E

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

The following priority adolescent populations were identified:

1. Adolescents living with HIV
2. 10-14 year olds
3. 15-19 year olds
4. Adolescent key populations (MSM, CSW, DU)
5. Adolescents who abuse alcohol
6. Orphans and vulnerable adolescents

Priority locations for acceleration are:

1. Nampula e Cabo Delgado Province in the north
2. Sofala e Zambézia province in Central Mozambique
3. Gaza, Maputo Cidade e Maputo Província in the south

The following interventions were proposed to accelerate achievement of the ALL IN targets:

1. HIV testing services
2. HIV treatment services
3. Peer education programmes
4. Life skills programmes at school level
5. SRH education in schools and at community level
6. Girl empowerment
7. Services for key populations

The main bottlenecks that affect the acceleration and implementation of these interventions are:

1. Low access to HIV services (from testing to care and treatment.
2. Stigma and discrimination is a barrier for retention to services
3. Low participation of adolescents in decision-making processes and programme design
4. Weak absorption capacity for adolescent programming at the community level by Global Fund primary recipients
5. Outdated surveillance information and lack of programmatic data disaggregated by age
6. Social norms associated with risk of infection:
    a. Initiation rituals
    b. Early marriage or early sexual debut
    c. Multiple concurrent partnerships
    d. Family and social exclusion of girls
    e. Child labour
    f. Widow purification ceremonies
7. Transactional and inter-generational sex

Progress in implementation of priority actions identified through assessments

2016 was a challenging year particularly due to competing, urgent priorities. As a consequence, ALL IN recommendations and subsequent steps (such as implementation of the in-depth analysis) have been postponed to early 2017. However, a certain number of actions supported by different partners are being undertaken, namely:

1. SMS Biz (supported by the UN): Mobile counselling and KAP assessment platform for SRH and HIV-related issues among adolescents and youth.[27]
2. Action for Girls project (One UN project, managed by UNFPA): Comprehensive SRH, including HIV prevention for adolescent girls.[28]
3. DREAMS (PEPFAR): Comprehensive interventions for adolescents and HIV in Xai-Xai City, Xai-Xai, Chokwe, Beira and Quelimane. Additionally, PEPFAR received funds to start implementation of services for adult males (as potential partners of young girls).
4. Geração Biz (supported by UNFPA): Includes SRH and HIV prevention and is aimed at reducing early pregnancy and unsafe abortion. This programme is supported by UNFPA and Pathfinder International with financial support from the Governments of Norway, Denmark and Sweden. The programme has 3 main prongs: health-based, school-based and community-based approaches. It has a national coverage and is present in 259 schools, 300 youth-friendly health services and 96 community youth centers.

Impact of the assessments on the use of strategic information on adolescents

The strategic information used in the country assessment helped to identify priority populations, locations, bottlenecks and proposed interventions. However, so far, it has not impacted on the use of routine data in the adolescent context, since the current paper-based M&E system does not allow for age group disaggregation.

However, Spectrum estimate exercises are now also focusing on HIV and adolescent data. Furthermore, the MoH has emphasized the need to report on adolescents as a specific population in the upcoming AIDS Indicator Survey report.

On the basis of the results of the rapid assessment on adolescents, the upcoming in-depth analysis will seek to identify gaps and barriers that limit impact of priority programme interventions. Additionally, the bottleneck analysis will highlight potential associations between prevalent social norms and cultural practices with risk of HIV infection.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

SMS Biz (U-Report) has proved to be a worthwhile investment in online and mobile technologies to improve access, utilization and monitoring of HIV and SRH services.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

Five key advocacy issues have framed engagement in 2015 and 2016:

1. Adolescents as a priority population at a policy and program level
   a. Included in NSP IV, Steering Committee at NAC, National Communication Strategy for retention in PMTCT and HIV treatment services (including adolescents aged 10-14.
   b. Establishment of a provincial (Zambezia. multi-sectoral or partner committee on adolescents, led by the provincial government permanent secretary.

27 http://www.unicef.org.mz/sms-biz-ira-providenciar-aconselhamento-personalizado-aos-adolescentes/
28 http://mptf.undp.org/factsheet/fund/JMZ00

2. Key populations
    a. Only very early advocacy and programming action has been undertaken so far. More effort is needed.
3. Data availability on adolescents
    a. There is a growing awareness about the need to have more age-disaggregated data for adolescents, as well as research to better understand social norms as potential drivers of the epidemic in adolescents. Some of these needs will be addressed through the in-depth analysis to be done in 2017.
4. Participation of adolescents
    a. Adolescents and youth are now part of the adolescent steering committee at national and provincial level.
5. Access and retention to services
    a. This is being addressed through ongoing work as part of the implementation of the Test and Treat strategy.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. Importance of government leadership to achieve progress.
2. Coordinated action among UN agencies is crucial. This led to one signature issue and one specific outcome in the UNDAF and UNJT on AIDS framework being dedicated to adolescents.
3. The ALL IN platform serves as a good basis for mobilization of partners.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

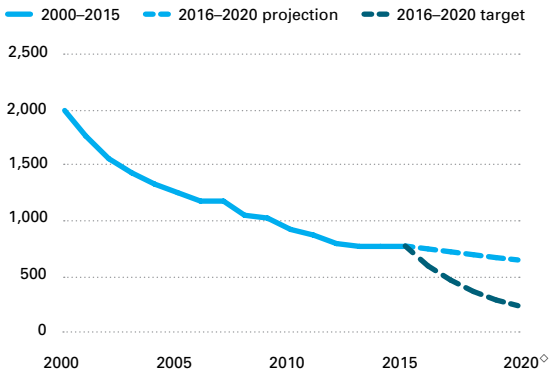
1. Further interagency coordination should be done, particularly to address GBV and human rights issues.
2. Implementation of ALL IN phase two.

A Progress Report **94**

COUNTRY I **NAMIBIA**

ADOLESCENT HIV TRENDS

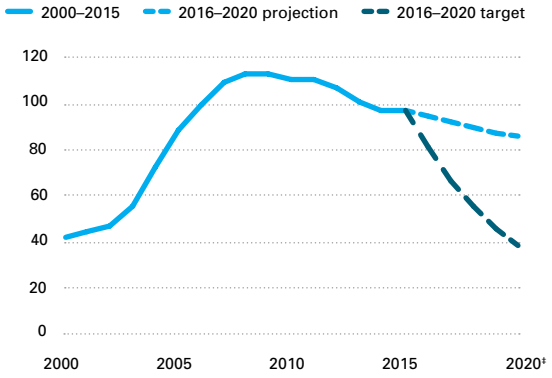
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

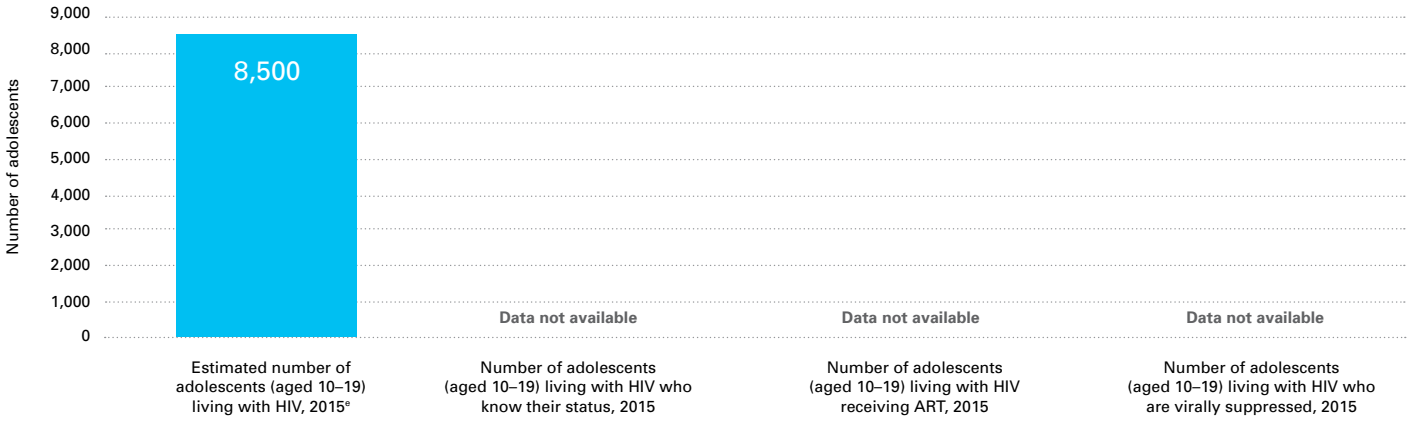
AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	2,500,000	1,300,000	1,200,000
	Estimated population of adolescents (aged 10–19), 2015[c]	540,000	270,000	270,000
	% of total population that is adolescents (aged 10–19), 2015[d]	21.9%	21.3%	22.5%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	70,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[bb]	–	14.9 (2013)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	1.4%	1.4%	1.4%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	1.7%	2.0%	1.5%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	4.2%	5.4%	3.0%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	8,500	4,600	3,900
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	<1,000	<1,000	<500
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<100	<100	<100
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	62.2 (2007) [cc]	58.5 (2007) [cc]	55.9 (2013) [bb]	51.4 (2013) [bb]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	1.1 (2007) [cc]	6.3 (2007) [cc]	2.1 (2013) [bb]	4.9 (2013) [bb]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	76.8 (2007) [cc]	84.0 (2007) [cc]	61.4 (2013) [bb]	75.1 (2013) [bb]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	12.8 (2007) [cc]	5.7 (2007) [cc]	28.5 (2013) [bb]	13.9 (2013) [bb]
% of adolescent boys (aged 15–19) who have been circumcised	–	16.6 (2007) [cc]	–	21.0 (2013) [bb]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	–	–	39.1 (2013) [bb]	33.2 (2013) [bb]
% of young people (aged 20–24) married or in union by age 18	–	–	6.9 (2013) [bb]	1.4 (2013) [bb]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

The coordination of the national HIV/AIDS response is guided by a well-stipulated National Coordination Framework for HIV/AIDS, with the National AIDS Executive Committee (NAEC) holding an overall coordination mandate. Membership includes youth-led and youth-serving organizations. One of these is AFRIYAN, an umbrella organization for adolescents and youth programmes in Namibia. Although there is no direct participation of adolescents in NAEC, AFRIYAN represents the voice of adolescents and their issues in this forum. Similarly, adolescents are represented through AFRIYAN in various technical working groups, including Education and Youth and HIV/AIDS TWG, ESA Commitment on Comprehensive Sexuality Education National Task Force and National Health Task Force. The engagement of youth-led organizations in this national coordination framework has raised the profile of adolescents and adolescent-targeted strategies.

In addition to these coordination mechanisms, AFRIYAN is representing adolescents in the end of term review of the National Strategic Framework Steering Committee and plays a central role in the National ALL IN Task Team. Through the ALL IN assessment and strategic planning process, UNICEF facilitated a partnership between government and two youth organizations – namely, AFRIYAN and AIESEC – wherein over 100 adolescents aged 10-19 were consulted through conversations, focus group discussions and workshops on the implementation of the adolescent component of the national HIV programme. A similar consultation was conducted with adolescents living with HIV through teen clubs. These consultations provided a forum to identify adolescents' representatives who then participated in the national validation workshop and the global ALL IN meeting in Harare in 2015. Their engagement has strengthened the voice of adolescents at programmatic and policy level in analysis of the programme environment.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

The government, with WHO and UNFPA support, has recently revised the Adolescent-Friendly Health Services Training Manual, developing a new training package for adolescents. This resource will be crucial in the implementation of regional plans where gaps in the delivery of adolescent-friendly services were identified. National ART guidelines are also being updated to align them with the new WHO guidelines. Adolescents' ART is a priority area in the guidelines.

The Child Care and Protection Act of 2015 has made provision for the age of HIV testing consent to be 14. This law is not yet enforced but awaiting the development of implementation guidelines. Once the guidelines are completed, the current age of consent of 16 will be reduced, thereby removing one significant barrier to HIV testing for adolescents in the country.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

1. The total number of adolescents living with HIV is 11,035, of which 6,087 are girls and 4,948 are boys.
2. The prevalence among females increases with age and the disparity widens between the ages of 20-24, which may indicate behavioural transmission as a new mode of infection during adolescence.
3. HIV testing is low among adolescents aged 15-19, with only 28.5 per cent and 13.9 per cent of female and male adolescents respectively having been tested over the past 12 months and received their results.
4. ART coverage among adolescents is 74 per cent among females and 86 per cent among males, which is below the national target. Coverage is highest in between ages 10-14, with 92 per cent among girls and 94 per cent among boys. It then declines between ages 15-19, reaching 61 per cent for females and 76 per cent for boys.

5. Viral suppression among 10-19 year olds on ARVs is 74 per cent for females and 70 per cent for males, which is below the national target of 80 per cent. The viral load suppression is higher among 10-14 year olds at 73 per cent, compared to 63 per cent among 15-19 year olds.
6. Condom use among adolescents is 61 per cent for females and 75 per cent for males. This coverage is lower than the national target of 85 per cent and 90 per cent, respectively.
7. Coverage for adolescent male circumcision is 21 per cent compared to the national target of 45 per cent.
8. Comprehensive knowledge of HIV amongst adolescents aged 15-19 is low, estimated at 56 per cent among girls and 51 per cent among boys.
9. The proportion of sexually active adolescents who reported having had an STI or symptoms of an STI in the last 12 months was 10 per cent and 5 per cent among females and males, respectively. The rate of adolescent pregnancy is 19 per cent.

There is no available data on comprehensive knowledge of HIV among adolescents aged 10-14, nor on age-disaggregated data for PMTCT. Although there is no data for adolescent key populations, there are some programmes that target these groups, including Society for Family Health (SFH) with support from PEPFAR and GFATM. During the assessment period, 610 female adolescent sex workers and 259 adolescent MSM were reached with prevention interventions.

Based on available data, 7 high-burden regions and 7 high impact interventions were identified for bottleneck analysis. These targeted population groups of adolescent girls and young women, adolescents living with HIV, adolescent mothers and pregnant adolescents, adolescents out of school, adolescents engaged in transactional sex and adolescents aged 10-14. The sub-national level in-depth analysis unveiled multiple bottlenecks, including:

1. Stock outs of HTC and VMMC supplies and ARV drugs
2. Health workers who are not trained in adolescents health-friendly services
3. Low levels of testing
4. Adolescents, particularly males, not initiated on ART after testing positive
5. Adolescent females lost to follow-up and not traceable
6. Poor data collection and management

To address these bottlenecks, regions have developed corrective action plans aimed at:

1. Stock management system strengthening
2. Increasing retention of rate of ART amongst adolescents
3. Increasing numbers of health workers trained in AFHS
4. Increasing number of ART sites providing AFHS
5. Achieving 100 per cent viral load suppression
6. Curbing teen age pregnancies.

There will be increased joint support towards adolescent-focused messages. Efforts will also be made to encourage parents and communities to support adolescent health-seeking behaviour for both HTC and ART in order to improve uptake, adherence and virological suppression.

These corrective action plans were validated at a national meeting held on 25-26 October 2016 and are currently being refined and costed to inform the development of national work plans and strategies for 2017 onwards.

Progress in implementation of priority actions identified through assessments

While implementation of regional plans is yet to commence, some notable progress has been made. The strategic information generated through ALL IN informed the Global Fund reprogramming process, particularly in the AGYW

service delivery area where US$ 3.5 million was mobilized. CDC provided the funding to UNICEF for the ALL IN assessments and has been an active partner in using the findings to inform programming and strategy development. In fact, ALL IN has raised the profile of adolescents to such a level that key national strategies including the Combination Prevention Strategy, National HTC Guidelines, End of Term Review of NSF process and the National AIDS Conference have incorporated adolescent-specific activities, as well as placing adolescents at the center of the national response. There has also been an increase in the participation of youth-led organizations in various national coordination mechanisms and technical working groups, strengthening adolescent voices.

The teen club approach for adolescents living with HIV has been scaled-up from 8 to 15 facilities, reaching over 500 adolescents every month. This has helped to improve retention and increase the number of boys and girls with full disclosure. The teen clubs have also been instrumental in the provision of psychosocial support for both adolescents and parents, which addressed depression and hopelessness amongst adolescents living with HIV.

Impact of the assessments on the use of strategic information on adolescents

The experience from the bottleneck analysis methodology not only equipped regional teams with knowledge and skills in data-driven planning, but is also informing their regular regional data review processes. The consolidated data from the assessment produced regional adolescent profiles, which visually highlighted low performance interventions. The regional profiles offered an opportunity for regions to interrogate, update and utilize data for planning purposes. This has created data demand and promoted data utilization at region level, strengthening ownership and a bottom-up approach to designing and improving quality of programme implementation. Through the bottleneck analysis process, regions have also identified data gaps and formulated plans to strengthen routine data collection, monitoring and reporting of interventions.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

Mobile phones and other technology will be among the tools used to address some of the identified programme gaps and bottlenecks in future. Currently, there has not been any initiative in this area.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

One of the main advocacy achievements, and a direct result of ALL IN, was the designation of an Adolescents Programme Officer in the Directorate of Special Programmes (HIV and AIDS) in the Ministry of Health and Social Services. This position had been vacant for a long time and will enhance coordination among sectors and partners.

Programmatic advocacy achievements include:

1. Featuring adolescents in the end term review of NSF, which is currently underway and will inform the new NSF 2017-2021.
2. Incorporation of adolescents in the combination prevention strategy.
3. The communication advocacy work on targeting adolescents in preparation for the National AIDS Conference which took place from 28-30 November 2016 as a build up to World AIDS Day on December 1st 2016.

This adolescent assessment and programme improvement also provided an opportunity for South-South learning, since Namibia learned from the experience of other countries (such as Nigeria) and offered an opportunity for other countries (Rwanda and Uganda) to learn first-hand through their participation in the launch of the in-depth analysis.

The First Lady of Namibia, H.E. Monica Geingos, was recently appointed UNAIDS Special Advocate for Young Women and Adolescent Girls, providing the country with a high-level platform for championing the newly-launched Start Free, Stay Free, AIDS Free agenda. The First Lady will launch the 3-Frees agenda before the end of 2017.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. There is a huge gap in programming for adolescents in terms of coordination, technical expertise, engagement of adolescents at national level and the actual delivery of services at sub-national levels.
2. There is a mismatch between availability of resources at national level and resources available to address key needs at sub-national level.
3. There is a need to strengthen the human resources capacity for health, with a focus on adolescent programming for an effective adolescent focus in the national response.
4. Absence of disaggregated data, especially for the 10-14 age group, has hindered effective programming for the early adolescent.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

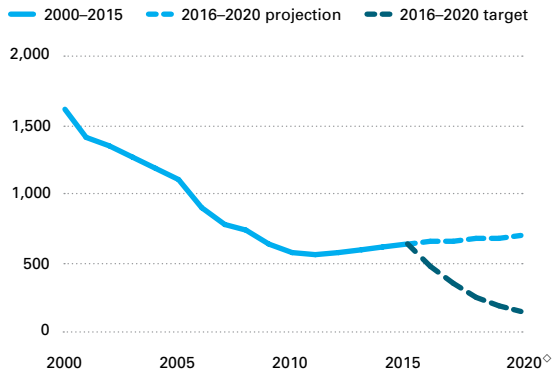
1. Intensify advocacy work on adolescents and HIV/SRH programming.
2. Redirect resources and efforts to priority areas at the sub-national level.
3. Support government efforts to deliver high impact HIV prevention, treatment and care interventions to adolescents, as well as interventions that address their broader needs to reduce vulnerability, risk of HIV infection, illness and AIDS-related death.
4. Conduct implementation science to determine best practices and target the most vulnerable adolescents for delivery of combined interventions.
5. Strengthen partnerships, especially with CDC/PEPFAR in data improvement and resource mobilization.
6. Follow the lead of WHO and UNFPA in rolling out the revised AFHS guidelines and ART guidelines targeting adolescents.
7. Use the findings and lessons learned from ALL IN to advocate for the bottleneck analysis and response planning to be repeated and extended to other regions.

A Progress Report **100**

COUNTRY I **RWANDA**

ADOLESCENT HIV TRENDS

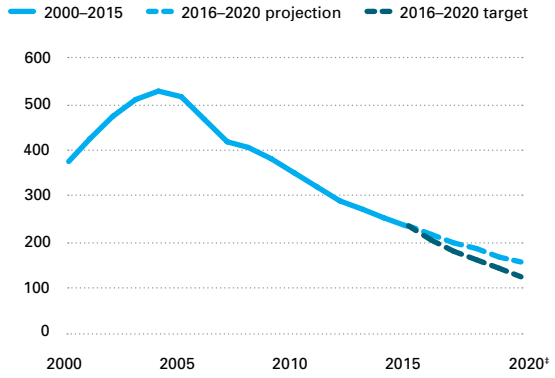
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	11,600,000	6,100,000	5,600,000
	Estimated population of adolescents (aged 10–19), 2015[c]	2,700,000	1,300,000	1,300,000
	% of total population that is adolescents (aged 10–19), 2015[d]	22.9%	22.0%	23.8%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	360,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[dd]	–	6.1 (2015)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.4%	0.4%	0.4%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.6%	0.6%	0.5%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	1.1%	1.3%	0.9%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	13,000	6,700	6,100
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	<1,000	<500	<200
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<500	<200	<200
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS

ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	49.3 (2010) [ee]	43.5 (2010) [ee]	61.6 (2015) [dd]	59.5 (2015) [dd]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	0.3 (2010) [ee]	0.4 (2010) [ee]	0.5 (2015) [dd]	0.7 (2015) [dd]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	–	–	–	–
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	27.3 (2010) [ee]	23.9 (2010) [ee]	27.4 (2015) [dd]	21.9 (2015) [dd]
% of adolescent boys (aged 15–19) who have been circumcised	–	10.0 (2010) [ee]	–	26.5 (2015) [dd]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	12.0 (2010) [ee]	–	14.5 (2015) [dd]	–
% of youth who have completed secondary school	9.4 (2010) [ee]	11.0 (2010) [ee]	–	–
% of young people (aged 20–24) married or in union by age 18	8.1 (2010) [ee]	–	6.8 (2015) [dd]	0.6 (2015) [dd]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

1. Districts located in north-eastern and western parts of the country are home to the majority of adolescents.
2. HIV prevalence among adolescents and young adults is below 1 per cent and varies by geographic location, with approximately one third of the districts having HIV prevalence above 1 per cent.
3. There is little difference in HIV prevalence between adolescent girls and boys aged 10-14, but among young adults aged 20-24, girls have higher prevalence than boys. Disparity in HIV prevalence between older adolescent girls and boys and young adult women and their male peers indicates the effects of sexual transmission and inter-generational sex.
4. New HIV infections declined between 2000-2008 as a result of the scale-up of HIV prevention interventions. However, the rate has slowed since 2008, indicating that current HIV prevention strategies have achieved maximum impact. Innovative strategies are needed to accelerate the rate of decline in HIV incidence. As long as the incidence rate remains unchanged, new HIV infections will continue to increase with population growth.
5. Mapping of new HIV infections has revealed that 50 per cent are found in 10 out of 30 districts. This means that if maximum efforts are put in place to address HIV prevention in these districts, at least half of the population in need would be covered, particularly girls who constitute 74 per cent of the estimated number of new HIV infections.
6. During earlier years of the HIV epidemic, AIDS-related deaths were increasing due to limited access to antiretroviral drugs. However, the scale-up of ART has since resulted in a decline in AIDS-related deaths, particularly among adults and children less than 10 years. The decline in HIV-related deaths among adolescents has been slower because the majority of those living with HIV are not receiving ART.
7. It is estimated that coverage of HIV interventions is generally low.
    a. Approximately 30 per cent of adolescents aged 15-19 tested and received results in a period of 12 months prior to the national household demographic survey conducted in 2014/2015.
    b. The majority (60 per cent) of the adolescent girls and boys living with HIV are not accessing ART services.
    c. Condom use is low (61 per cent among girls and 75 per cent among boys), as is medical circumcision for boys (24 per cent).
    d. Only 60 per cent of adolescents have comprehensive knowledge on HIV prevention.
8. The assessment showed that districts with higher levels of comprehensive knowledge also have relatively better coverage of HIV prevention services. This is a clear indication that deliberately providing adolescents with a combination of information, commodities and support to reduce risk behavior is critical to behavior change and impact. Similar efforts are required to improve coverage of HIV prevention interventions elsewhere in the country, particularly in the 10 districts with the lowest levels of knowledge at 25 per cent.
9. Access to secondary school seems to be a great challenge for adolescent boys and girls. The low secondary school attendance is a missed opportunity to reach adolescents with information on HIV and sexual and reproductive health.
10. The levels of young women in marriage or in union by 18 years of age is as high as 8 per cent and, despite being sexually active before the age of fifteen, only 33 per cent of the girls are using condoms. These observations could explain the high 6 per cent pregnancy rates among adolescent girls.
11. ANC attendance of up to 4 visits is low among adolescents.
12. Unlike ANC, coverage of human papilloma virus vaccination (HPV) vaccination is high and the country managed to provide 99.4 per cent of girls with three doses in 2014.
    a. Evidence from a study conducted in 2011, which showed that cervical cancer accounted for 27.3 per cent of

cancers among women in Rwanda, was behind the government commitment to implement a comprehensive national cervical cancer prevention programme for girls.

b. Main strategies included:

   i. Creation of a multi-disciplinary team of professionals to lead promotion and planning for delivery of the vaccine. This team included the Ministry of Education whose role was critical given that over 98 per cent of the girls targeted were in school.

   ii. Capacity-building of nurses, community health care workers and teachers to discuss cervical cancer and HPV vaccine.

   iii. Establishment of public-private partnerships with Merck for the initial supply of HPV vaccines, and with GAVI to ensure continuity of supplies through 2017.

   iv. Effective communication for awareness and demand creation through local government officials, the media, girls aged 11 and 12, schools, and community health workers for girls who are out of school.

Key bottlenecks found in relation to each intervention for HIV prevention, treatment and care were:

1. ART for adolescents living with HIV: Inadequate quality of services for adolescents living with HIV. For instance, 38 per cent of health facilities are not offering adolescent-friendly services and 23 per cent of adolescents on ART are not virally suppressed.
2. Maternal services for pregnant and breastfeeding adolescents: A low proportion of adolescents attend the first ANC in the first trimester and adolescents living with HIV are not initiated on ART on time.
3. In and out-of-school HIV prevention and SRH education: Low comprehensive knowledge and limited access to HIV prevention and SRH services.
4. Condom use and ASRH among adolescents: Limited access to condoms and SRH information, as well as low utilization of condom and contraceptive method.
5. Control of STIs for adolescents: Insufficient health facilities with trained health providers on STI control for adolescents and limited access to adolescent-friendly services at health centers.
6. HIV testing and counselling for adolescents: Low HIV testing among adolescents, inadequate number of staff with skills to provide HIV services and a high proportion of adolescents not receiving HIV test results.
7. Voluntary Medical Male Circumcision: Limited access to VMMC for adolescents and a lack of continuity between completion of the mandatory two doses of tetanus vaccine and circumcision.

Progress in implementation of priority actions identified through assessments

Having identified the priority interventions, Rwanda is in the process of developing a national operational plan and the government has engaged stakeholders, implementing partners and service providers to identify priority actions for each of the interventions. The operational plan will articulate strategic action, responsible parties and the results to be achieved by end of 2018.

Impact of the assessments on the use of strategic information on adolescents

The process of conducting the country data assessment enabled programmers and policy makers to appreciate the importance of programme coverage, identify gaps, and determine the population and geographic location which are most underserved. Using the data, stakeholders were able to analyze and understand how the programmes were performing, how to achieve better coverage, how to understand the underlying causes and how to prioritize actions to improve intervention coverage. In the event where data was either not reported or not available, data abstraction informed the adolescent situation. For example, the rapid assessment revealed that data on ART was not routinely disaggregated by age bands (10-14, 15-19) and that during the in-depth analysis, data for some generic indicators were found to be missing. In both of these situations, mechanisms were put in place to collect data from the facilities to fill in the gaps and, going forward, plans were laid out to that ensure data is adequately disaggregated and regularly reported at national and sub-national levels. The use of strategic information has been critical in identifying districts that are performing well and those that are not, and experiences and lessons learned from these have contributed to the process of developing a national plan to operationalize adolescent HIV and SRH national strategic frameworks.

B. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

Priority populations identified for advocacy are:

1. Adolescent girls and young women
2. Adolescents living with HIV, who need to be tested and enrolled on ART
3. Adolescents with special needs – adolescent mothers, adolescents and young women with disabilities, and adolescents out of school.

Findings from the rapid assessment informed the launch of ALL IN by the First Lady of Rwanda, providing a platform for high-level advocacy and commitment from policy makers on adolescent issues. The event was instrumental in mobilizing national stakeholders, including adolescents, and created awareness around the evidence that shows an increasing number of AIDS-related deaths and new HIV infections among adolescents. As a result, a series of awareness-raising campaigns have been held at district levels and among civil society organizations.

C. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. Knowledge of the geographical distribution of adolescents is key to inform planning and could guide how resources should be allocated for greater impact on adolescent outcomes.
2. Age-disaggregated data is critical to understand the populations that are left behind and most in need of interventions. Investing in routine service delivery data and in secondary analysis of survey data is crucial to inform adolescent programming.
3. Comprehensive knowledge and demand creation activities can improve the utilization of services by adolescents.
4. The high coverage of HPV vaccination among adolescents is an indication that it is possible to reach adolescents with key interventions if there is political commitment and clear policies.

D. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

The key priorities are to:

1. Finalize the 2017-2018 national operational plan for adolescent programming and support implementation and monitoring of priority programme interventions to achieve the set coverage targets.
2. Enhance multi-sectoral coordination mechanisms on adolescent health and wellbeing at national and sub-national levels.

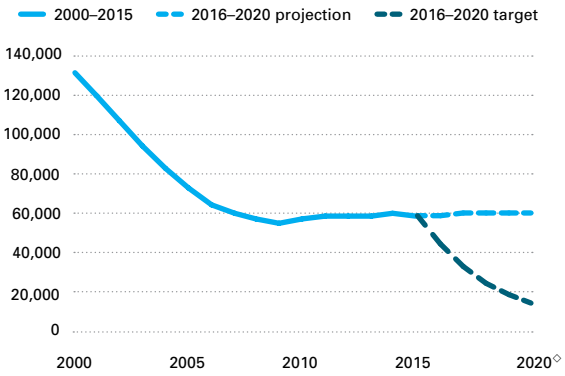
From the perspective of the team in Rwanda, these are the three most strategic opportunities that they will be seeking to leverage in 2017:

1. The ALL IN to end Adolescent AIDS agenda has come at the right time for Rwanda, given that the government is conducting a mid-term review of programme and sector-specific strategic plans such HSSP, NSP of HIV, etc. This is an opportunity to ensure adolescent issues are addressed and budgeted for.
2. To align organizations working alongside adolescents with priority programme interventions, strengthening coordination within and between sectors.
3. To make a case for adolescents to support in networking with organizations such as PEPFAR to leverage resources through the DREAMS.

COUNTRY I **SOUTH AFRICA**

ADOLESCENT HIV TRENDS

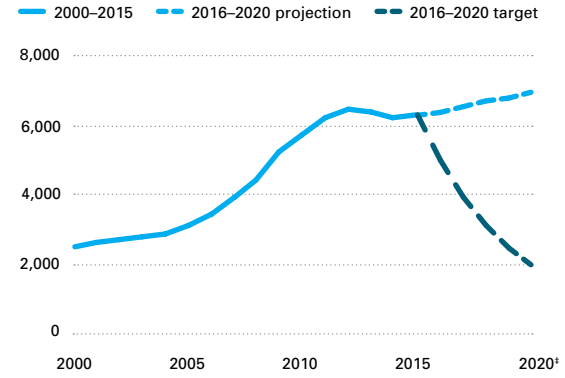
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	54,500,000	27,700,000	26,800,000
	Estimated population of adolescents (aged 10–19), 2015[c]	10,300,000	4,900,000	5,400,000
	% of total population that is adolescents (aged 10–19), 2015[d]	19.0%	17.8%	20.1%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	1,100,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[ff]	–	15.0 (2003)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	2.4%	2.3%	2.4%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	4.3%	7.0%	2.0%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	10.6%	16.1%	5.4%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	350,000	230,000	120,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	59,000	49,000	9,800
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	6,300	3,300	3,000
Policy	Age of consent for HIV testing[f]	12	12	12

HIV TREATMENT FOR ADOLESCENTS

ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	18.7 (1998) [gg]	–	–	–
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	2.9 (2003) [ff]	8.2 (2003) [ff]	–	–
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	1.4 (2003) [ff]	6.4 (2003) [ff]	–	–
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	–	–	–	–
% of adolescent boys (aged 15–19) who have been circumcised	–	–	–	33.3 (2012) [hh]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	–	–	54.7 (2014) [ii]	45.5 (2014) [ii]
% of young people (aged 20–24) married or in union by age 18	5.6 (2003) [ff]	–	–	–

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

South Africa undertook a consultative process towards developing the new National Strategic Plan on HIV, STIs and TB for the next five years. The Youth sector in South African National AIDS Council, as well as NGOs working with young people, were encouraged to participate in discussions and contribute towards its development. Some innovative national initiatives create a strong basis for the new strategy to powerfully address the needs of young people, including adolescents.

The first ever all-national campaign, SHE Conquers, was launched in June 2016 as part of efforts to prevent HIV and unwanted pregnancies among young women and adolescent girls, keep them in schools, fight sexual and gender-based violence, and empower them and their male partners with improved health and self-reliance. UNAIDS actively supports activation of this 3-year campaign, bringing together landmark initiatives implemented under PEPFAR's DREAMS, the GF, GIZ, and KFW, as well as other development partners. Through provincial consultations, priority packages of interventions and integrated reporting tools, the campaign was implemented at provincial, district and sub-district level, primarily focusing on locations with the highest burden of HIV, especially among adolescent girls and young women. Twenty-two districts in 7 provinces will be actively engaged by March 2017 and, by the end of the campaign, 52 districts in all 9 provinces will be covered, with continuous support from UNAIDS. UNAIDS' decentralized work at the provincial level plays a pivotal role in encouraging young people to engage further and lead the campaign.

In 2016, over 17,890 young people (49 per cent female) have benefited from the UNICEF-supported Sports for Development (S4D) programme with the Department of Education. The S4D Youth Leadership Programme sets the agenda for positive youth development, giving young people the chance to engage in meaningful activities, have a voice, take responsibility for their actions, and actively participate in sport and youth development programmes within their school. The initiative is based on the idea that sport can inspire positive change.

UNICEF partnered with iSchoolAfrica to equip 750 learners from 131 schools with the technology skills to develop and air messages and videos with a focus on GBV. The videos and GBV messages have received exposure on Facebook and Twitter, while media partners such as Mindset, Soweto TV, Bay TV, and 1KZN have also come on board to increase the exposure of the campaign. At the last count, over 2 million people have viewed the winning video.

Both UNICEF and the Department of Basic Education (DBE) have been working together to strengthen advocacy and communication activities through the Girls and Boys Education Movement (GEM/BEM). These are school-based clubs, formed by learners to help with access to training and information, as well as being a space where learners can discuss issues that matter to them. A guide for the learners and a manual for educators to address issues of violence in schools have been developed and finalized. Just over 200 GBEM members have been trained on how to prevent and respond to violence in their schools.

UNICEF also partnered with the University of Cape Town to explore the use of m-Health to engage adolescents living with HIV and improve their retention in HIV care and treatment. Using participatory action research, the Ecological Momentary Assessment App for Adolescents Living with HIV (EMA App Project) mobile application offers clinical symptom reporting, interoperability with existing medical records, lab reporting, real world contexts, situational and structural confounders, and future ideations and goal setting.

The first phase yielded many findings. Most interesting was the discovery that youth want to be represented as themselves in virtual worlds, despite the research team anticipating a preference for celebrities or other 'heroes'. This provides credibility to the idea of using a virtual avatar to aid symptom reporting (e.g., when reporting pain on a specific part of the body). Findings also indicated that future planning and ideation did not correlate to context or levels of education.

UNICEF also supported preliminary discussions and participatory dialogue with young people as part of the formative work towards delivery of PrEP for adolescents in select sites. Adolescent advisory community boards were engaged in understanding the knowledge, barriers and facilitators for HIV prevention package service delivery and the inclusion of PrEP.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

The National Department of Social Development developed the National Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Framework Strategy 2014-2019. This is an action guide for stakeholders which underscores SRHR as a basic human right for adolescents and therefore aligned to the South African Constitution and the Bill of Rights. The National ASRH&R Framework Strategy outlines five key priority areas that focus on:

1. Increasing co-ordination, collaboration, information and knowledge sharing of ASRH&R activities amongst stakeholders.
2. Developing innovative approaches to comprehensive SRHR information, education and counselling for adolescents.
3. Strengthening service delivery and support for various health concerns.
4. Creating effective community support networks for adolescents
5. Formulating evidence-based revisions of legislation, policies, strategies and guidelines

The National Department of Health developed the Adolescent and Youth Health Policy 2016-2020 to promote health and wellbeing of young people aged 10-24. The new policy recognizes and focuses on behavioural and structural causes of health and disease, while emphasizing the importance of increasing effectiveness of the adolescent health programme and achieving national coverage. The policy identifies six principle objectives, namely:

1. Use innovation to promote health and wellbeing
2. Provide comprehensive integrated sexual and reproductive health services
3. Prevent, test and treat HIV, TB and noncommunicable diseases
4. Reduce substance abuse and violence
5. Promote healthy nutrition and reduce obesity
6. Empower adolescents and youth to engage with policies and programmes on youth health

Under the leadership of the National Department of Health, a new HIV Testing Services (HTS) Policy 2016 has been developed. UNAIDS has supported high-level advocacy around the new policy with a landmark publication, '15 Million and More: How South Africa Revolutionized HIV Counselling and Testing', and successfully guiding continuous social and political mobilization for accelerated HIV testing, especially among young people and adolescents. The new HTS policy identifies groups of adolescents who need to be considered for HTS, including adolescents infected vertically who have not been diagnosed, adolescents acquiring HIV horizontally through early sex, and adolescents from key populations. Adolescents should be routinely tested for HIV and provided with adequate support for disclosure of HIV status. Girls and young women, including in- and out-of-school youth with an emphasis on those living in informal settlements, would particularly benefit from the implementation of the policy.

After the introduction of a revitalized and targeted HIV testing strategy, the National Sex Worker HIV Plan (2016-19) was launched by South Africa's deputy president, endorsing combination prevention approaches that include PrEP, UTT (Universal Testing and offering Treatment) and access to legal and other social services for young women and girls engaged in sex work.

The national PrEP programme has been initiated at demonstration pilot sites and early lessons analyzed, with support from UNAIDS and WHO. Currently, innovative approaches are being adopted to expand PrEP among SWs and MSM, strengthening prevention among key populations, especially young people, with clear, practical guidelines essential in ensuring that PrEP is delivered safely according to latest global recommendations.

The new National Strategic Plan on HIV, STIs and TB 2017-2022 (NSP) is currently being developed and emphasizes the need for a comprehensive multi-sectoral prevention programme that focuses on high-burden areas and priority populations. Prevention efforts should result in changes to behavior such as early sexual debut, low condom use, multiple concurrent partnerships, and alcohol and substance abuse. The new NSP aims to reduce HIV incidence and teenage pregnancy by 75 per cent, and to keep girls in school. Some of the priority programmes identified for

implementation over the 5-year period include:

- Ensure mapping of hotspots and targeted prevention responses in all districts.
- Combination prevention programmes involving multiple government departments that focus on increasing condom use and addressing social and structural drivers such as GBV, poverty, intergenerational and transactional sex, and alcohol and substance abuse.
- Ramp up programmes to reduce HIV, STIs and teenage pregnancies.
- Fully implement the new Department of Basic Education policy on HIV, TB and STIs in schools. Reach all universities and colleges with comprehensive programmes.
- Address STI and HIV risk associated with GBV, intimate partner violence, and alcohol and substance abuse.
- Ensure that 90 per cent of all people living with HIV know their status, that 90 per cent of all people diagnosed with HIV receive ART, and that 90 per cent of all people receiving ART are supported to adhere to it and achieve viral suppression.
- Ensure that proven biomedical prevention programmes are scaled up, including medical (and safe traditional) male circumcision, PMTCT and PrEP.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

South Africa did not conduct the formal ALL IN assessments (as per the tools and processes outlined in ALL IN guidance). Given the country context and the various initiatives and focus on adolescents, the approach was different – namely, reviewing the assessment tools and pulling together necessary data and information to highlight key gaps, challenges and actions to accelerate adolescent HIV prevention, treatment and retention in care. There are several initiatives in the country that have helped to put together adolescent HIV information, including work with DREAMS, the HSRC surveys, MRC PMTCT impact study and the generation of UNAIDS Spectrum estimates. In addition, UNAIDS is working with partners to provide demographically-disaggregated (by sex and age) estimates of PLHIV, ART coverage and incidence. This geospatial model will be a major step forward in HIV estimation and crucial for informing prevention and 90-90-90 target setting, as well as measuring the impact of the NSP and She Conquers targets. The proposed next steps include reviewing information on adolescents and HIV at decentralized levels, selecting high prevalence districts, understanding gaps in data and using the cascade approach towards highlighting this data, understanding bottleneck analysis, prioritizing actions and tracking results. There will also be a focus on leveraging partnerships at decentralized levels towards achieving results for adolescents.

Below are highlights of the adolescent HIV programming activities that UNICEF and UNAIDS South Africa have been directly involved in:

a. *Supporting better understanding of data for adolescents and HIV*

Ongoing technical and financial support to the National Department of Health (NDOH) in partnership with Human Sciences Research Council (HSRC) to conduct secondary analysis on existing data sets and the 2016 South African Behavioral Survey (SABSSM) at national, provincial and selected district levels, thereby improving understanding and planning of HIV/ART programmes for adolescents aged 10-14 and 15-19. This work is in progress with reports expected in 2017.

Technical support was provided for the development of protocols and questionnaires in preparation for field-level data collection for the 2016 South Africa Behavior Surveillance Survey (SABSSM V). A pilot study was completed in October 2016 and the main survey commenced with fieldwork data collection in half of the country. The final report is expected in 2017.

Preliminary data analysis of disaggregated data for adolescent HIV treatment in selected facilities in

implementation districts gave a better understanding of the gaps and the need to prioritize and focus on adolescents.

b. *Supporting the design, roll out and monitoring of the 90-90-90 campaign for HIV and TB, with a specific focus on adolescents*

This work was conducted closely with the technical working group, reviewing the pediatric and adolescent-specific HIV targets, cascades and indicators.

Significant losses are clear along the continuum of care cascade, from estimated number of children and adolescents living with HIV, to those who know their HIV status, to treatment. One of the key challenges faced during this work was the lack of disaggregated data for age groups 10-14, 15-19 and 20-24. Routine data for the HIV and TB programmes is currently available for 0-15 years and 15-49 years. However, the National Indicator Data set for the District Health Information System (DHIS) has been revised and is expected to be in place from April 2017, which will help to provide disaggregated data on adolescents more routinely in 2017-2018.

UNICEF South Africa is working with districts in the Eastern Cape Province to identify bottlenecks in the cascades and develop specific actions linked with results and the 90-90-90 targets using the bottom-up planning approach (3 feet). For example, work was undertaken in one sub-district in the Nelson Mandela Bay Metro District to understand the data on adolescents along the HIV continuum of care. The analysis from the programme data available showed that over 30 per cent of HIV positive adolescents are lost to follow-up within 6 months after initiation on ART. UNICEF continued to work with the district and facility teams to identify bottlenecks and action plans to improve coverage and retention for adolescents. There are limitations in the programme data sourced through Tier.Net, as the data does not currently capture how many of the adolescents returned to the treatment programme after follow-up.

A key bottleneck identified during the facility-level analysis of data was keeping patients on HIV treatment in retention and care. Facility staff expressed specific concern and one action identified was to set up adherence clubs at facilities. In March 2016, support was provided for training of district and facility staff, in partnership with Nelson Mandela Bay Metro district management and an implementing partner to establish and run these adherence clubs. UNICEF is working with the district to explore setting up these clubs for and with adolescents.

c. *Understanding the estimates for adolescents and HIV*

UNICEF South Africa continued to provide technical support to the generation of UNAIDS-led HIV Spectrum estimates for 2015. These estimates help to understand the magnitude of the HIV burden, including the estimated need for HIV prevention, treatment, care and support services. For 2015, there was a specific effort to generate estimates on adolescents aged 10 -19. The national-level HIV estimates were completed and are available online.

d. *Understanding the data on pregnant adolescents within the larger cohort of pregnant women in the MRC led PMTCT Impact study*

The Medical Research Council (MRC) -led PMTCT Impact study has provided critical information on the challenges and gaps involved in the PMTCT cascade over three time periods, namely, 2010, 2011, 2012. Further analysis of the data caused concern over rates of MTCT transmission amongst adolescent mothers – for example, that young pregnant mothers under the age of 20 contributed significantly more new HIV infections in children than any other age group. This has led to an interest and focus on further analyzing the data to understand the issues and factors affecting adolescents in order to facilitate action. This work is ongoing and further data, including an understanding of adolescent data, is underway.

Progress in implementation of priority actions identified through assessments

There are several initiatives aiming to reach adolescents with comprehensive HIV prevention and treatment programmes, with a focus on adolescent girls. These include:

1. The three-year She Conquers campaign (2016-2019) focuses on prevention of HIV and teenage pregnancy among young women aged 15-24. Specific aims are to decrease new HIV infections (by at least 30 per cent from 90,000 to 60,000), decrease teen pregnancy (by at least 30 per cent from 73,000 to 50,000), keep girls

in school (by increasing retention by 20 per cent), decrease GBV by 10 per cent, and increase economic opportunities for young people by 10 per cent. Through a data-driven approach, 22 priority sub-districts have been identified for interventions by March 2017.

2. DREAMS is a global partnership between PEPFAR, the Bill and Melinda Gates Foundation, and Girl Effect. It seeks to reduce new HIV infections in adolescent girls and young women in 10 sub-Saharan African countries, including South Africa. The DREAMS initiative is being implemented in five districts – eThekwini, uMgungundlovu, uMkhanyakude in KwaZulu Natal (KZN), the City of Johannesburg and Ekurhuleni in Gauteng (GP). Its focus will be on 31 sub-districts and,within these, 19 high-transmission areas.
3. Through a grant from UNITAID, UNICEF has partnered with the NDoH to implement a 5-year (2016-2021) project to scale PrEP delivery and linkage to testing for sexually active older adolescents in South Africa (aged 15-19) in three districts – uMkhanyakude in KZN, City of Johannesburg in GP and City of Cape Town in Western Cape. The lessons learned in this project will contribute to HIV prevention programmes for adolescents, including She Conquers campaign and the eventual roll-out of quality comprehensive HIV prevention for adolescents such as bio medical, structural and social interventions.

Impact of the assessments on the use of strategic information on adolescents

South Africa did not conduct formal ALL IN country assessments. However, as described above, several ongoing initiatives have analyzed the data and reinforced the need for a synergized, coordinated approach at sub-national levels.

Advocacy on the need for robust disaggregated data for adolescents has led to a revision in national data collection systems. This will be included in the revised data set for 2017/2018.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

There are a number of programmes or projects attempting to reach adolescents through mobile technology that share key messages on health, sexual and reproductive health:

1. B-Wise is the NDoH platform that allows sharing of health messages with adolescents, including online discussions with technical experts in relevant fields.
2. UNICEF South Africa has been working to understand and support digital platforms in South Africa that provide HIV and SRH information to young people. Work was completed in partnership with Health Enabled, and a report which included recommendations on how to address identified gaps using digital technologies is available.
3. UNICEF also partnered with the University of Cape Town to explore the use of m-Health to engage adolescents living with HIV and improve their retention in HIV care and treatment. Using participatory action research, the Ecological Momentary Assessment App for Adolescents Living with HIV (EMA App Project) mobile application offers clinical symptom reporting, interoperability with existing medical records, lab reporting, real world contexts, situational and structural confounders, and future ideations and goal setting.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

1. Multi-sectoral approach to HIV Combination Prevention services delivery to include promotion of condom and lubricant use, PrEP, reduction in multiple sexual partnerships, delaying sexual debut, highlighting the risks of intergenerational and transactional sex, and emphasizing the dangers of alcohol and substance use.
2. Integrated HIV, STI and TB services for optimum utilization of resources, while maximizing entry points to care such as screening and testing.

3. Address social and structural barriers for adolescents in demanding and accessing quality combination HIV prevention and SRH services. May include services for adolescents who have experienced GBV and sexual coercion, youth-focused livelihood protection, Isibindi programmes targeted for OVCs, and community mobilization and norms change programmes.
4. Initiate ART for all PLHIVs, strengthen linkage and retention to care so as to achieve viral suppression, and reduce ongoing HIV transmission.
5. Explore scaling-up of available technology as a priority for building communication avenues and social mobilization to reach all adolescents with a package of core services.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. National leadership for a sustained adolescent HIV prevention response is critical. The NDoH, South African AIDS Council and the Presidency have provided leadership and guidance in ensuring that adolescent and youth HIV prevention programmes are prioritized and adequately resourced over the next 5 years. This is evident in the development of the new Adolescent and Youth Policy 2016-2020, the HTS Policy 2016, She Conquers campaign and the National Strategic Plan for HIV, STI and TB 2017-2022.
2. There is a continual need to review and use adolescent health information collected at primary health care level and reported to DHIS and Tier.net, to effectively inform and improve access and uptake of services, as well as target interventions to age-groups in need.
3. For successful adolescent programmes, services must be offered in an integrated fashion, leveraging existing HIV, STI and TB services provided at health facilities.
4. Build on current national adolescent and youth prevention efforts, such as S4D YLP, Girls and Boys Education Movement and She Conquers, to yield high impact results and ensure youth engagement at all levels and times in the programme.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

UNICEF South Africa will contribute by focusing on:

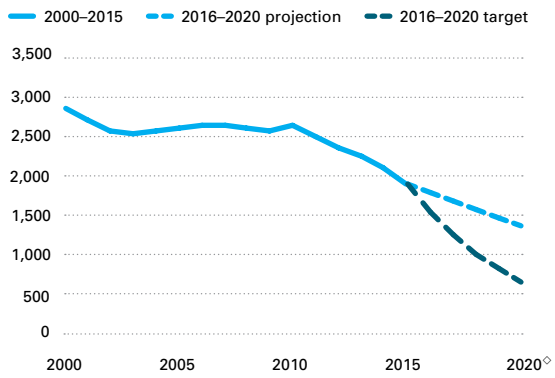
1. Supporting the Government on implementing the She Conquers campaign
    a. Decreasing new HIV infections (by at least 30 per cent from 90,000 to 60,000)
    b. Decrease teen pregnancy (by at least 30 per cent from 73,000 to 50,000)
    c. Keep girls in school (increase retention by 20 per cent)
    d. Decrease GBV (by 10 per cent)
    e. Increase economic opportunities for young people
2. Reducing new HIV infections in adolescents in line with the new NSP by:
    a. Supporting adolescent-focused activities within the PMTCT programme
    b. Rolling out PrEP demonstration projects for adolescent 15-19 year olds
    c. Improving the retention and care of adolescents living with HIV in 3-feet districts through different approaches (including the implementation of a virtual portal and app to support improved access)
    d. Strengthening the implementation of evidence-informed community-based SRH interventions
    e. Improving disaggregation of adolescent HIV data across 3 feet districts
3. Reaching 90-90-90 targets for adolescents by developing HIV prevention and continuum of care cascades, as well as technical assistance for district micro-planning in 3 feet districts.

4. Creating a geospatial module to provide demographically-disaggregated estimates of PLHIV, ART coverage and incidence at sub-national levels.
5. Continual collaboration with relevant sectors and partners (including UN family) on other important areas, such as reducing teenage pregnancies, keeping girls in school and addressing structural drivers of the HIV epidemic in adolescents.
6. Raising awareness of SRH interventions through community engagement within the areas identified. This includes identifying platforms at schools and healthcare centers for information dissemination and social behavior change strategies.
7. Utilizing community radio platforms to disseminate key messages and information to achieve social and behavior change within target groups in key areas.

COUNTRY I **SWAZILAND**

ADOLESCENT HIV TRENDS

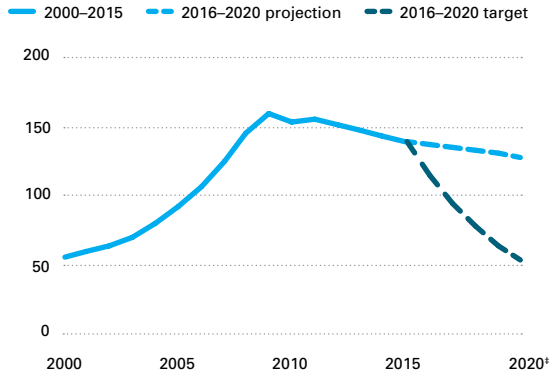
New HIV infections among adolescents (aged 15–19), 2000–2020[◇a∞]



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

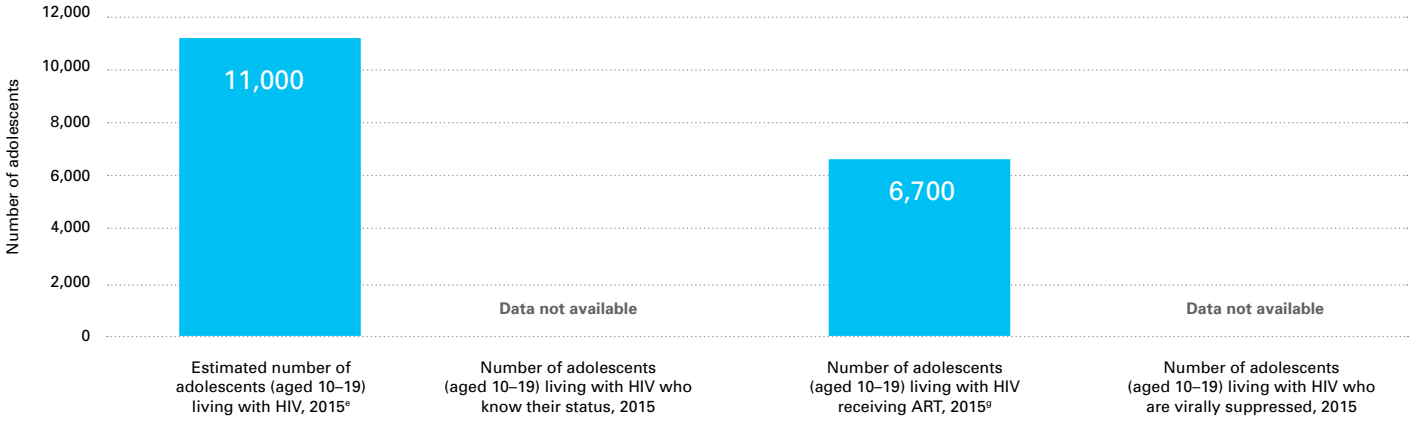
AIDS-related deaths among adolescents (aged 10–19), 2000–2020[‡b∞]



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	1,300,000	650,000	640,000
	Estimated population of adolescents (aged 10–19), 2015[c]	300,000	150,000	150,000
	% of total population that is adolescents (aged 10–19), 2015[d]	22.9%	22.4%	23.3%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	37,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[ii]	–	16.7 (2014)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	2.4%	2.4%	2.4%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	5.3%	7.4%	3.1%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	16.2%	22.8%	9.9%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	11,000	7,100	4,100
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	1,900	1,500	<500
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<200	<100	<100
Policy	Age of consent for HIV testing[f]	12	12	12

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	52.0 (2007) [kk]	50.4 (2007) [kk]	56.4 (2010) [ll]	52.1 (2010) [ll]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	1.3 (2007) [kk]	3.8 (2007) [kk]	1.1 (2010) [ll]	2.7 (2010) [ll]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	–	74.8 (2007) [kk]	–	92.4 (2010) [ll]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	10.0 (2007) [kk]	1.8 (2007) [kk]	22.8 (2010) [ll]	18.4 (2010) [ll]
% of adolescent boys (aged 15–19) who have been circumcised	–	33.3 (2007) [kk]	–	–
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	28.7 (2010) [ll]	27.4 (2010) [ll]	–	–
% of young people (aged 20–24) married or in union by age 18	6.5 (2010) [ll]	0.4 (2010) [ll]	–	–

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

As part of efforts to strengthen adolescent engagement, including on the HIV response, the government has institutionalized a 'Youth Parliament' with the support of UN partners – an annual forum where young people engage with leaders and decision-makers to show them that they too are a meaningful voice in the crafting of their future. The 2016 forum was attended by 94 adolescents chosen from all four regions of Swaziland, with a focus on the Sustainable Development Goals (SDGs). It included discussion on ending AIDS and participants hoped to influence government and parliamentary decision-making processes as active citizens. Initiated in 2009, the forum has been institutionalized since 2015.

Following the findings of the ALL IN assessment, a series of national dialogues on HIV prevention were held to better understand adolescent and young people's needs through meaningful engagement and collaboration with youth networks.

Furthermore, the National Emergency Response Council on HIV and AIDS (NERCHA), in partnership with UNAIDS and UNICEF, hosted a high level dialogue on HIV Prevention for Young People in Swaziland in April 2016. This meeting provided a forum for young people to articulate their needs and voice their perspective on HIV prevention programming in order to guide the development and implementation of tailored HIV prevention interventions. This dialogue was informed by focused community and regional level consultations, where young people aged 10-24 in and out of school, young people living with HIV and key populations including young sex workers, men having sex with men and drug users, were engaged through mass media, social media and focus group discussions. The regional consultations resulted in the development of a national young peoples' communiqué on HIV prevention, presented at the High-Level Meeting on Ending AIDS in New York in June 2016 by Her Royal Highness Princess Sikhanyiso.

In addition, a national CSE/ASRH Technical Working Group has been established with young people from youth-led and youth-serving organizations, helping to coordinate partners working on CSE/ASRH. This is critical to avoid duplication and promote decentralization of efforts, particularly to underserved rural communities. A community-based network has been strengthened through the established Tinkhundla Youth Associations. These useful associations ensure that the voice of young people is heard during programing within their communities.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

1. A draft Sexual Offences and Domestic Violence Bill, which has been under discussion for several years, has been re-submitted to Parliament and is awaiting debate. It is expected that the improved legal environment will improve protection for adolescents, especially girls, against sexual abuse and exploitation – a key driver of adolescent vulnerability to HIV.
2. Swaziland launched the HIV Investment Case as a road map for fast-tracking HIV Response to ending AIDS by 2030, with women and young girls as the top priority population to be reached and engaged.
3. A number of studies have either been concluded or are currently underway with the aim to inform polices and or legal reform. These include:
    a. A Conditional Cash Transfer Study with the aim of retaining young girls in school. Findings will be used to better inform the national social protection strategy.
    b. A PrEP modelling study with special focus on young women and girls and a related feasibility study that has been developed and is awaiting implementation.
    c. Swaziland has participated in a regional study to assess laws promoting or hindering access to ASRH services. The validation of the national report and development of an action plan will be undertaken in 2017.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

The 2015 ALL IN phase one assessment highlighted the following key findings:

1. HIV prevalence among young adolescent girls and boys aged 10-14 was above 3 per cent (3.4 per cent in females and 3.5 per cent in males). However, in later adolescence (ages 15-19), a higher HIV prevalence of 5 per cent was recorded among girls when compared to their male counterparts (3 per cent).
2. Very slow decline in AIDS-related deaths was recorded between 2010-2013. During the same period, there was a slow decline in new HIV infections.
3. While HIV incidence among adolescents aged 10-19 is not known, a current survey indicates higher rates among adolescent girls (aged 18-19) at 3.9 per cent compared to boys (aged 18-19) at 0.8 per cent. Figures also show HIV incidence rates of 4.2 per cent in young women (aged 20-24) compared to young men aged 20-24 (1.6 per cent).
4. Coverage levels are low in all interventions, where data was available for adolescents. HIV testing and counselling was 57 per cent in girls and 30 per cent in males, ART coverage was 51 per cent, VMMC was 18 per cent and access to media was 27 per cent.

The following bottlenecks were highlighted in the assessment:

1. Significant data gaps on programmatic progress and targets, therefore making it difficult to track against targets and limiting the scope of information for programme planning, including an equity-focus on access to services by adolescents.
2. Small representation of adolescents in surveys (i.e. ethical issues, sampling).
3. Challenging policy environment on the subject of social and programmatic enablers, with concerns including the protection of adolescent girls from sexual violence, discrimination, and the enabling environment for meaningful consultation with and engagement of adolescents.

Based on the findings from the rapid assessment and engagement with key stakeholders, the following key priority actions were defined:

1. **Understand barriers** to access, delivery, utilization of services and interventions on HIV for adolescents, with a focus on HIV testing and counselling (HTC), ART, condom use among sexually active adolescents, comprehensive life skills, sexuality education in school and communities, economic and family strengthening for vulnerable adolescents and their families, and scale-up of VMMC.
2. **Improve access and quality** of services and interventions by promoting innovation, integration of services for adolescents and strengthening systems for delivering programmes to adolescents in clinical settings, schools and communities.
3. **Strengthen policy implementation** and address contradictions in policy that affect access and programme delivery for adolescents.
4. **Meaningful engagement and collaboration with adolescents** to better understand their perspectives and jointly define programme response, including their engagement in monitoring activities.
5. **Improve data** availability on adolescents (ages 10-14 and 15-19) by improving survey sample size, disaggregation and alignment of indicators across surveys on HIV and adolescents. Address ethical limitations to involving adolescents younger than 18 in studies or research, and undertake adolescent-focused secondary analysis of existing data from surveys and centralized databases.
6. **Strengthen cross-sectoral coordination mechanism** for adolescent programming.
7. **Invest in advocacy and communication on policies** to raise awareness and demand among adolescents.

The in-depth data analysis on adolescents in priority sub-national areas (Tinkhundla) has been incorporated into the Mode of Transmission review, which is currently being conducted, and will include age and sex disaggregated data on adolescents. Results of this study are expected in the first quarter of 2017. The findings of the review will inform the development of a specific HIV response intervention package and plan for adolescents.

Progress in implementation of priority actions identified through assessments

The national Health Management Information System (HMIS) is currently being revised and a client-based information management system (CMIS) is being piloted in 23 selected health facilities. This real-time data collection system will improve accuracy, timeliness and reliability of data, including age and sex disaggregated data on adolescents in the coming years.

A total of 1,715 adolescents have been involved through the online platform U-Report to provide feedback on their fears, state preferences regarding HIV Testing Services (HTS) and inform service quality improvement.

As part of advocacy emerging from the results from the rapid assessment on adolescents, the country submitted a concept note to the Global Fund, focusing on HIV prevention among adolescents and young women. In February 2016, the Kingdom of Swaziland launched an ambitious programme to invest in education and socioeconomic needs of adolescent girls and young women, strongly supported by the Global Fund. The new approach combines innovative measures that improve health by removing barriers to education among girls, supporting access to sexual and reproductive services, addressing GBV, and improving the wellbeing of girls and their families. By addressing social factors that put adolescent girls and young women at increased risk for HIV, these investments will build on the leadership of Swaziland in addressing HIV and TB, in part by improving the integration of essential services that reach them.

A 2016 assessment on experiences of Adolescents Living with HIV (ALHIV) to identify programme gaps has been undertaken in partnership with the Swaziland National Network of People Living with HIV (SWANEPWHA). The findings from the assessment are being used by the network to provide psychosocial support to adolescents and reduce HIV associated stigma.

In 2015 and 2016, a new Ministry of Education and Training life skills curricula that strengthens HIV prevention and sexuality education programming was institutionalized in secondary schools. A total of 1,000 teachers have been trained on the application of the curriculum.

In partnership with Baylor College of Medicine Children's Foundation - Swaziland (BCMCF-SD), there has been collaboration with adolescents as peer providers, peer support groups (e.g. adolescent clubs or Teen Clubs) with a focus on ALHIV. The purpose of the Teen Clubs is to empower HIV-positive adolescents in Swaziland to live positively and to successfully transition into adulthood. Teen Club sessions have been conducted to provide psychosocial support and to create demand for adolescent sexual reproductive health services through teen support services. Approximately 2,000 adolescents (aged 10-19) have been actively engaged in the Baylor clinics and, of these, 83 per cent participated in the Teen Club sessions.

As part of efforts to improve comprehensive knowledge on AIDS, the UN has supported training of 27 peer educators in higher institutions of learning who have subsequently provided HIV prevention information to 5,000 young people in these institutions.

In addition, in 2016, with support of the UN system, 37,000 young people have received HIV prevention information through the annual traditional gathering Reed Dance, also attended by the Head of State.

In order to improve access to adolescent-friendly SRH services, a national training manual for health care workers has been developed and is being used to support capacity-building of service providers. Using the manual, 100 health care workers (nurses) have been trained on Adolescent and Youth Friendly Services (AYFS) and efforts are underway to establish Teen Clubs in selected health facilities.

Impact of the assessments on the use of strategic information on adolescents

With the support of the UN, an extensive HIV prevention assessment and geospatial mapping is being conducted.

It includes an in-depth analysis on adolescents and will be completed in early 2017. The work will assess the sub-national HIV programme response for adolescents, focusing on who, where and what will make maximum impact on new HIV infections and AIDS-related deaths. It wll also analyze gaps and barriers to improve effective coverage of priority programme interventions in priority locations. This will support improved targeting, as well as geographic, demographic and epidemiologic prioritization, and help to enhance equity in health access and outcomes. The findings will inform development of the next generation of the national strategic plan for HIV and related advocacy agenda, and the HIV combination prevention plan. This links to and will complement a national prevention package for adolescent girls that has been developed and is being implemented through support from both DREAMS and Global Fund.

Furthermore, findings from the rapid assessment have informed the revitalisation of a national focus on adolescents, emphasizing adolescents in the draft National Development Strategy and the National Health Sector Strategic Plan II, which has been finalised and launched.

Finally, with support of the UN system, the country has now developed an Adolescent Profile (2014) and used findings from the assessment to inform a State of Youth Report (2016).

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

Through the use of U-Report, adolescents have been providing feedback on quality of information and services, as well as to inform service quality improvement.

In addition, an online campaign used a sponsored Facebook page to raise awareness around sexual and reproductive health, reaching 33,928 adolescents in 2016.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

High-level advocacy by the UN and other partners in the country has highlighted violence against women and children (including adolescents). As a result, a high-level task force on violence and multi-sectoral task team on violence (MTTV) has been launched by the government, to provide political and technical leadership in the response to violence in Swaziland.

As a result of ALL IN advocacy efforts, the government is developing plans for disaggregation of data by age groups, including 10-14 years, and 15-19 years, as part of the development of a new client data management information system in the health sector.

The UN advocacy for strengthening comprehensive sexuality education has led to a successful scale-up of a life skills and HIV prevention education curriculum to all 254 secondary schools in the country.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. There is a need to have disaggregated data to inform both policy and programmes, and to benefit specific adolescent population sub-groups.
2. Partnerships are critical for successful implementation of specific interventions, including advocacy.
3. Advocacy on sustained resources for adolescent-focused interventions is essential to success.
4. There is a need for strengthened coordination across sectors and to develop and scale-up an integrated adolescent-focused programme.

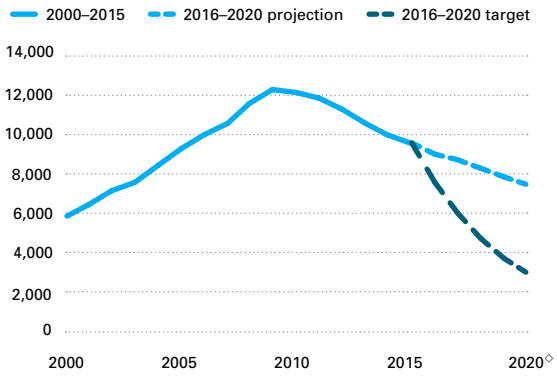
F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. National AIDS Commission (NERCHA. to develop both an adolescent-focused national strategic plan for HIV and a national costed HIV prevention plan.
2. Strengthening multi-stakeholder coordination to harmonize HIV and SRH programmes targeting adolescents.
3. In-service teacher training on CSE using an online course developed by the UN regional team.
4. Advocacy for the harmonization and consolidation of the national technical working groups that address the various needs of adolescents.
5. Capacity strengthening of youth associations at constituency level (Tinkhundla) on leadership, HIV, ASRH and GBV, and supporting their representation in the national technical working group for ASRH.

COUNTRY I **UGANDA**

ADOLESCENT HIV TRENDS

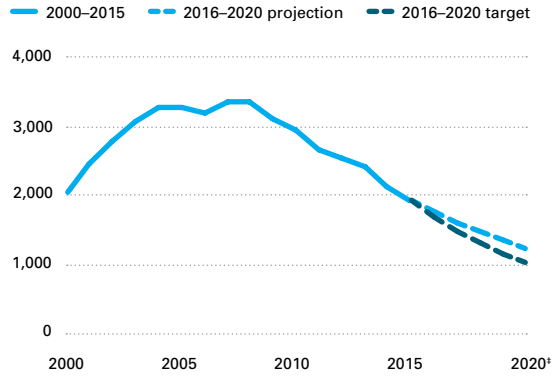
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

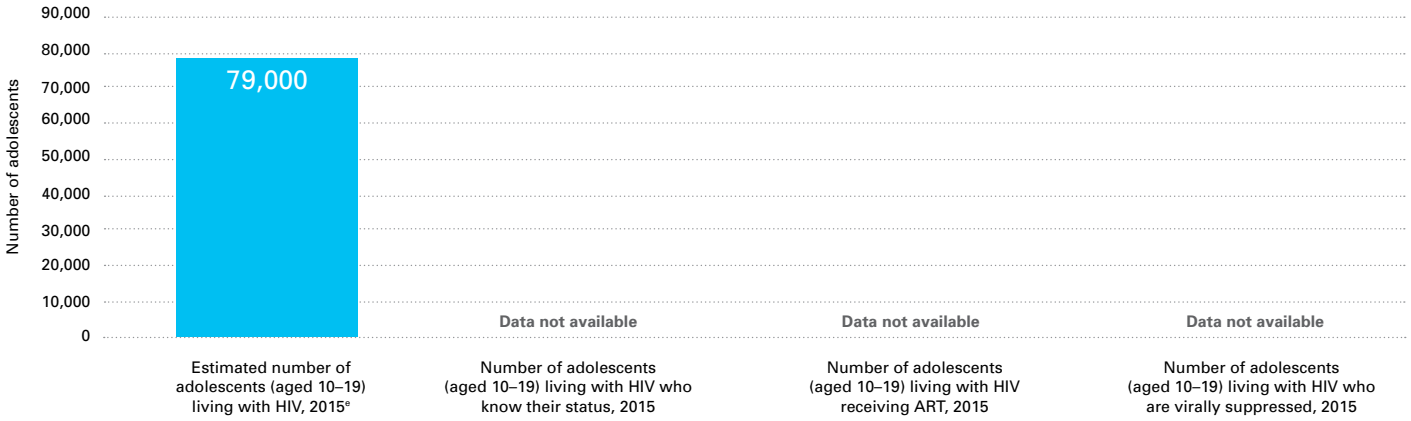
AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	39,000,000	19,500,000	19,500,000
	Estimated population of adolescents (aged 10–19), 2015[c]	9,600,000	4,800,000	4,800,000
	% of total population that is adolescents (aged 10–19), 2015[d]	24.6%	24.5%	24.7%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	1,600,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[mm]	–	33.0 (2011)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.6%	0.6%	0.6%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	1.1%	1.4%	0.9%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	3.9%	4.9%	2.9%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	79,000	45,000	34,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	9,600	6,700	2,900
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	1,900	<1,000	<1,000
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	31.0 (2006) [nn]	37.7 (2006) [nn]	35.6 (2011) [pp]	36.1 (2011) [pp]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	1.3 (2006) [nn]	4.6 (2006) [nn]	2.2 (2011) [pp]	4.7 (2011) [pp]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	–	47.3 (2006) [nn]	25.5 (2011) [pp]	31.7 (2011) [pp]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	9.1 (2006) [nn]	4.6 (2006) [nn]	30.7 (2011) [pp]	17.4 (2011) [pp]
% of adolescent boys (aged 15–19) who have been circumcised	–	21.8 (2005) [oo]	–	23.4 (2011) [pp]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	21.3 (2006) [nn]	–	18.9 (2011) [mm]	6.5 (2011) [mm]
% of youth who have completed secondary school	–	–	12.9 (2011) [mm]	18.4 (2011) [mm]
% of young people (aged 20–24) married or in union by age 18	–	–	39.7 (2011) [mm]	5.5 (2011) [mm]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

Platforms for adolescent engagement in policy discussions are in place, such as the National Pediatric and Adolescent conference. This is a bi-annual event and the 8th conference was held in October 2016, with the support of UNICEF and other partners. It provided an opportunity for adolescents from various regions of the country to engage in dialogue, both during the pre-conference workshop and with programmers and policy makers during the three-day conference.

In addition, the country utilized the National Adolescent Health Stakeholders' conference and pre-youth conference to advocate for the advancement and implementation of best practices, Global and National commitments, and resolutions for the health and wellbeing of adolescents in Uganda under the theme 'Closing the Gaps in Pediatric and Adolescent HIV Care Now'.

Adolescents and adolescent-focused civil society organizations are members of the Adolescent Health Technical Working Group at the Ministry of Health and lead the pre-youth meeting.

UN Women has partnered with IPPF to implement a pilot initiative "Empowerment + Engagement = Equality to ensure inclusion of adolescent girls and young women as advocates in the All In assessments and the broader HIV response. More than 1,000 girls were mobilized across three priority countries (Kenya, Malawi and Uganda).

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

An adolescent health roadmap has been developed. This outlines major actions to address ongoing challenges, accelerate the response through a set of comprehensive interventions for adolescent health and improve coordination among key players.

The national Most at Risk Populations (MARPs) priority plan involving key populations was developed by the Uganda AIDS Commission. In addition, the HIV and AIDS Prevention Control and Act includes adolescents, although it does not make specific recommendations to address any unique considerations for this population.

Advocacy has been mobilized through the Technical Working Group on Adolescent Health at the Ministry of Health to establish specific guidelines and the development of national action plan for adolescent health.

Advocacy was also conducted to include key populations in programming through the MARPS national working group at Uganda AIDS Commission. However, this is not very active and there is a need to revitalize and maintain the momentum which was previously achieved.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

HCT

On the supply side, the key bottleneck was inadequate human resource.

- Only 44 per cent of the health facilities currently providing HCT services reported to have at least one heath worker trained in testing and counselling adolescents.

On the demand side, low HCT utilisation was the key bottleneck.

- Less than one third (29 per cent) of adolescents reported ever testing for HIV, while only 27 per cent of the those who reported to have tested in the last 12 months received their results.
- HIV prevalence among young people aged 15-24 is at 3.7 per cent (5.4 per cent among ages 20-24 and 2.4 per cent

among ages 15-19), with 3.0 per cent prevalence among women aged 15-19. For every HIV positive male, there are 2 to 3 girls infected.

Among the causes identified by stakeholders that contribute to these bottlenecks in HTC are inadequate staff numbers and limited training or skills development on the supply side, and poor knowledge of HTC, transport costs, a lack of trust in health workers and policy constraints on the demand side.

ART services
Key bottlenecks noted were human resources and geographical access.

- Only 57 per cent of the ART sites providing HIV treatment reported to have at least one health worker trained to counsel adolescents on ART.
- Only 44 per cent of ART sites were providing adolescent-friendly services as per national guidelines.

The causes identified that contribute to these bottlenecks in ART are delays in recruitment and replacement of health workers, regular transfer of staff, limited dissemination of guidelines on provision of adolescent services and limited training of staff in provision of responsive adolescent services.

Condom use
The main bottleneck identified was condom utilization among adolescents.

- Only 63 per cent of the adolescents (aged 15 -19) knew a source of condoms.
- Only 36 per cent of adolescents who had sex in the last 12 months reported ever using a condom.
- Only 29 per cent of adolescents who had more than one sexual partner in the last 12 months reported using condom at the last sex.

The main causes identified that contribute to this bottleneck in condom use are inadequate condom education for adolescents, misconceptions on condom use, poor social attitudes that discourage condoms use among adolescents, and cost of condoms to adolescents.

VMMC
The main bottlenecks found were inadequate commodities and low VMMC utilisation.

- 55 per cent of the health facilities providing VMMC reported to have experienced stock-outs of essential VMMC commodities in the last 3 months.
- Only 30 per cent of adolescents (aged 10-19) in need of VMMC reported to have received the service and, of these, just 11 per cent reported to have attended a post-operative follow-up visit during the last 12 months.

The main causes identified that contribute to these bottlenecks in VMMC are intermittent stock-out of VMMC commodities, cultural norms with preference to traditional circumcision, perceived fear of circumcision due to previously reported cases of tetanus arising from VMMC, and misconceptions related to VMMC, e.g. change of religion.

Four adolescent key population groups have been identified in Uganda and included in the National Strategic Plan on HIV/AIDS (2015-2020):

1. Adolescent sex workers
2. Adolescent MSM
3. Adolescents in fishing communities
4. Adolescents involved in cross-country trucking

The assessment also helped to identify five priority geographic locations based on high burden and low performance. These are the West Nile region, North Eastern region, Mid-Eastern region, Mid-western region and Mid Northern region.

Priority corrective actions agreed upon to improve delivery of HIV and adolescent services are:

1. Enhance policy and advocacy for effective ADH service delivery.

2. Advocate for policy and programme change.
3. Enhance institutional and technical capacity for effective adolescent health and HIV. programming and service delivery at all levels.
4. Promote uptake of adolescent health services through adolescent-tailored SBCC and other innovative approaches.
5. Enhance adolescent engagement and participation in ADH programming.
6. Improve ADH data collection, analysis and utilization with appropriate dis-aggregation for ages 10-14 and 15-19.

Progress in implementation of priority actions identified through assessments

Guidelines for the prevention and management of HIV/AIDS and teenage or unintended pregnancy in school settings is now being drafted by the Ministry of Education, Science, Technology and Sports.

An adolescent framework for action is being established under the championship of the First Lady to guide Uganda's national response.

The in-depth analysis on adolescents has been completed, filling in key knowledge and data gaps on 10-14 and 15-19 year olds, the prevalence of risk behaviors and multiple health outcomes. This work has been conducted through a research partnership on adolescent health risk behaviors between UNICEF, WHO, UNFPA, UN-WOMEN, UNAIDS and Makerere University School of Public Health.

This assessment experience has enhanced programming to address adolescent HIV/AIDS by bringing several actors together and facilitating joint strategic planning. Uganda is currently experiencing a wave of action towards addressing HIV and AIDS in adolescents, with some partners scaling up programming and investment in the area of health and HIV/AIDS response. The assessment has helped further steer and leverage this additional technical and financial commitment for the national adolescent HIV response.

Findings from the assessment informed the design of the new multi-sectoral National Action Plan (2016-2020) for the adolescent HIV response. The newly developed draft plan mainly focuses on improving knowledge among adolescents of HIV/AIDS prevention and care through provision of relevant information. It also advocates for the establishment and revitalization of functional youth corners in health facilities, including:

1. Life skills education and scaling-up of the Presidential Initiative on AIDS Strategy for Youth (PIASCY) curriculum in school
2. The establishment of community structures to promote dialogue
3. Training and mentorship of health workers on adolescent health
4. Innovative ideas for voluntary medical male circumcision
5. Provision of ARVs for 3-month periods as opposed to 1 month to reduce workload of health workers

Impact of the assessments on the use of strategic information on adolescents

Adolescent-related information will be captured for the first time in the national AIDS indicator survey, as a means of providing disaggregated data suitable for programming purposes.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

UNAIDS is improving the Health Management Information System to enable better reporting and advocacy for identified gaps.

As part of the UN Women/IPPF initiative "Empowerment + Engagement = Equality" the young advocates set up

WhatsApp groups to serve as safe spaces to meet, mobilize, provide peer support and discuss not only HIV but broader issues affecting gender equality.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

1. Policies and programmes for improved Adolescent Health service delivery.
2. Expanded adolescent-responsive health services to accelerate HIV results for adolescents, such as scheduling services to meet the needs of in-school adolescents and tailored training of health care providers to adopt the right skills and attitudes to increase service utilization by adolescents.
3. Improved supply of adolescent health and HIV/AIDS commodities through improved push and pull system of supply of commodities to reduce stock-outs especially for VMMC and HTC related commodities – e.g. drugs, especially for opportunistic infections for ALHIV.
4. Increased resource allocation and utilization through increased domestic funding by government to ensure expansion and sustainability of adolescent health services.
5. Implementation of comprehensive sexuality education in a culturally-sensitive manner.
6. Investments in the mentorship and mobilizing adolescent girls and young women, including those living with HIV, to advocate for their needs and priorities.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. The joint planning, advocacy and assessment processes that define the ALL IN approach are time-consuming, but the outcome in terms of engagement of stakeholders and different actors is good.
2. Government ownership through the Ministry of Health is very important.
3. Involvement of adolescents in programming and policy discussions is critical to effective programming.
4. Engagement of the adolescent girls and young women in the assessment design and implementation, as well as into the national HIV response, was critical to ensure the young advocates have a space to voice their needs and to see their priorities are well reflected in the assessments and resulting decisions.

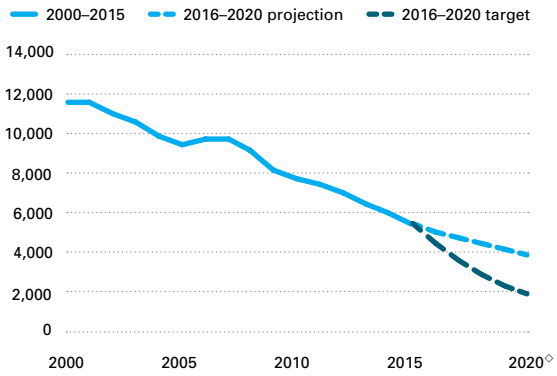
F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

Implementation of the identified and agreed-on priorities shall be guided by the multi-sectoral National Plan of Action (2016-2020).

COUNTRY I **UNITED REPUBLIC OF TANZANIA**

ADOLESCENT HIV TRENDS

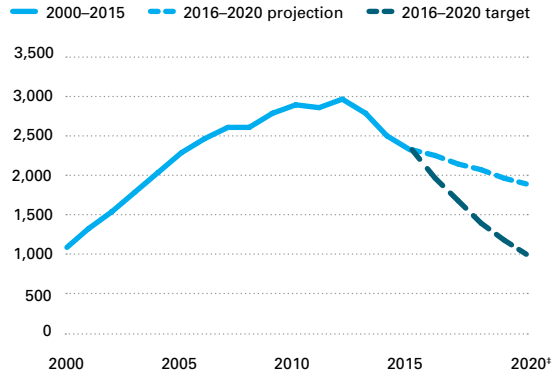
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

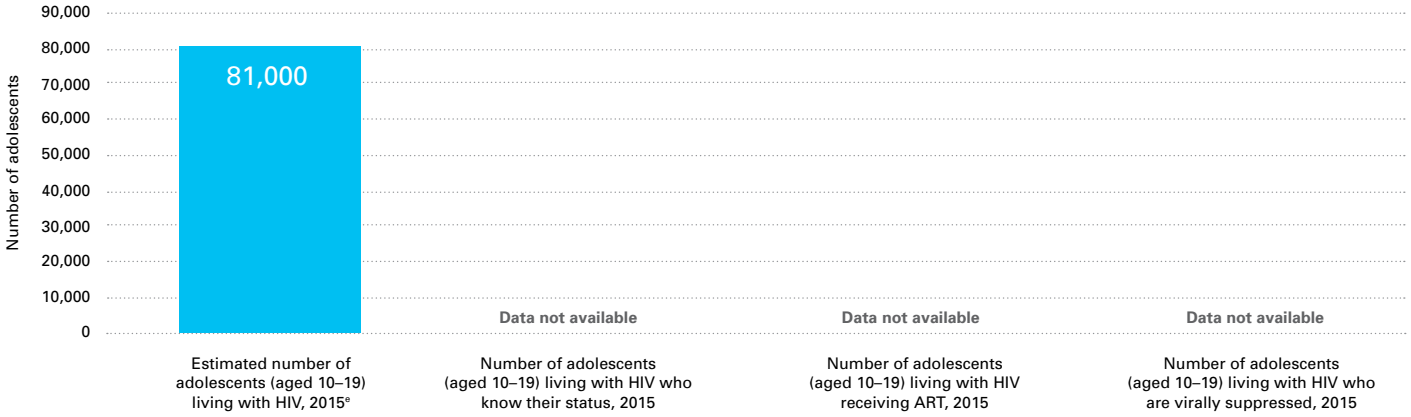
AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	53,500,000	26,900,000	26,600,000
	Estimated population of adolescents (aged 10–19), 2015[c]	12,300,000	6,200,000	6,100,000
	% of total population that is adolescents (aged 10–19), 2015[d]	23.0%	22.9%	23.1%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	2,000,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[qq]	–	28.3 (2010)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.5%	0.5%	0.6%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.8%	0.9%	0.7%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	1.9%	2.4%	1.5%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	81,000	44,000	37,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	5,500	3,800	1,600
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	2,300	1,100	1,300
Policy	Age of consent for HIV testing[f]	16	16	16

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	46.3 (2010) [qq]	40.9 (2010) [qq]	36.8 (2012) [rr]	41.9 (2012) [rr]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	1.9 (2010) [qq]	6.8 (2010) [qq]	3.0 (2012) [rr]	7.1 (2012) [rr]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	35.3 (2010) [qq]	34.2 (2010) [qq]	37.7 (2012) [rr]	45.2 (2012) [rr]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	20.5 (2010) [qq]	13.0 (2010) [qq]	20.8 (2012) [rr]	13.1 (2012) [rr]
% of adolescent boys (aged 15–19) who have been circumcised	–	64.3 (2010) [qq]	–	66.2 (2012) [rr]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	13.2 (2010) [qq]	–	–	–
% of youth who have completed secondary school	2.4 (2010) [qq]	3.6 (2010) [qq]	–	–
% of young people (aged 20–24) married or in union by age 18	36.9 (2010) [qq]	1.3 (2010) [qq]	–	–

ADOLESCENT KEY POPULATIONS

Population	**Indicator**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

The Adolescent and Young Adult Stakeholders Group (AYAS) is a strong and functional national multi-sectoral coordinating body that was established by the Tanzania Commission for AIDS in September 2015. It was established in response to the urgent need for a coordinated, multi-sectoral effort to reduce adverse sexual and reproductive health outcomes among Tanzanian adolescents and young people aged 10-24. AYAS is chaired by director-level cadres from the Ministries of Health and Education, providing oversight of key global, regional and national adolescent and youth initiatives including ESA Ministerial Commitment on Comprehensive Sexuality Education (CSE) and Sexual and Reproductive Health and Rights (SRHR), DREAMS and ALL IN. It has a strong focus on CSE, youth-friendly SRHS, and improved multi-sectoral support to adolescents, including ALHIV, with linkages to various national technical working groups including the National Adolescent Sexual Reproductive Health group.

AYAS was instrumental in providing technical guidance and oversight for the roll-out of ALL IN, ensuring effective participation of adolescents and young people in the implementation of phase one's rapid data assessment. This included convening stakeholders with young people at the national and sub-national levels, facilitating young people's effective engagement throughout the entire process, including the organization of the first National Youth Stakeholders' Meeting in Tanzania mainland that was held from May 17-19, 2016. The meeting was well attended by high-level government representatives, including ministers, deputy ministers, permanent secretaries, and directors from relevant ministries working with youth, and provided a platform for high-level advocacy and action for adolescents and youth in Tanzania.

Other mechanisms in place that ensure meaningful adolescent engagement in the HIV response include:

- The Tanzania National Coordination Mechanism for the Global Fund includes two youth representatives.
- The Young Reporters Network programme trains and mentors adolescents to facilitate media productions and advance the children and youth agenda, including health related issues.
- Youth of the United Nations, Youth Advisory Panel, Next Generation Task Force.
- Youth organizations such as FEMINA HIP that deliver CSE and HIV education through media products (magazines, television, radio, social media, websites) and outreach through clubs, festivals, youth conferences, SMS and active learning trainings.
- TAYOA promotes engagement of young people through mobile phones and social media to support HIV prevention and treatment among young people.
- Various youth networks and clubs at national and sub-national levels.

In terms of adolescent engagement, ALL IN efforts have contributed to the following:

- More space for adolescents and young people to engage in matters of concern to them, including participation in key national consultative and decision-making processes, ensuring that their priorities are being addressed.
- Improved strategic information to facilitate targeted programming for adolescents and young people.
- Enhanced multi-sectoral coordination for adolescent and youth programming, including through AYAS, and bringing together actors from relevant sectors.
- High-level advocacy and engagement with national leaders on strengthening coordination and support for adolescents and youth programming.
- Strengthened adolescent and youth focus within national strategic plans, guidelines and programmes.
- Implementation of comprehensive HIV prevention interventions (biomedical, behavioural and structural) for adolescents and youth interventions.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

Tanzania has benefited from several global and regional initiatives for adolescents and young people, including

DREAMS, ACT, ALL IN and ESA Ministerial Commitment, providing opportunities for high-level advocacy on the implementation and scale-up of high impact interventions for adolescents and young people, including discussions on policy issues. The Government of Tanzania, with support from the UN, USG and other key stakeholders, has made strides towards an improved policy and legal environment for HIV and SRH services for adolescents in the following ways:

1. Adolescents and youth have been prioritized within the national development agenda (FYDP II). The Government of Tanzania has passed the Youth Council of Tanzania Act and is currently in the process of reviewing the national youth development policy, actions that will contribute to a conducive environment for programming for adolescents and youth in the country.
2. Several national strategies and plans relevant to adolescents are in place within the health, HIV, education, child protection and section protection sectors.
3. National HIV services guidelines have been reviewed to strengthen the adolescent component and to align to international standards (HTS, care and treatment).
4. The 2016 Tanzania HIV Investment case has prioritized eight programme components for scale-up, including interventions for adolescent girls and young women.
5. Recommendations drawn from the Population Council, Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC) and UNICEF 2015 Adolescent Experience In-Depth report informed more effective policies and programmes that address adolescents in the country, and provided data to continue advocacy for policy and guideline change around child marriage, school re-entry after dropout and age of consent for HTC.
6. A national Test and Treat policy has been approved, effective October 2016. It is expected that the roll-out of this treat all strategy will be catalytic and contribute to accelerating efforts to lower the age of consent for HIV testing, as well as improving access to HTS by adolescents.
7. A Legal Environment Assessment in relation to HIV and AIDS Response has been conducted and provides recommendations for improved access to services for PLHIV and key vulnerable populations.
8. The government has initiated the process to review the HIV and AIDS Prevention and Control Act of 2008. This will include a review of the age of consent for HIV testing, with the potential to lower the age of consent to 12-15 years.
9. Life skills-based SRH and HIV education has been integrated into the primary school curriculum, and the Ministry of Education is currently in the process of reviewing the secondary school curriculum.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

1. The majority of adolescents living with HIV were perinatally infected (almost 90 per cent), indicating the importance of early ART initiation and follow-up care and treatment, as well as transitioning mechanisms of children into adolescent care.
2. Among newly infected adolescents aged 15-19, 70 per cent are girls.
3. At early adolescence (ages 10-14), the number of girls and boys living with HIV who are likely to have been vertically infected is about the same. The difference starts to emerge in late adolescence (ages 15-19), widening further in young adulthood (ages 20-24). Young girls (aged 20-24) are 3 times more vulnerable to HIV infections compared with boys of the same age.
4. There was an overall decrease in the number of new HIV infections among adolescents (aged 15-19) in 2010-2015, from 7,000 to 6,000. However, accelerated efforts are required in order to reach the target of a 75 per cent reduction in new infections by 2020. At the current pace, reductions will only reach 25 per cent by 2020.

5. Trends in AIDS-related deaths among adolescents are declining, but not at the pace necessary to meet the target of 65 per cent reduction by 2020.
6. HIV testing rates are low among adolescents and data on ART is available only for children and adults, but not for adolescents at national level.
7. Comprehensive knowledge of HIV is low among adolescents and condom use is very low among sexually active adolescents with multiple partners.
8. Teenage pregnancy is high, as is the number of young girls in marriage or in union.
9. Data suggests pervasive gender-based violence.
10. There is low net secondary school attendance.
11. There are multiple delivery platforms and sectors offering programmes and services for adolescents, and multi-sectoral coordination mechanisms for programming on adolescents are weak.
12. There are contradictory legal and policy provisions on consent (to sex, marriage, HTC and health services).
13. Adolescent participation and engagement are often tokenistic.

Key bottlenecks found in each intervention for HIV prevention, treatment and care were:

1. Multiple rich data sources, readily accessible – however, many need updating.
2. Bad quality data may negatively influence spectrum outputs.
3. For most indicators, there is a lack of disaggregated data for young adolescents aged 10-14.
4. Data on adolescent key populations is not available.
5. Small sample sizes for regional data in national surveys (e.g. THMIS).
6. Multiple monitoring systems and data sources generate similar and sometimes contradictory information (e.g. HIV testing from surveys, programme data, spectrum estimates versus survey data), which highlights the need for data review and triangulation.
7. Differences in indicator definitions by different stakeholders hamper data comparability.
8. Most recent national surveys did not include data on adolescents aged 10-14.
9. Age-disaggregated data is available at the facility level, but is not routinely analyzed and reported at national and sub-national levels.

Priority actions moving forward:

1. Improve M&E and data availability on adolescents, including key populations, and ensure that routine and survey data is disaggregated according to ages 10-14, 15-19 and 20-24 at national and sub-national levels.
2. Ensure meaningful engagement and collaboration with adolescents and young people in all issues that affect their lives, including policy making and programmes.
3. Strengthen coordination and leadership of adolescent response across sectors.
4. Ensure an AIDS-free generation of adolescents and young people in Tanzania through implementation and scale-up of key priority interventions identified through the various in-country consultations within technical working groups, as well as through the development of national strategic plans, programmes and initiatives (e.g. the 3rd National Multi-sectoral Strategic Framework for HIV and AIDS and Investment Case). Priority populations include adolescents and young people in and out of school, adolescent girls and young women, adolescents living with HIV, and other vulnerable adolescent populations. The priority biomedical, behavioral and structural interventions are as follows:
    a. HTC, ART, PMTCT, VMMC, condom use, comprehensive sexuality education, gender equality and gender-based violence, parenting/care giving and social protection/economic empowerment interventions.

b. Ensuring that services are adolescent and youth friendly, that young people are engaged, and ICT, social media and innovations are promoted is key.

Geographically, the national response has prioritized 10 high HIV prevalence regions. However, further analysis is required to target adolescent groups and geographic locations (districts) based on consideration of evidence from the ALL IN country assessment, investment case report, NMF3 mid-term review, adolescent in-depth report and hot spot mapping, DREAMS and COP 16 analysis, as well as other surveys and assessments available in the country.

Progress in implementation of priority actions identified through assessments

Progress has been in four areas:

1. **High-level advocacy**: Priority actions from the national youth stakeholders meeting were shared at a meeting with the Permanent Secretary from the Prime Minister's office and other senior government officials on June 27, 2016. Issues discussed included the need for high-level government commitment, enhanced coordination and coherent programming for adolescents and young people across sectors. It was recommended that a meeting with permanent secretaries from all government ministries should be convened to discuss the youth agenda and agree on priority actions going forward. The Chief Secretary from the President's office has now requested TACAIDS to work with the Prime Minister's office to organize this meeting, scheduled to take place during the last quarter of 2016.
2. **Enhanced coordination:** The need to strengthen multi-sectoral coordination and improve participation of government ministries was prioritized, with a proposal to elevate the coordination mechanism to the Prime Minister's office, with Director for Youth Department chairing AYAS meetings, and with key sectors such as Ministry of Health, Community Development, Gender, Elderly and Children and the Ministry of Education as active members, and with TACAIDS as the secretariat.
3. **Coherent programming:** To ensure that youth priorities from different sectors are clear, AYAS will take the lead in the development of a national inter-sectoral work plan to guide adolescent and youth programming and solicit government support.
4. **Implementation and scale-up of high impact interventions for adolescents and youth**: Involving DREAMS, ESA Commitments (CSE and ASRH), ACT, Social Protection Plus, Economic Empowerment and Livelihood.

Impact of the assessments on the use of strategic information on adolescents

The ALL IN Country assessment has highlighted data gaps and opportunities to strengthen national data collection. The rapid assessment process served to reinforce the value of data-driven programming and working across sectors, and has been catalytic in bringing different sectors together to discuss cross-sectoral issues affecting adolescents.

- The country assessment highlighted the importance of M & E and data availability on adolescents, including KPs. It also highlighted the importance of ensuring that routine and survey data are disaggregated by 10-14, 15-19 and 20-24 age groups at national and sub-national level, and that age disaggregation is accommodated in routine reporting of health service statistics to track the uptake of adolescents and youth (10-14, 15-19, 20-24) in health management information system/care and treatment center database.
- The recently completed adolescent HIV and SRH data abstraction exercise showed that access to services among adolescents and young people is low. Key recommendations to MoHGCDEC to ensure reporting on adolescents and young people should be included in routine reports as data is available, and policies put in place to improve adolescents and young people's access to services by reducing age of consent from 18 years.
- In 2015, the UN-led advocacy for adolescents – to be prioritized in social protection programmes together with the UNICEF Innocenti Research Center and a local research organization REPOA – supported fielding of a baseline questionnaire to assess outcomes related to school attendance, aspirations, mental health, physical and sexual violence, early sexual debut, pregnancy, marriage, risk behaviors, and future expectations among adolescent beneficiaries of the national social protection programme. Based on global evidence, cash transfers should reduce the HIV risk of adolescent members among TASAF households.
- Measurement of the education sectors' contribution to the HIV response and linking up of data collected on HIV and sexuality education at schools with TOMSHA (The Tanzania Output Monitoring System for HIV and AIDS) – a

system that is used by TACAIDS to monitor health activities in communities – to complement the monitoring of interventions conducted in health facilities by MoH.

These actions have filled critical information gaps about adolescents and HIV, as well as programming across sectors, which will in turn be used to guide future efforts to reach adolescents and youth with HIV prevention, care, treatment and support interventions.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

- Delivery of comprehensive sexuality education through media products, strategic communication and outreach to Tanzanian youth aged 13-30, including content on sexual reproductive health and rights, economic empowerment and citizen engagement. Edutainment media products include magazines, television, radio, social media, websites. Outreach conducted through Fema Clubs, festivals, youth conferences, SMS counseling and active learning trainings
- Tanzania adapted the Shuga radio programme, a multi-country 12 episode drama that promotes HIV testing and counselling and condom use among youth, broadcasting it on national and community stations with a special focus on the regions with high HIV prevalence. Surveys were conducted to measure HTC awareness and uptake among youth aged 15–24 before and after broadcasting the Shuga radio programme. The baseline and endline survey was conducted by mobile phone, among youth aged 15-24 in 3,000 randomly selected households in six districts, with 1,086 and 1,012 respondents reached at baseline and endline. The surveys demonstrated that HTC awareness and uptake increased from baseline to endline, with radio confirmed as an important source of information about HTC.
- Tanzania Youth Alliance (TAYOA), a local organization that embraces creativity and innovation through ICT, uses mobile phones and social media to support HIV prevention and treatment among young people. Services provided include a free national health helpline, free SMS, a Facebook page for youth, blog posts and development of social media content.
- Since 2015/16, a strategic partnership between the UN and DREAMS has been established to deliver HIV combination prevention services (biomedical, behavioral and structural) for vulnerable adolescent girls and young women (AGYW) at sub-regional levels in Tanzania. The partnership has resulted in the engagement of 537 (135 Male, 402 Female) adolescents and young people as beneficiaries of livelihood and economic empowerment programmes.
- Partnership with the informal sector strengthened through formalization of AGYW group associations and subsequent certification by Local Government Authorities. The formalization of AGYW group association increases AGYW's access to gender-sensitive HIV services and financial services through ILO Revolving Fund. Access to financial services has enabled AGYW to improve their livelihoods through income-generating activities, thus mitigating the impact of HIV and AIDS.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

The ALL IN country assessment has highlighted data gaps and opportunities to strengthen national data collection, as well as serving to reinforce the value of data-driven programming and working across sectors. Other issues that were highlighted include the need for effective engagement and involvement of adolescents and youth on matters of concern to them, the need to strengthen resource mobilization and budget allocations for adolescent and youth programming, and the need to strengthen coordination and leadership among the adolescent and youth response across sectors, including cross-sectoral accountability, planning and improvements in programming for adolescents.

Continuous advocacy efforts have contributed to:

1. The National AIDS Control Programme carrying out an age-disaggregated ART cohort analysis
2. Reducing the age of inclusion in the 2016 Zanzibar Integrated Behavioral and Biological Surveillance (IBBS) of young KPs (aged 15 and above)
3. Inclusion of an early adolescent module in the 2016 Tanzania HIV Impact Assessment

The ALL IN rapid assessment on adolescents was completed in May 2016 in mainland Tanzania. There are ongoing discussions to roll out the in-depth analysis to address priorities identified as noted above.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

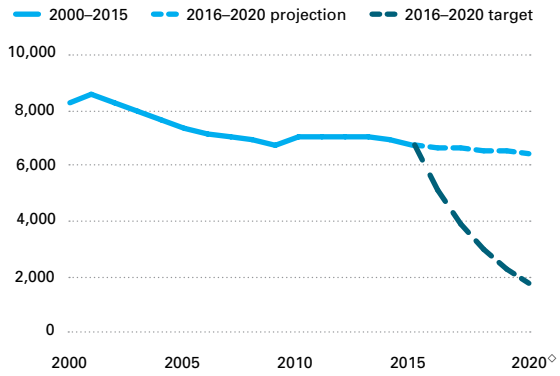
1. Government leadership and oversight role with AYAS was instrumental in ensuring a successful country assessment process.
2. The assessments highlighted data gaps and opportunities to strengthen national data collection, analysis and use.
3. The rapid assessment participatory process served to reinforce the value of data-driven programming and working across sectors, and has been catalytic in bringing different sectors together to discuss cross-sectoral issues affecting adolescents.
4. ALL IN country assessments to date have reinforced the role of One UN in the adolescent and youth agenda and highlighted some of the priority areas that the UN needs to focus on.
5. Great momentum generated within UN agencies and USG (ESA, DREAMS, ACT) to support the government to address adolescent and youth HIV and other social issues.
6. Using the AADM tool was a systematic way to identify equity and performance gaps in adolescent and youth programming. The tool provided a dashboard with sectoral and cross-sectoral data on adolescents and youth.
7. The ALL IN process provided a forum for enhanced engagement with adolescents and youth. They were engaged throughout the entire process, including in TWG meetings and national and sub-national level consultative processes, and played a key role in organizing and facilitating the national youth stakeholders, as well as coming up with priority actions for youth, which have been discussed with national leaders.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. Strengthen data collection, analysis and use in relation to adolescents.
2. Prioritize adolescents in efforts to end the HIV epidemic, including in the next Global Fund country proposal to be finalized by mid-2017 and in PEPFAR COP 2017.
3. Strengthen the institutional capacity of the Prime Minister's office for improved multi-sectoral coordination of adolescent and youth programmes.
4. Conduct sub-national analysis to identify bottlenecks limiting impact from key programmes in selected districts (in-depth analysis).
5. Modify policies and laws on age of consent. HAPCA review completed and age of consent for HIV testing lowered.
6. Development of a costed inter-sectoral work plan to guide adolescent and youth priority interventions across sectors.
7. Dissemination of key surveys, including THIS 2016/2017, TASAF end-line impact evaluation (adolescent module), Cash Plus baseline evaluation, secondary data analysis of DHS 2015/16 and THIS 2016/17.
8. Roll-out of Cash Plus pilot for adolescent wellbeing and transition to adulthood.
9. Continuous oversight of DREAMS, ACT, ESA Commitment, ALL IN and other initiatives for adolescents and youth.
10. Review National Youth Development Policy.

ADOLESCENT HIV TRENDS

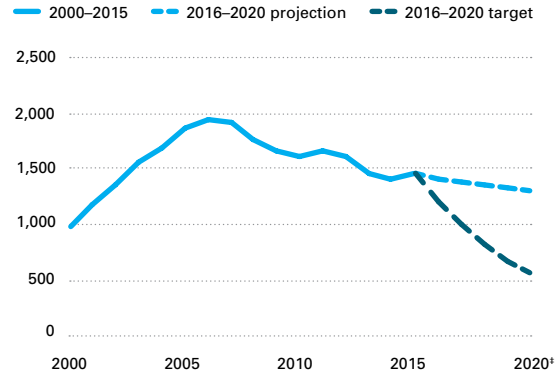
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	16,200,000	8,100,000	8,100,000
	Estimated population of adolescents (aged 10–19), 2015[c]	3,900,000	1,900,000	1,900,000
	% of total population that is adolescents (aged 10–19), 2015[d]	23.8%	23.7%	24.0%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	610,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[ss]	–	30.7 (2014)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	1.4%	1.4%	1.4%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	2.2%	2.7%	1.8%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	6.0%	7.5%	4.4%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	68,000	38,000	31,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	6,800	4,700	2,000
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	1,400	<1,000	<1,000
Policy	Age of consent for HIV testing[f]	16	16	16

HIV TREATMENT FOR ADOLESCENTS

ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	36.3 (2009) [tt]	37.5 (2009) [tt]	38.9 (2014) [ss]	42.3 (2014) [ss]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	1.9 (2007) [uu]	4.5 (2007) [uu]	1.5 (2014) [ss]	7.5 (2014) [ss]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	47.0 (2007) [uu]	49.8 (2007) [uu]	33.0 (2014) [ss]	37.7 (2014) [ss]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	22.3 (2009) [tt]	9.7 (2009) [tt]	32.6 (2014) [ss]	19.4 (2014) [ss]
% of adolescent boys (aged 15–19) who have been circumcised	–	11.3 (2009) [tt]	–	22.7 (2014) [ss]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	15.5 (2007) [ll]	–	8.2 (2014) [ss]	–
% of youth who have completed secondary school	–	–	22.6 (2014) [ss]	34.0 (2014) [ss]
% of young people (aged 20–24) married or in union by age 18	–	–	31.4 (2014) [ss]	2.2 (2014) [ss]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

The ALL IN response in Zambia has applied a two-track approach. The first track has focused on early adolescents aged 10-14, and on strengthening the treatment and prevention continuum. Significant resources for interventions and activities for adolescents living with HIV were available under the PEPFAR/USAID Accelerate Children's Treatment (ACT) initiative. The approach was to promote the prioritization of young adolescents and their treatment needs under the Ministry of Health's Paediatric Technical Working Group, supporting the national response to harmonize efforts for children and young adolescents. A national programme review of paediatric and adolescent HIV implementation was jointly supported by UNICEF and WHO under the leadership of the Ministry of Health, with strong USAID participation. This process, which started in September 2015, was led by the national Pediatric AIDS Technical Working Group and generated recommendations for accelerating the Children's HIV/AIDS Treatment Initiative, strengthening district level target setting, and the integration of EID with EPI. UNAIDS supported the National AIDS Council (NAC) and Ministry of Health (MoH) to develop national pediatric HIV epidemic estimates and projections up to 2020 for national and sub-national levels. With government leadership, this process has culminated in the development by the MoH of a National Pediatric and Adolescent Prevention, Treatment and Care Implementation Plan for 2017-2021, entitled 'Scaling Up and Making Gains'. National partners, within the Pediatric AIDS Technical Working Group, will incorporate its strategies and targets into their 2017 annual work plans.

The second ALL IN track in Zambia has focused on adolescents aged 15-19. Under the second track, partners agreed to build on and strengthen existing adolescent HIV and SRH initiatives in Zambia. Since mid-2015, the National AIDS Council had been convening partners around the operationalization of the PEPFAR DREAMS initiative, which has been articulated as PEPFAR's contribution to ALL IN in Zambia. Under this initiative, the NAC established a DREAMS Technical Working Group, with a cross-section of government and civil society partners, including UNAIDS and adolescent representatives, to design an evidence-based US$ 16 million operational plan for reaching 64,000 high-risk adolescent girls and young women in three high HIV prevalence districts, with a package of prevention activities. An estimated 19,000 adolescents had been reached through 21 zones established by the end of third quarter of 2015. DREAMS has also initiated 8 innovation projects to expand male engagement, prevention and response to GBV among adolescents girls.

Prior to the DREAMS initiative, UNICEF, UNFPA, UNESCO and UNAIDS had been supporting the MoH, through the National Adolescent Health Technical Working Group (ADH TWG), to implement the National Adolescent Health Strategy. ADH TWG membership represents all key line ministries, government, UN, NGO and civil society partners, including youth-run civil society organizations. The ADH TWG has a multi-sectoral annual work plan, meets monthly, and is accountable for coordinating and harmonizing all partners' adolescent health HIV and SRH work.

UNICEF and UNFPA have been assisting the MoH to scale up adolescent-sensitive HIV and SRH services, with a priority focus on 11 districts in the two highest HIV prevalence provinces in Zambia (Copperbelt and Lusaka), under the Millennium Development Goals Initiative (MDGi) which is funded by the European Union. This effort led to the establishment of 11 district ADH TWGs, which are supporting partners to harmonize adolescent health HIV prevention and SRH efforts at sub-district and community levels.

Linked to this process has been on-going decentralized district-level training of health staff from 55 clinics on the adolescent health standards and the deployment of trained adolescent peer educators to these health centres. District ADH TWGs are tasked with ensuring that each center has an adolescent health focal point and that peer educators are represented on the health center management teams. This initiative also provided some assistance to the Ministry of Basic Education for the training of teachers on the new CSE curriculum, developed with support from UNESCO and UNFPA. In three of the 11 districts, DREAMS and MDGi efforts complement each other, with DREAMS focused on community-level engagement with adolescent girls and MDGI developing the capacity of health centres to provide adolescent responsive HIV and SRH services.

To strengthen links between DREAMS and MDGi, the NAC supported the establishment of the National Adolescent HIV Prevention Advisory Committee (AHPAC). Membership includes all of key line ministries, UNICEF and UNAIDS,

and key international and national NGO partners who are working on DREAMS and MDGi. The committee also includes adolescent DREAMS ambassadors. UNICEF has been chairing the AHPAC and, in close collaboration with USAID, recently supported NAC to convene a national adolescents and HIV stakeholders consultation to expand both the membership and focus of the AHPAC. Representatives of adolescents living with HIV have now been added to the committee and its advisory mandate has been expanded to cover both prevention and treatment programming with and for adolescents.

USAID is currently undertaking a mapping of all partners, including adolescent organizations, that work in DREAMS districts. UNICEF is supporting the MoH to scale up adolescent responsive HIV and SRH services to an additional 14 districts and 62 health centers, as well as the creation of district ADH TWGs in these additional districts. These ADH TWGs will be tasked with ensuring meaningful adolescent participation in their district HIV and SRH responses.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

In 2016, the Adolescent HIV Advisory Committee expanded its membership to include the chairperson of the key national TWGs. These are the Behavioral and Social Change TWG, the HIV Testing Services (HTS) TWG, the Condoms and STI Programming TWG, and the ADH TWG. This ensures that these TWGs effectively prioritize adolescents HIV issues and engage with adolescents during their 2017 work planning.

Two of the TWGs are addressing policy issues related to adolescent clients. The HIV Testing and Counselling (HTC) TWG is looking at the age of consent for HIV testing and counselling. Adolescents aged 15 and younger require parental consent for services, unless a health worker deems them to be, as married, pregnant or parent children, 'emancipated minors'. The HTS TWG is looking at the feasibility of reducing the age of consent to 12, based on the experiences of both Malawi and South Africa. With 4.9 per cent of adolescent girls aged 15 having started childbearing, and 2.1 per cent being already married, the ADH TWG has prioritized the age of consent for family planning services as a priority issue.

Both UNICEF and UNFPA are supporting the MoH to revise and update the National Adolescent Health Strategy. A draft should be completed by the end of 2016 for MoH management review. Lowering the age of consent will be addressed within this document, along with other key policy issues such as the collection of routine disaggregated data on the use of key HIV and SRH services by adolescents for better programme monitoring and management. The development of minimum ADH service standards, strengthened case management and better tracking of adolescent referrals will also be addressed, as well as adolescent representation within district and facility adolescent health management structures.

Both the national AIDS Policy and the National AIDS Strategic Framework are currently being revised. UNAIDS has been convening the UN Joint Team to harmonize support for this process to the NAC. UNICEF and UNFPA are supporting the NAC to conven a national consultation of adolescents and young adults on these two policy documents at the end of November 2016, with representatives from all of Zambia's provinces. The consultation will allow adolescents to assess and analyze these two documents – identifying and developing recommendations around issues such as access to high impact HIV interventions and improved targets for adolescents – before presenting them to the national stakeholders NASF validation meeting in early December 2016.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

Under the Zambia ALL IN two-track process, the development of the new National Pediatric and Adolescent Prevention, Treatment and Care Implementation Plan for 2017-2021 included an analysis of HIV prevention and treatment bottlenecks facing young adolescents aged 10-14. This lead to specific actions in the document aimed at delaying sexual debut in early adolescence (10-14), prioritizing provider-initiated testing and counseling for adolescents and increased access to adolescent-responsive health services (HTC, ART, MC, CCP, FP).

Based on the ZDHS 2014 data, partners estimated that there were approximately 244,000 females aged 15-19 (28.9 per cent) who had started childbearing, with 44,000 pregnant in 2014. Because adolescent mothers (and their children) are high-risk clients, partners noted the need for stronger prioritization within ANC and the provision of an adolescent-sensitive PMTCT service across all four prongs (HIV prevention, family planning, HIV testing and treatment).

The reproductive and adolescent health service findings from the MDGi assessment of health services in Zambia's two most populous districts, Lusaka and Copperbelt provinces, found that family planning services were provided in around half of health posts and three-quarters of health centers, as well as 38 per cent of hospitals.

The 2014 HIV prevalence rate suggests that over 2,500 of the pregnant girls would have tested HIV positive and required extra support to deal with their pregnancy, their adolescent motherhood and child caring, and support for living positively with HIV.

The MDGi assessment also found that ART services for adolescents were available in only 57 per cent of facilities. This suggests a need to increase access to ART services for adolescents and to strengthen the capacity to provide integrated care, referral and follow-up services for adolescents living with HIV. The revised Zambia Consolidated Guidelines for Treatment and Prevention of HIV Infection, finalized in 2016, have now incorporated specific ART treatment and care actions for adolescents aged 10-14 and 15-19.

UNAIDS supports the MoH and NAC to develop the AIDS Response Fast Track Strategy 2017-2021, which will be reflected within the revised National AIDS Strategic framework. The situation analysis assessed HIV prevalence among adolescent boys and girls, and noted that rates had been declining among girls while increasing among boys. A different response to HIV prevention for adolescent girls and boys in Zambia was recommended.

Under the second track, the new Zambia Demographic Health Survey (2013-14) data and the MDGI adolescent health district assessment findings were utilized during the development of the Zambia DREAMS Initiative to inform the ALL IN programme review and strategic planning discussions. The ZDHS trend in HIV prevalence among adolescents aged 15-19, from 2007 to 2014, showed only a slight decline from 4.7 to 4.4 per cent. Unpacking this data, partners found that there was a marked decline for females (from 5.7 to 4.8 per cent) and an increase for males (from 3.6 to 4.1 per cent). Although DREAMS Zambia remained focused on reducing incidence by 40 per cent within their 3 priority districts, among adolescent girls aged 15-19 and young women aged 20-24, the initiative did recognize the need to focus on adolescent boys as well as the older men who are sexual partners of these girls and young women.

The ZDHS found that the percentage of females aged 15-19 who reported a recent sexual partner more than 10 years their age also increased from 4.5 per cent in 2007 to 7.2 per cent in 2014. There was no change in the percentage of 15-19 year old females who had started childbearing (28 per cent) between 2007 and 2014.

There was a very significant reported reduction among adolescent girls aged 15-19 who had ever experienced sexual violence, from 15.5 to 8.2 per cent.

Over the same period, there had been only a slight increase in the percentage of adolescent girls aged 15-19 who were sexually active, from 35.5 per cent in 2007 to 37 per cent in 2014, while sex before the age of 15 declined slightly from 12.3 to 11.7 per cent. The analysis also determined that a significant proportion of this sexual activity was taking place in the context of marriage, with 17 per cent of females aged 15-19 reporting they were married in 2013-14. This is around 48 per cent of the one-third of females aged 15-19 who are sexually active.

HIV prevalence was also higher among married females aged 15-24 at 8.3 per cent, compared to 6.5 per cent among those who were not married. Of married females aged 15-19, only 10 per cent said they were accessing family planning services, although 60 per cent said the service was meeting their desired fertility needs. The MDGi Facility assessment found that oral contraceptives were available at 79 per cent of health posts and 89 per cent of health centers, and that injectable contraceptives were available at 74 per cent of health posts and 89 per cent of health centers. The assessment also found that only 63 per cent of facilities had family planning guidelines clearly posted on the walls. This suggests that in addition to reducing early marriage, family planning demand creation, with a focus on married adolescents, HIV testing and dual protection, should also be a priority under track two.

Between 2007 and 2014, condom use at last sex among sexually active, non-married adolescents aged 15-19 did not increase in Zambia. It remained very low at 38 per cent for females aged 15-19 and 42 per cent among males aged 15-19 (although it did increase 3 per cent points among females and males aged 15-17). Partners calculated that around 118,000 non-married females and 151,000 non-married males, aged 15-19, had put themselves at risk of teenage pregnancy and HIV at least once in 2014.

During the MDGi health facility assessment, periodic condom stock outs were identified as a bottleneck, with 93 per cent of health centers having had at least one condom stock out in the 3 month period preceding the mid-2014 assessment. National level condom stock during 2015 and 2016 has been sufficient, increasing from 12 male condoms per male aged 15-64 per year in 2012 to 24 per male per year in 2015. However, national to sub-national condom distribution still faces challenges. Increasing consistent and correct condom use was therefore prioritized among partners for sexually active adolescents aged 15-19, with UNFPA tasked to support national condom programming to address gaps between knowledge, supply and consistent utilization.

HTC has been the main HIV prevention intervention supported by the Zambia government. DHS trend data showed a 150 per cent increase in utilization of HTC by non-married sexually active adolescents, with 50 per cent of girls and 27 per cent of boys aged 15-19 reporting that they had been tested for HIV in 2014. Of the estimated 646,000 non-married sexually active adolescents in Zambia, partners estimated that 233,000 of them had gone for at least one HIV testing and counselling session in 2014 (129,000 females and 104,000 males). Partners saw this as a significant missed opportunity to promote 'other high impact HIV services' – specifically condom use (and distribution), as well as male circumcision.

The MDGi baseline facilities assessment also showed that education on safe sex practices was only being provided in 65 per cent of facilities. Ensuring that post-test counselling was made more responsive to adolescent clients in order to strengthen risk reduction planning and counseling, and to include improved condom promotion and distribution and referrals to services (family planning, STI, VMMC, etc.) within HTS (HTS Plus) were identified as key priorities.

Between 2007 and 2014, VMMC among adolescent males increased 130 per cent, from 10 to 23 per cent. Because adolescents account for a significant amount of the VMMC (estimated at 60 per cent), MoH and USAID Zambia had already initiated actions to prioritize adolescents aged 10-19, as well as young adults aged 20-29, within VMMC services in Zambia.

Progress in implementation of priority actions identified through assessments

Under the Zambia two track ALL IN approach, the Pediatric AIDS TWG has been leading on guiding partners to improve the coverage, quality, delivery of HIV prevention, treatment and care services for early adolescents aged 10-14, who are counted as children under the MOH response. In addition, they have been engaging with the PMTCT TWG to ensure that adolescent mothers are being prioritized within ANC services. The new National Pediatric and Adolescent Prevention, Treatment and Care Implementation Plan for the 2017-2021 is the key programming document for monitoring track one ALL IN implementation for early adolescents.

Under track two, the DREAMS TWG and the Adolescent Health TWG have been coordinating a mix of partners around scaling up the HIV and SRH response for adolescents aged 15-19. The DREAMS TWG has recently brought on board a number of new DREAMS Innovation partners, and a national planning meeting was held at the end of October 2016 to orientate all partners on the comprehensive mix of community and school-based HIV prevention activities – these are now being deployed to the three DREAMS districts. A total of 17,000 of the targeted 64,000 high risk girls and young women have been enrolled in the DREAMS mentoring programme and 11,000 parents have been trained on adolescent parenting skills. The first 3 of 21 community-based DREAMS centers have been established and linkages with the 15 MDGi supported health centers that are delivering adolescent responsive HIV and SRH health services across the DREAMS districts are being operationalized.

Under the Adolescent Health TWG, efforts have focused on strengthening systems with the MoH at district and community level. A minimum package has been agreed, and is now being scaled out to 25 districts and 117 health centers, with all provinces having at least one district implementing the minimum package with UNICEF support. The

package includes the establishment of District Adolescent Health TWGs, the training and designation of adolescent health Focal Points at district medical offices and health centers, and the training of all health workers from the 117 priority health centers on the adolescent health standards (ten days for 1,300 health workers). The peer education package, including new training, supervision and reporting tools, has been revised and approximately 1,200 young people across 15 districts received 5 days of training in 2016. At health facilities, 60 adolescent-friendly health spaces are being established across 15 districts, based on new guidelines, and are operated by trained peer educators who provide condoms, HIV and SRH information, and referrals to HIV and SRH services in the local health center. All 117 facilities have been collecting disaggregated age and sex data on the utilization of HIV and SRH services by adolescents aged 10-14, 15-19 and young adults 20-24.

The Adolescents HIV Advisory Committee, under the NAC, recently convened all stakeholders working on HIV and adolescents. A number of new members for the advisory committee were identified and recommendations generated to strengthen improved reporting, coordination and harmonization of approaches and tools. Overall, partners are committed to better joint programming, and working within the government system to strengthen the national HIV response with and for adolescents.

Impact of the assessments on the use of strategic information on adolescents

The Zambia ALL IN process built off existing assessment processes, specifically the Global Fund and PEPFAR DREAMS planning process. UNICEF Zambia had produced an Adolescent Report Card and supported the MoH to conduct the MDGi Health Service assessment in 11 districts. The new 2013-2014 ZDHS also provided all partners with national and provincial level data, for assessing progress, coverage and trends.

The collection of routine age and sex disaggregated data on adolescent utilization of HIV and SRH services was initiated in four districts during the last quarter of 2015. It was then expanded to the 11 MDGI districts in early 2016. From mid-2016, it was increased to an additional 11 districts for a coverage total of 26 districts out of a national total of 105. These initial 25 districts cover approximately 40 per cent of adolescents in the country. Routine data collection on use of family planning, HIV testing and ANC services has demonstrated significantly high utilization of HIV testing services by adolescents (approximately 1 in 5 clients), prior to any interventions being implemented within health centers to make the services more responsive.

A parallel process is on-going, working with the Health Information Management System to ensure that the next updated District Health Information System 2 facility data collection tool will incorporate indicators for the collection of adolescent age and sex disaggregated data on the use of HIV and SRH services. Currently, there is a national consultation process underway around indicators, timelines and processes for a transition from paper-based to mobile service data collection from facility to district medical offices.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

Zambia has an SMS U-Report platform, coordinated by the NAC through a core group of government, UN, iNGO and civil society partners, including representatives from adolescent-run organizations. There are currently 119,000 subscribers on the service, with 21 per cent aged 15-19 (45 per cent are aged 20-24). The Zambia U-Report platform has four components: counseling, polling, campaigning and reporting. Under the counseling component, subscribers are encouraged to send questions about HIV and SRH information and services by SMS to trained counsellors. Under the polling component, targeted questions are sent to adolescents and young adults, to ask about specific issues. This year, adolescents were polled on the reach of mass media HTC and condom messages, attitudes to condom negotiation, access and utilization of health services, stigma issues and livelihood skills. Under the campaigning component, information based on polling results is repackaged and sent out to subscribers, with specific services such as HTC routinely promoted. The reporting component is under re-design, as members want to pilot real-time monitoring by peer educators on the utilization of select HIV services in district high-yield 'monitoring' health centers.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

UNAIDS has been leading on the 90-90-90 targets and the Fast Track initiative, tailoring their advocacy messages to effectively cover prevention and treatment for adolescents and young people. UNAIDS has been making the fast track case in all national HIV forums. It also led, with NAC and MOH, the development of the National Fast Track Strategy, which includes prevention and treatment priorities for adolescents.

The lack of any increase in condom use between 2007 and 2014 among adolescents was identified as key advocacy issue. Since the last quarter of 2015, a radio campaign has been running on national radio, promoting the use of HTC by young people whose condom use has been inconsistent. A more controversial component of the campaign has been a set adverts where young males and young females explain how they were able to convince their sexual partner to use a condom. These adverts have generated significant discussion in national forums, to the extent that the national Behavioral and Social Change Communication TWG was asked by the NAC to re-test two of the adverts, based on concerns from faith-based organizations. The next phase of the condom promotion campaign will shift to commercial radio. During the recent national adolescents and HIV stakeholder consultation there was significant debate among stakeholders on the issue of condom promotion, demonstration and distribution in schools. This issue will be a priority for 2017.

Once the National ADH TWG finalizes the policy briefs on adolescents and age of consent for HIV and SRH services, key messages will be identified and added to the radio advocacy campaign.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

Through the DREAMS initiative in Zambia, PEPFAR has contributed US$ 16 million to accelerating the response to HIV in adolescent girls and young women, hence national partners decided to build ALL IN coordination around this initiative, and to use this initiative to learn lessons and to strengthen the standardization and harmonization of the HIV response with and for adolescents.

Partners did not want to create another ‘standalone’ branded initiative for ALL IN. To ensure effective government ownership, as well as coordination, harmonization, standardization and sustainability, the focus was on prioritizing adolescents within existing structures. This lead to the two track approach, where the MoH National Adolescent Health TWG, which was already coordinating a large number of partners on adolescent SRH, was identified to promote the ALL IN HIV prevention focus and to strengthen partners on HIV and SRH integration for adolescents. Through the CSE initiative, 406 teachers and 40 health workers were trained, while 115 head-teachers participated in training on management of CSE. In addition, prevention and early detection of cervical cancer was included as a new theme in CSE training materials to complement activities underway in preparation for the introduction of HPV vaccinations in the country.

National partners also recognized that other initiatives focused on treatment. One with significant resources was the PEPFAR/USAID Accelerate Children’s Treatment (ACT) initiative, which involved interventions and activities for ALHIV. The approach was to promote the prioritization of young adolescents and their treatment needs, using the UN’s convening power to bring the ACT coordinating committee back under the MoH’s Paediatric Technical Working Group and helping the government to develop one national plan for the acceleration of HIV prevention and treatment for children and early adolescents.

With the establishment of a NAC-USAID Dreams Technical Working Group – and as a way to bring together DREAMS/USAID partners, adolescent health partners and key Paediatric/ACT partners – the Adolescent HIV Advisory Committee (AHAC), under the NAC (which was originally proposed as a DREAMS advisory mechanism) has, as of mid-2016, transitioned into the programming advisory body for all partners around adolescents and HIV.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

The AHAC will now meet bi-monthly, instead of quarterly. A core group has been established to undertake field visits every other month, with a focus on Lusaka district, which accounts for 14 per cent of the country's population. DREAMS partners are working with community structures in 11 Health Center Zones, and UNICEF is supporting the MoH to make health services adolescent-responsive in 9 of the same zones. The aim is to accelerate field-based learning around systems strengthening, integration and harmonization's of efforts for adolescents.

The National AIDS Strategic Framework and National AIDS Policy will be finalized in the first quarter of 2017. Funds have been provided to ensure adolescent representation through NGOs and youth service organizations, and the prioritization of adolescents and HIV will be an integral part of the process, starting with the National Consultation at the end of 2016.

Addressing issues around treatment and adherence for older adolescents living with HIV has only recently been made part of the AHAC agenda. Under the ACT, the training package for ALHIV has been revised. Resources will be made available to support adolescents to establish a network of teen clubs under the district ADH TWGs, in a number of high-burden districts.

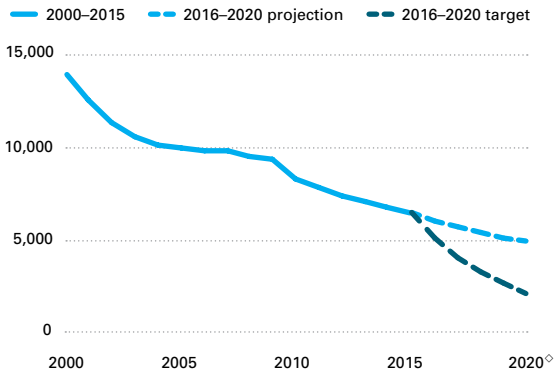
The adolescent health HIV/SRH/GBV package will be consolidated in 25 districts and 117 health centers. The number of health centers across these districts will be expanded to ensure 50 per cent coverage of facilities with the minimum adolescent health package. The package includes all health workers trained on government adolescent health standards, peer educators trained, deployed and supervised, and routine school and community outreach being undertaken, with government managed and peer educator-run adolescent-friendly health spaces in all of the sites. An additional 18 districts will be engaged, with a focus on 72 health center catchment areas. In 110 rural sites, adolescents from social cash transfer households will receive a minimum HIV prevention package to strengthen social protection and HIV linkages. By the end of 2017, 43 districts and 244 health centers will be coordinating and providing adolescent-responsive HIV and SRH services.

Sixteen new partners have been brought into the U-Report stakeholders forum, with agreements to promote the U-Report SMS communication package to adolescents. The national target is to add 80,000 adolescent subscribers to the platform in 2017, as well as a focus on improving the geographic coverage of adolescent subscribers. Co-funding of the initiative now comes from UNICEF, EU, Global Fund, German Cooperation, and Save the Children USA.

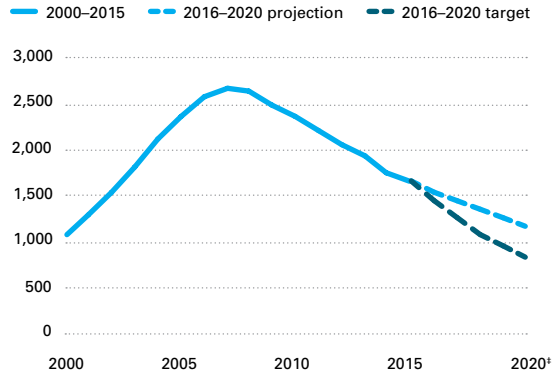
COUNTRY I **ZIMBABWE**

ADOLESCENT HIV TRENDS

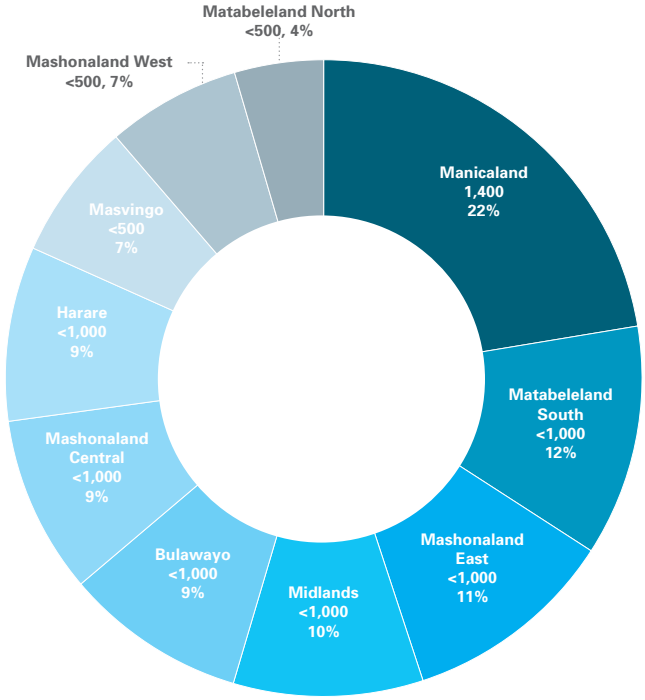
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



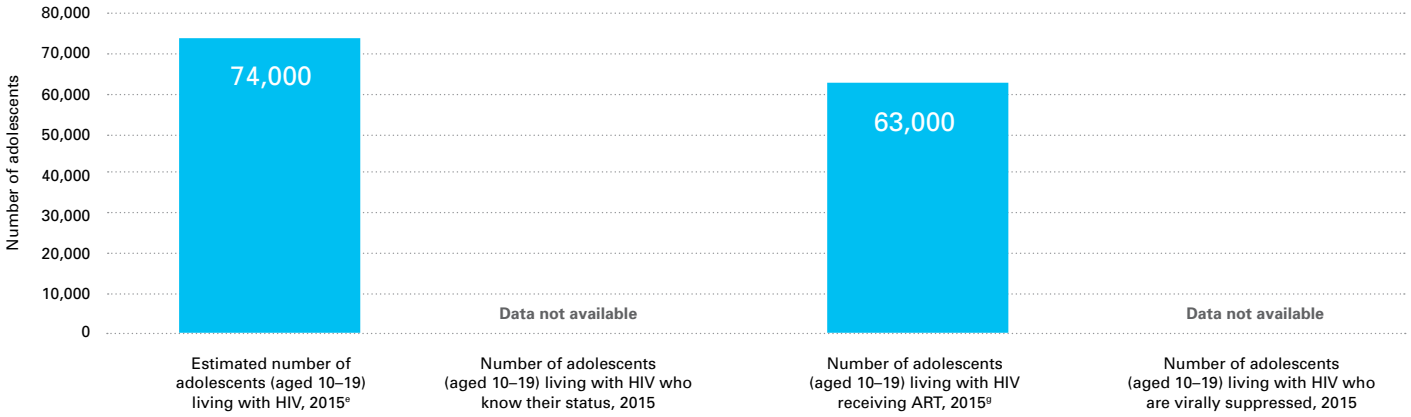
Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015e



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015c	15,600,000	7,900,000	7,700,000
	Estimated population of adolescents (aged 10–19), 2015c	3,500,000	1,800,000	1,800,000
	% of total population that is adolescents (aged 10–19), 2015d	22.5%	22.1%	22.8%
	Estimated annual number of live births, 2010–2015 (annual average)c	530,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recentvv	–	22.4 (2014)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015a	1.6%	1.5%	1.6%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015a	2.7%	3.1%	2.3%
	Estimated HIV prevalence among youth (aged 20–24), 2015a	6.7%	8.3%	5.1%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015e	74,000	40,000	33,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015e	6,400	4,500	1,900
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015e	1,700	<1,000	<1,000
Policy	Age of consent for HIV testingf	16	16	16

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	41.4 (2006) [ww]	43.5 (2006) [ww]	51.4 (2014) [vv]	48.7 (2014) [vv]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	0.8 (2006) [ww]	2.7 (2006) [ww]	0.7 (2014) [vv]	4.3 (2014) [vv]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	–	70.6 (2006) [ww]	–	61.9 (2014) [vv]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	4.8 (2006) [ww]	2.9 (2006) [ww]	34.5 (2014) [vv]	24.3 (2014) [vv]
% of adolescent boys (aged 15–19) who have been circumcised	–	7.9 (2006) [ww]	–	15.3 (2014) [vv]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	15.5 (2006) [ww]	–	18.0 (2011) [xx]	–
% of youth who have completed secondary school	–	–	8.1 (2014) [vv]	11.9 (2014) [vv]
% of young people (aged 20–24) married or in union by age 18	–	–	33.5 (2014) [vv]	2.1 (2014) [vv]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

The ALL IN Assessment has led to increased attention on adolescents and young people's issues at all levels. The UN Joint Team on HIV/AIDS also identified adolescents and young people as a flagship priority and has developed a joint adolescents and young people programme to address teenage pregnancies and reduce HIV incidence over the next five years.

The engagement of adolescents and young people during the National Rapid Assessment, along with recommendations from young people on the need to improve their involvement and participation on issues concerning them, has led to active involvement and participation of adolescents and young people in key processes, including:

1. Involvement of young people in the National Education Curriculum to develop the Guidance and Counselling Syllabus. This includes content on life skills, HIV, SRH and other health issues and is the first time that young people and NGO representatives have been involved in such a national exercise that is usually carried out by teachers from the Ministry of Education.
2. Adolescents living with HIV participated in the development of the Accelerated Action Plan for the Nationwide Scale-up of Infant, Pediatric and Adolescent ART in Zimbabwe (2015-2018).
3. Young people also participated at the ICASA conference in December 2015 as facilitators, presenters and rapporteurs, with support from the UN team and NGOs. Connections made have opened doors for youth engagement in new projects, such as the Right Here, Right Now (RHRN) partnership which focuses on young people's SRHR.
4. UNAIDS supported participation of young people at the HLM in New York in June 2016, and UNAIDS and UNDP supported participation of young people including those living with HIV and young LGBTIQ at the International Aids Conference in Durban. The youngsters from Zimbabwe saw the AIDS conference as a unique platform to make their voices heard on issues concerning adolescents and young people with HIV. As such, the Zimbabwe youth representation stood out, with advocates such as Loyce Maturu speaking on the same panel as Elton John and Prince Harry. Young people from Zimbabwe made sure they were present throughout the conference, facilitating workshops, participating in panels, screening their own videos and managing stands. Their activities are summarized in a report produced by the youth participants after the conference.
5. The adaptation of the WHO guidelines saw adolescents and young people share their views about Test and Treat, PrEP and HIV self-testing.
6. Adolescents were involved in the development of the HTS 2016-20, Health Strategy 2016-20, National ASRH Strategy II, National Clinical guidelines on ASRH.
7. A review of National ASRH training manual, EWEC, UNGASS, HLM.
8. Adolescents were involved in the National HIV Symposium on Pediatric and Adolescents in November 2016 in Harare as part of the Start Free, Stay Free and AIDS Free Campaign, participating as session co-chairs and guest speakers for the opening and closing sessions.
9. A pre-consultation for young people for the new Global Fund application in Zimbabwe is being planned.
10. Involvement in the development and implementation of the Ending Child Marriage Plan of Action/

One national youth member (a member of Youth Engage and the ACT!2015 Alliance) was recently selected to be the new adviser to Point 7 Delegation to the Global Fund board.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

While no new policies and laws have been put in place or revised, efforts are being made to disseminate current policies and guidelines at all levels including district and community levels, in a simplified way, to facilitate correct interpretation of the policies and guidelines – e.g. the issue of consent for HTS of children and adolescents and provision of contraceptives to adolescents and young people.

UNAIDS will be supporting an advocacy training for adolescents and young people, on the age of consent, from 25 to 26 November 2016. This will be followed by a youth meeting with parliamentarians on the same advocacy topic.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

1. Adolescent girls between 15-19 years and young women between 20-24 are at higher risk of HIV infection in Zimbabwe.
2. HIV testing among sexually active adolescents aged 15-19 was much lower than the target for both boys and girls.
3. Approximately half of the adolescents living with HIV and in need of ART were not on treatment.
4. If Zimbabwe took a 'business as usual' approach in responding to HIV among adolescents and young people, it would not reach the global ALL IN targets of reducing HIV infections by 75 per cent and reducing AIDS related deaths by 65 per cent by 2020.
5. Out of the 10 provinces, Masvingo, Midlands, Harare, Mashonaland Central and Manicaland had the highest HIV prevalence in adolescents aged 10 – 19 years, ranging from 11 to 17 per cent for both males and females.
6. There is a lack of adequate data on adolescents, particularly on mental health and key populations. Mental health was also noted by stakeholders as a major challenge.
7. Limited participation of younger adolescents below the age of 18 who were at school.

Progress in implementation of priority actions identified through assessments

Support has been provided to the Government of Zimbabwe to strengthen and scale up interventions to reduce HIV infections and improve access to services, focusing on key strategic areas such as policy, strategy and guidelines development, leadership and coordination, services delivery, community systems and improved continuum of care, accountability through monitoring and evaluation for adolescents, with an emphasis on age and sex disaggregated data.

Achievements made to date in response to the results of the ALL IN assessment include:

1. **HIV testing in adolescents**
    a. Using the U-Report platform, views of adolescents and young people were sought on why they do not undertake HIV testing. The most common reason was fear. Other reasons are health workers' attitudes and distance to testing sites. The issue of fear was further investigated and results showed that the adolescents and young people specifically feared receiving HIV positive results and what their parents, friends and partners would say. Several U-Report polls have also been conducted around VMMC and SRH. The U-Report has been helpful in analyzing the poll results by sex, age and geographical location.
    b. With funding and technical support from UNICEF, Global Fund and other partners, the Ministry of Health and Child Care (MOHCC) is conducting targeted HTS campaigns, targeting HIV hot spots in provinces and districts. This community-based, family-centered campaign has led to more adolescents being tested compared to levels at health facilities. In addition, the NAC has also been supporting HIV testing through music galas with positive results, using popular musicians in selected HIV hotspot areas, at growth points and in towns where majority of the people who attend would be young men.
    c. Efforts are also being made to strengthen PITC in health facilities. At the same time, new HIV testing approaches such as HIV self-testing and index testing are being piloted in selected provinces and districts, also focusing on adolescents. Preliminary findings of the pilot interventions will be shared at the end of this year.
2. **Higher risk of HIV infection in adolescent girls aged 15-19 and young women aged 20-24:**
    a. The DREAMS initiative funded by PEPFAR provides a comprehensive package of services, including cash

transfers managed by UNICEF and aimed at reducing girls' vulnerability to HIV. This is being implemented in 6 selected HIV hotspot districts through NGO partners, and complements national HIV policy, guidelines and strategies.

3. **Lower access to ART for children and adolescents compared with adults:**
   a. Development and dissemination of a costed Accelerated Action Plan for the National Scale-Up of Infant, Pediatric and Adolescents Antiretroviral Therapy 2015-2018. The main goal of this is to improve the survival and quality of life of infants, children and adolescents living with HIV. The target is to increase the percentage of children and adolescents (aged 10-19) living with HIV and on ART from 38 and 34 per cent respectively to 67 and 65 per cent by 2018, rising to 81 per cent by 2020. The expected results are:
      - HIV and AIDS related mortality among children aged 0-14 is reduced by at least 50 per cent from 6,713 in 2014 to 3,357 by 2018
      - HIV and AIDS related mortality among children aged 10-19 is reduced by at least 50 per cent from 3,528 in 2014 to 1,764 by 2018

   b. As a follow up, UNICEF provided funding to MoHCC to conduct a bottleneck analysis for 44 low performing districts in the areas of pediatric and adolescents ART. This analysis was facilitated by a joint team including MOHCC, UNICEF, UNAIDS and WHO. NGO partners including CHAI, EGPAF, Organization for Public Health Interventions and Development (OPHID), FHI 360 and AFRICAID also provided technical support to the districts to develop their evidence-based plans. UNICEF provided technical and financial support to implement 23 out of the 44 district plans. The other districts were supported by NGO partners using their own resources, including PEPFAR.

   c. Adoption and scaling up of the Zvandiri community care model by the MoHCC and use of the Community Adolescents Treatment Supporters (CATS) in about 40 districts. This has led to improved communication between health workers, children, adolescents and their caregivers. Some facilities have also initiated support groups for children and adolescents who live with HIV, working with their caregivers. Some facilities have days and times set aside for young people.

   d. The revised Operational and Service Delivery Manual for Prevention, Care and Treatment of HIV in Zimbabwe now includes adolescents and young people.

   e. Community-based approaches include the use of champions or mentors for young women living with HIV, improving treatment literacy and supported by UNAIDS and ZNNP+.

   f. Working in collaboration with Ministry of Public Service, Labour and Social Welfare (MoPLSW), MOHCC, Ministry of Primary and Secondary Education, Networks of People living with HIV, National AIDS Council and NGO partners, UNICEF is supporting the integration of HIV in the national case management system and social protection services in 10 districts that are benefiting from the Harmonized Social Cash Transfer Scheme.

4. **High teenage pregnancies:**
   a. With funding from UNFPA and technical support from MoHCC, UN partners and NGO partners, a national ASRH strategy has been developed, using a theory of change and with the primary aim of reducing teenage pregnancy and HIV infection.

5. **Lack of data on key populations:**
   a. The National AIDS Council, with support from UNAIDS, UNFPA and other partners, is supporting a mapping of young female sex workers.

Impact of the assessments on the use of strategic information on adolescents

1. The involvement of policy makers and senior staff members from relevant ministries and partners (including the National HIV/AIDS Strategic Information Coordinator during the ALL IN assessment) enhanced their knowledge on adolescents, the kind of challenges they face and the importance of age and sex disaggregated data. The 2016 HIV/AIDS quarter 3 report presented by the National HIV/AIDS Strategic Information Coordinator clearly shows how the country is performing for adolescents and young people by age and sex for HIV testing and ART.

2. The national HIV and AIDS quarterly and annual reports include age and sex disaggregated data on adolescents.
3. During the bottleneck analysis, each district was able to assess its own performance and identify areas of poor performance, using the HIV cascade. The data and gaps then informed the analysis process and development of evidence-informed action plans.
4. The National Aids Council, with technical support from UNAIDS and financial support from partners, is conducting a mapping of young sex workers to address some of the data gaps noted about key populations. In addition, the Young People's Network on HIV and SRH now have a LGBTI representative, which was noted as a gap during the assessment.
5. Maternal deaths reporting also includes analysis of death among young people.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

Mobile technologies are among common approaches being used in Zimbabwe. They include the **'Tune Me'**, which is being supported by an NGO called SayWhat to provide information about dating and relationships, working with young people in colleges and tertiary institutions.

In 2016, UNESCO issued a call for expressions of interest in collaborating on a SMS platform to increase uptake of SRH information and services among University Students'

U-Report, supported by UNICEF, is being used as a research tool and to send messages to young people. Africaid, an NGO working with adolescents and young people living with HIV, is piloting use of U-Report as a counseling tool.

Other platforms are Facebook, Twitter and Whatsapp groups. UNFPA and AFRICAID are also supporting use of tablets for sending real-time data from district to national level.

UNDP Innovation Facility supported Youth Engage to conduct a pilot project using social media to communicate HIV results and issues.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

1. **Improved coordination** of programmes for adolescents and young people at all levels. There has been an improvement noted within the MoHCC where such programmes are being coordinated through the ASRH Unit under the Family and Child Health Department. This has also enhanced links between SRH, HIV and VMMC. The new ASRH strategy is aimed at reducing teenage pregnancy and HIV infection in line with the ALL IN target. However, further advocacy is needed to ensure active participation and involvement of the education sector as a key player in HIV and SRH issues for adolescents and young people.
2. **Improved accountability** through strengthened monitoring and evaluation of adolescent-related interventions, ensuring that all national reporting systems and tools capture data by sex and age and that national reports include analysis of adolescent-specific issues. The ASRH Forum continues to advocate for standardization of age disaggregation across all programmes for adolescents and young people including reproductive health.
3. **Improved resource allocation** for these programmes, particularly HIV prevention and ASRH. In this regard, UNICEF supported the Ministry of Youth to develop a business case for investing in young people which included the benefits of reducing HIV infection. The Youth Investment and HIV paper was presented at the National HIV Symposium on Pediatric and Adolescents held on 17 and 18 November 2016, in Harare.
4. Continued advocacy on the need to collect and report on **age and sex disaggregated data** for adolescents and young people across all programmes. The new ASRH strategy and ASRH M&E framework under development

is aimed at addressing some of the data challenges. However, the data flow and reporting should be clarified to ensure that the data is used appropriately and in a timely manner.

5. **Ending child marriages**. A National Plan of Action supported by UNICEF, UNFPA, UNICEF, UN Women and other partners has been developed and is being implemented with a lot of support and commitment by stakeholders, including young and national leaders.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. The provision of age and sex disaggregated data, along with geographical mapping, is critical to achieve greater and more targeted impact, monitoring performance and equitable allocation of resources. This is crucial, given the limited resources available.
2. Involvement of adolescents and young people in planning, implementation, monitoring and evaluation of their own activities builds confidence and gives ownership of their programmes. Young people are also able to share their views and advise service providers about what does or does not work for them.
3. Social media is a strategic tool to reach adolescents and young people with SRH and HIV-related messages or questions, provided the cost is minimal or free of charge.
4. While HIV-related stigma has significantly reduced among adults, it is still a major challenge among adolescents and young people.
5. The use of peer approaches, such as support groups for adolescents living with HIV and the involvement of care givers, are effective in addressing stigma and adherence issues among adolescents living with HIV.
6. A comprehensive package of services, including counseling, should be provided for adolescents and young people for maximum impact. Therefore, a multi-sectoral approach to provision of services is key.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

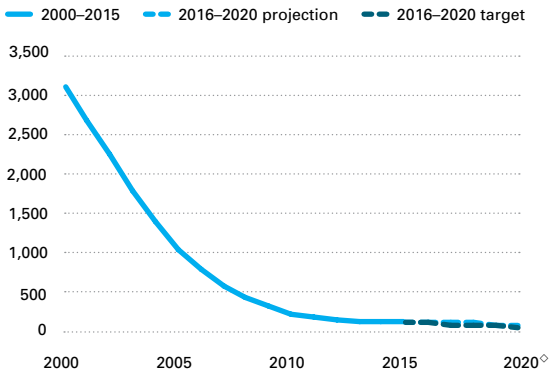
1. Support implementation of the in-depth analysis on adolescents (phase 2 of the ALL IN assessment).
2. Improve coordination of adolescents and young people at all levels for greater impact and to maximize on the limited resources available.
3. Review progress on implementation of the accelerated plan on ART for infants, children and adolescents.
4. Leverage resources for adolescents through the new Global Fund proposal application, informed by evidence from ALL IN, DREAMS, YWSW mapping, and results from other studies and evaluations.
5. Increase uptake of HIV testing services among adolescents and young people, targeting HIV hotspot areas using community-based approaches and going to where adolescents and young people are.
6. Support implementation of the ASRH and HTS strategy, as well as building the capacity of teachers to use the new life skills, HIV and sexuality training manual.
7. Improve access to HIV testing, ART services and retention in care for young people, including in humanitarian situations.
8. Strengthen HIV-sensitive social protection services for adolescents, young people and their families.
9. Address data gaps on mental health.
10. Improve capacity of service providers and quality of services.
11. Conduct operational research on access to ART post-HTS and review the DREAMS Initiative.

LATIN AMERICA AND THE CARIBBEAN

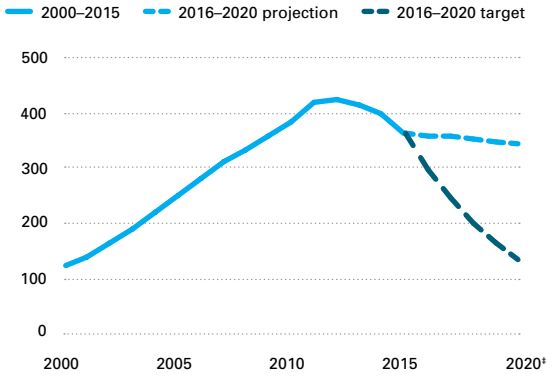
COUNTRY I **HAITI**

ADOLESCENT HIV TRENDS

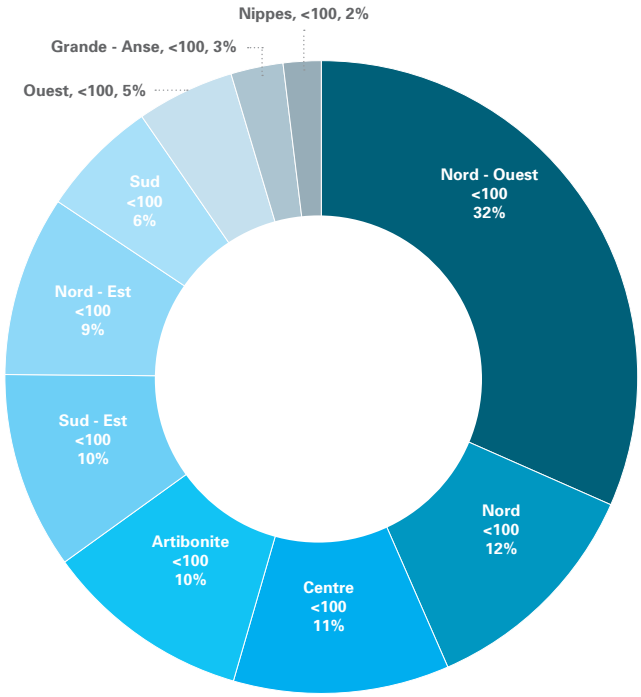
New HIV infections among adolescents (aged 15–19), 2000–2020[◇a∞]



AIDS-related deaths among adolescents (aged 10–19), 2000–2020[‡b∞]



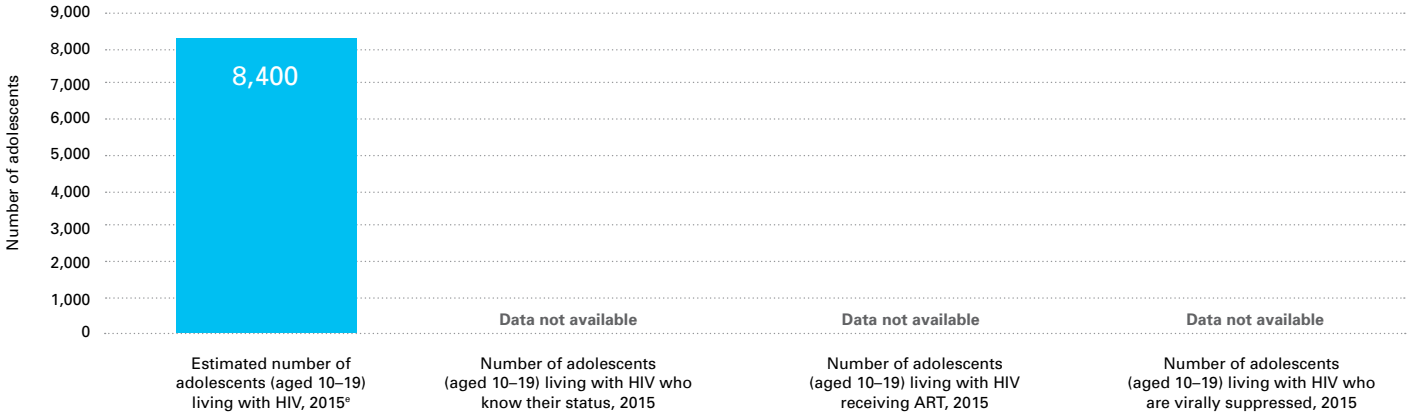
Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015[e]



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	10,700,000	5,400,000	5,300,000
	Estimated population of adolescents (aged 10–19), 2015[c]	2,300,000	1,100,000	1,200,000
	% of total population that is adolescents (aged 10–19), 2015[d]	21.3%	20.9%	21.8%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	260,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[vy]	–	12.9 (2012)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.4%	0.4%	0.4%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.4%	0.4%	0.3%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	0.4%	0.5%	0.3%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	8,400	4,300	4,100
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	<200	<200	<100
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<500	<200	<200
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15-19) with comprehensive, correct knowledge of HIV	32.6 (2006) [zz]	33.7 (2006) [zz]	31.7 (2012) [yy]	25.4 (2012) [yy]
% of adolescents (aged 15-19) reporting multiple sexual partners in the last 12 months	0.9 (2006) [zz]	12.9 (2006) [zz]	1.6 (2012) [yy]	14.2 (2012) [yy]
% of adolescents (aged 15-19) reporting multiple sexual partners who reported condom use at last sex	31.2 (2006) [zz]	42.0 (2006) [zz]	41.9 (2012) [yy]	58.0 (2012) [yy]
% of adolescents (aged 15-19) who were tested for HIV in the last 12 months received the results of the last test	4.0 (2006) [zz]	1.7 (2006) [zz]	9.3 (2012) [yy]	4.3 (2012) [yy]
% of adolescent boys (aged 15-19) who have been circumcised	–	–	–	–
% of adolescent girls (aged 15-19) who have ever experienced sexual violence	–	–	9.8 (2012) [yy]	–
% of youth who have completed secondary school	–	–	8.5 (2012) [yy]	11.7 (2012) [yy]
% of young people (aged 20-24) married or in union by age 18	–	–	17.5 (2012) [yy]	2.6 (2012) [yy]

ADOLESCENT KEY POPULATIONS

Population	**Indicator**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

In Haiti, the ALL IN initiative was launched on 10 September 2015 and the focus was on prevention among young people. All partners involved in this initiative worked closely with organizations that support young people and continue to encourage good practices to protect them against AIDS. During the launch, 90 per cent of the activities were organised by young people with the support of UNAIDS and UNICEF.

Mechanisms that are in place to ensure meaningful adolescent engagement in the HIV response are as follows:

1. The 'Conseil Consultatif des Adolescents' (CCA) is composed of about 20 youth members from organizations engaged in ALL IN. These adolescents were identified as youth leaders during information sessions and workshops, based on their communication skills, quick learning ability about HIV and youth, and ability to lead others within their organizations.
2. UNICEF, UNAIDS and the MoH have continued to involve the CCA in several activities involving youth. They have participated in radio broadcasting, with a special focus on issues faced by young people, including sexual and reproductive health, HIV and STIs. They have also contributed to the planning of activities related to adolescents and HIV with UNICEF and its partners in different areas of the country.
3. Since 2015, UNAIDS has mobilized resources for capacity building on HIV, SRH, unwanted and early pregnancy, advocacy and communication among young girls and boys. Around 180 adolescents and youth from 5 departments have trained.
4. The CCM in Haiti includes representation from networks of young people.
5. During development of the national strategic plan and the GF concept note, with support from PAHO and WHO, youth were involved in the process through focus group consultation on priorities to be considered.
6. The MoH has initiated 'comite sante jeune et adolescent' at department level.
7. The Ministry of Education has launched health school clubs in public and private secondary schools. An operational guide has been developed for these clubs, based on consultations with national and international partners and young people. The scope of interventions supported through these clubs includes: Hygiene, sexual and reproductive health, HIV prevention, environment and citizenship.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

After the ALL IN launch in September 2015, a series of activities including information sessions with youth groups and a rapid assessment of the current situation were implemented. During the launch, representatives of adolescents and young people defined key priorities that were added to a commitment charter and signed by youth representatives and several ministries.

The Ministry of Education is developing its new post-2015 strategic operational plan with support from UNESCO. Among the key priorities identified by young people that will be taken into account in the framework is access to comprehensive quality health and HIV prevention education for all adolescents.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

Country assessment not completed.

Progress in implementation of priority actions identified through assessments

Scattered actions have been implemented since the launch of the initiative. There is a need to conduct a comprehensive assessment of adolescents and youth on HIV and RH issues.

Impact of the assessments on the use of strategic information on adolescents
N/A

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents.

The plan with innovative approaches was developed but, due to lack of resources, it has yet to be implemented.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

Key advocacy priorities of this initiative in Haiti and actions to date include the following:

1. A commitment charter signed by the Office of the First Lady, ministries, UN agencies and civil society organizations, which holds them accountable to continuing actions that seek to end the AIDS epidemic in adolescents.
2. The creation of the "Conseil Consultatif des Adolescents" (CCA), composed of around 20 youth members. The CCA continues to meet regularly.
3. The UN Joint Programme has prioritised many ALL IN initiatives. However, resource mobilization is still a key issue. UN agencies such as UNICEF, UNAIDS, UNESCO, UNFPA, PAHO/WHO and the MINUSTAH are very committed to supporting ALL IN.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

Young people and especially adolescents can be effective agents of change if they are fully engaged and supported.

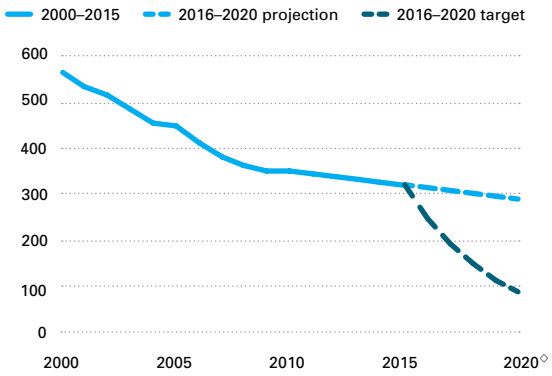
F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. Complete a comprehensive assessment to ensure strategic information is available to support policy development and other initiatives.
2. Develop a joint programme, targeting high-risk youth and adolescents.
3. Support innovative outreach, using ICT to increase prevention of HIV and SRH services.
4. Design and initiate a demonstration project or implementation science on effective approaches for delivery of targeted interventions to high-risk youth and adolescents in Haiti.
5. Strengthen the capacity of the 'Conseil Consultatif des Adolescents' and youth groups.

COUNTRY I **JAMAICA**

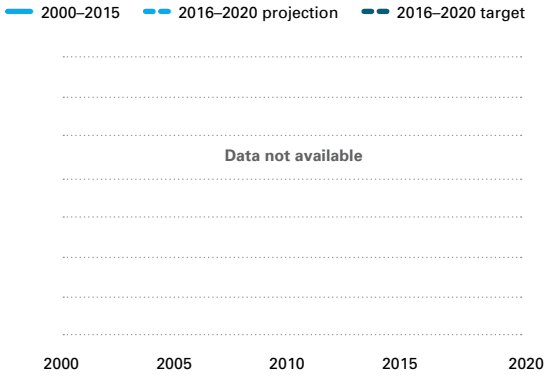
ADOLESCENT HIV TRENDS

New HIV infections among adolescents (aged 15–19), 2000–2020[◇a∞]



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

AIDS-related deaths among adolescents (aged 10–19), 2000–2020[λb∞]



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	2,800,000	1,400,000	1,400,000
	Estimated population of adolescents (aged 10–19), 2015[c]	510,000	250,000	260,000
	% of total population that is adolescents (aged 10–19), 2015[d]	18.3%	17.8%	18.8%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	49,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent	–	–	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.1%	0.1%	0.1%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.4%	0.4%	0.4%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	0.5%	0.8%	0.2%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	1,200	<1,000	<1,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	<500	<200	<200
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<100	<100	<100
Policy	Age of consent for HIV testing[f]	16	16	16

HIV TREATMENT FOR ADOLESCENTS

ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15-19) with comprehensive, correct knowledge of HIV	58.9 (2005) [aaa]	–	39.1 (2012) [bbb]	33.7 (2012) [bbb]
% of adolescents (aged 15-19) reporting multiple sexual partners in the last 12 months	–	–	15.8 (2012) [bbb]	38.9 (2012) [bbb]
% of adolescents (aged 15-19) reporting multiple sexual partners who reported condom use at last sex	–	–	55.9 (2012) [bbb]	75.2 (2012) [bbb]
% of adolescents (aged 15-19) who were tested for HIV in the last 12 months received the results of the last test	–	–	34.7 (2012) [bbb]	20.0 (2012) [bbb]
% of adolescent boys (aged 15-19) who have been circumcised	–	–	–	–
% of adolescent girls (aged 15-19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	–	–	–	–
% of young people (aged 20-24) married or in union by age 18	–	–	7.9 (2011) [ccc]	–

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

"ALL IN represents the most sensible and practical way to move forward on adolescents and youth issues. The truth is that there is a generation gap and the older generation don't understand the realities of this time, as it has changed. Our meaningful engagement is therefore the only way in which any adolescent-centric or youth focused initiative will be successful. On another level, it feels good to be more than 'figurines' for a change." - Aldane Walters (member, ALL IN Youth and Adolescent Technical Working Group)

The ALL IN platform was launched in Jamaica in 2015. The process has been fully supported and led by the Government of Jamaica at a high level. The Planning Institute of Jamaica, the agency tasked with responsibility for the National Development Plan-Vision 2030, led the implementation process in partnership with the Ministry of Health. The Planning Institute of Jamaica counts ALL IN among the country's flagship programmes to improve the health status of young Jamaican citizens. The ALL IN platform remains a high priority area in multiple government sectors, despite a change in administration during the implementation phase.

A technical working group, comprising national partners working in the interest of the adolescent, was formed. Strategically, the planning team selected members whose work would complete the adolescent as a whole, taking into consideration the WHO definition of health. Partners include Ministries of Health, Education and Youth, Local Government, Statistical Institute of Jamaica, and agencies with responsibility for child protection and civil society.

The Joint Programme of Support UNJT on AIDS prioritizes work relating to the adolescent population and ensures that the ALL IN movement is used as a platform to rationalize investments.

This initiative has been facilitated with strong guidance, as well as technical and financial support, from UNICEF, UNAIDS and the UN Joint Team on HIV.

The following are the main mechanisms used to ensure adolescent engagement:

1. The national response now systematically incorporates adolescent participation through the establishment of an adolescent and HIV working group, which provides inputs on policy and prevention strategies. The adolescent TWG assists in planning ALL IN related activities.
2. A plan for action developed by the adolescent TWG informed Jamaica's presentation to the HLM in June 2016.
3. The TWG led a social media campaign in preparation for the HLM June in 2015.
4. A plan of action was developed as part of the planning exercise that followed the in-depth ALL IN assessment. The government has committed to implementing this.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

The ALL IN rapid assessment findings have provided the data needed to make an investment case for adolescents and address the legal and policy barriers to access. Jamaica now has population and prevalence estimates of young key affected populations, and there is a strong evidence base to justify a focus on adolescent girls and boys. The data shows similar prevalence and risk for adolescent boys and girls, which differs from what national reports had previously implied. Previously, girls were reported to be 3 times more likely to be infected with HIV than boys the same age.

In direct response to the findings of the ALL IN rapid assessment, the Global Fund has reprogrammed US$ 395,178 to implement adolescent-focused interventions. This is significant since the GFTAM had previously informed the country that it would not consider interventions among adolescents and youth without critical data on how the epidemic is affecting these populations. These funds include activities for policy and legal reform.

Findings from the country assessment have already begun to influence planning at the macro and sector planning levels. The Planning Institute of Jamaica has used the findings to inform its midterm strategic framework (MTSF) for

the health, education and protection sectors. The health sector has also used the findings to guide its annual plans for the National HIV Programme.

The findings from the assessment have also strengthened a MoH proposal to Parliament to change laws that restrict adolescent access to sexual and reproductive health services, including HIV testing, condoms and other contraceptives.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

1. **HIV Testing and counseling**
   a. Adolescents below the age of 16 cannot access HIV testing without parents' consent.
   b. The health system better captures HIV status for vulnerable girls because they are tested as a part of the EMTCT programme, while boys are less likely to be tested.
   c. HIV prevention services are not reaching all the populations that need interventions. This is especially true in the school population.
   d. Insufficient targeted testing among vulnerable adolescents and youth (including MSM, TG and SW and incarcerated youth..
2. **HIV treatment and adherence to ARV**
   a. High levels of stigma (health care, self-stigma, family, community) lead to denial, non-disclosure and failure to access treatment and care.
   b. Stock out of ARV.
   c. The age of consent is inflexibly enforced. Adolescents below the age of 16 who need to access HIV treatment and care must have consent of parents or guardians.
   d. Limited patient literacy specific to adolescents HIV treatment regimen and adherence support.
   e. No adolescent-friendly clinics.
   f. Lost to follow-up protocols are not adapted to suit adolescent needs.
   g. Expand knowledge among medical and support staff for adolescent adherence issues
3. **HIV prevention - comprehensive knowledge**
   a. The Health and Family Life (HFLE) curriculum is not delivered in all schools, even though it has been mandated by the Ministry of Education. The roles and accountability for the delivery of the curriculum need to be effectively managed.
   b. Alternative and new media must be utilized to reach younger audiences.
   c. Lack of youth-friendly HIV prevention messages.
   d. Limited prevention interventions that target adolescents and youth due to funding constraints.
   e. Limited coordination of multi-sector teams on adolescent SHR responses.
4. **HIV prevention – access and availability of condoms**
   a. Inconsistent supply of condoms to people or groups who do not identify as a member of a key population. Condoms funded through donors are usually for members of key populations.
   b. A lack of condom promotion specifically for adolescents and key populations.
   c. Adolescents are refused condoms at health facilities.

5. **Prevention of teen pregnancy**
    a. Legislative barriers restrict adolescents' access to contraceptives.
    b. Psychosocial support for teenage mothers is limited.
    c. Social Safety Net programmes for pregnant and nursing women do not benefit adolescent mothers due to their age.
    d. Inconsistent supply of various contraceptive methods – some methods such as implants are not always available.

Progress in implementation of priority actions identified through assessments

The MoH has revised its M&E tools and systems to disaggregate adolescent data. National behavioural surveys (e.g. National Knowledge, Attitudes, Behaviours and Practices survey, National Behavioural Surveillance Survey among men who have sex with men) which inform programme planning are also being revised to capture behavioural trends among adolescent boys and girls.

The adolescent treatment cascade generated through the ALL IN assessment is now being used by the MoH to design its interventions among adolescents living with HIV. As a result, retention in care for adolescents has become a priority issue and the ministry has added officers specializing in adolescent psychologists to its cadre of workers in HIV treatment sites, as part of its drive to deliver a comprehensive package of services to adolescent PLHIV.

Impact of the assessments on the use of strategic information on adolescents

Findings from the country assessment have already begun to influence planning at the macro and sector planning levels. In addition to the progress reported above, the Planning Institute of Jamaica has used the findings to inform its midterm strategic framework (MTSF) for the health, education and protection sectors. The health sector has also used the findings to guide its annual plans for the National HIV Programme.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

The use of social media to improve access, utilization and monitoring has not yet been realized. However, social media has been utilized to garner support for the report produced by young people for the HLM in June, 2016. This was done through a Twitter chat around key HIV related data from the ALL IN rapid assessment.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

1. Addressing the legislative barriers to accessing sexual and reproductive health services.
2. The Government of Jamaica led and completed the Rapid Assessment in 2015. This led to prioritization of adolescent girls and adolescent MSM for prevention, HIV testing and treatment for adolescents living with HIV, and better age-disaggregation and tailored planning for adolescents across sectors to address priorities emerging out of the assessment (teenage pregnancy, sexual violence and mental health).
3. The UNJT on AIDS, with government support, has successfully advocated the Global Fund for increased financial resources for adolescents. Specific UN agency work plans have also linked resources pertaining to adolescents to the ALL IN movement.
4. Adolescents are at the center of the UNJT's AIDS support to national activities as both planners and beneficiaries.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. Data analysis through the ALL IN process showed that both adolescent girls and boys share a similar risk of HIV transmission. More needs to be understood about this risk in order to improve effective and evidence-based programming, especially for boys. This is critical to ensure that this subset of adolescents is not left behind. Previously, the HIV response had prioritized girls in its programming strategies as they were thought to be three times more at risk than boys.
2. While data was available for adolescents, detailed analysis needs to be done to inform effective programming.
3. Meaningful involvement of adolescents goes beyond mere inviting them to a meeting. It means ensuring that they are the foundation and center of all activities and programmes that are related to their wellbeing.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

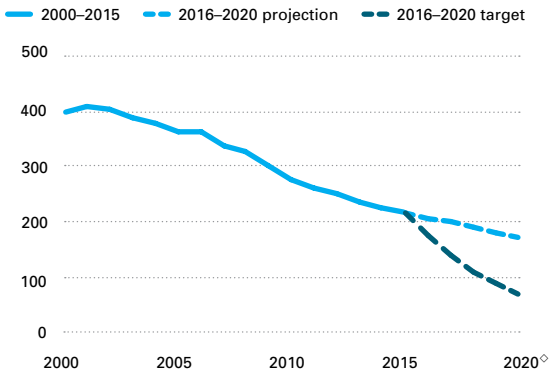
1. An action plan aimed at fostering stronger cooperation and collaboration across sectors is to be developed by December 2016 to guide programming in 2017. The plan will be guided by the ALL IN assessment findings from phases 1 and 2.
2. A mid-term review of the National Strategic Plan (NSP) and accompanying M&E Plan provides an opportunity for recommendations from the ALL IN plan to be put into effect.
3. The Planning Institute of Jamaica has committed to include the recommendations from Phase 3 of ALL IN in the national development plan.
4. The State Minister of Youth has announced that youth ambassadors will be appointed to continue political advocacy around the SDG. The UNJT on AIDS will support stakeholders to have HIV and SRH included in the advocacy package.
5. Plans are in place to have HIV prevention messages developed by adolescents and youth for adolescents and youth. This will be a continuation of the World AIDS Day HIV prevention campaign.

MIDDLE EAST AND NORTH AFRICA

COUNTRY I **IRAN (ISLAMIC REPUBLIC OF)**

ADOLESCENT HIV TRENDS

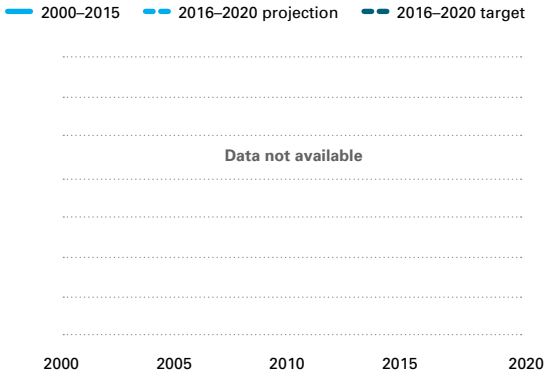
New HIV infections among adolescents (aged 15–19), 2000–2020[◇a∞]



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

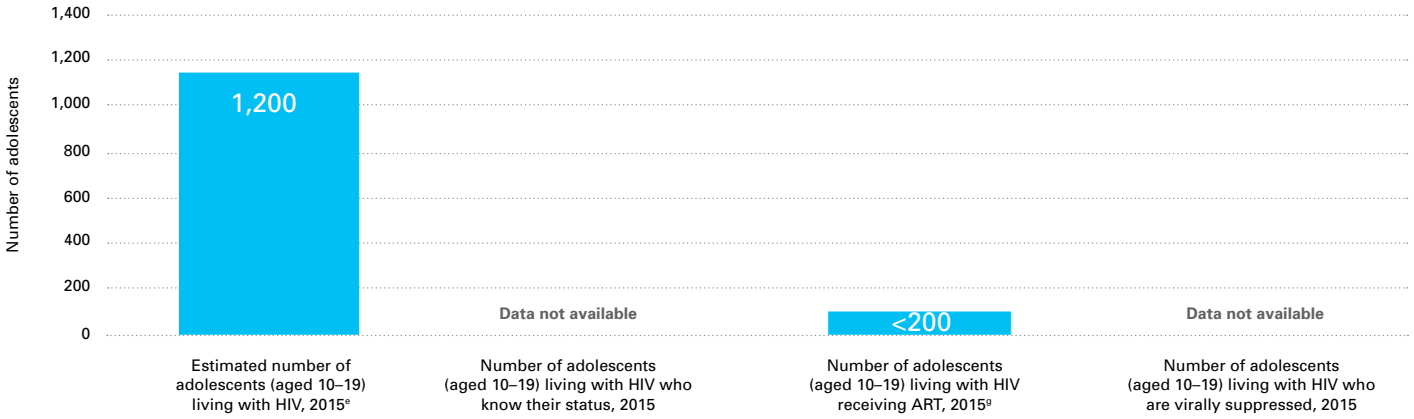
AIDS-related deaths among adolescents (aged 10–19), 2000–2020[λb∞]



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	79,100,000	39,300,000	39,800,000
	Estimated population of adolescents (aged 10–19), 2015[c]	10,900,000	5,200,000	5,700,000
	% of total population that is adolescents (aged 10–19), 2015[d]	13.8%	13.3%	14.3%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	1,400,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[ddd]	–	5.2 (2010)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.0%	0.0%	0.0%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.0%	0.0%	0.0%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	0.1%	0.0%	0.1%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	1,200	<1,000	<1,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	<500	<200	<100
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<100	<100	<100
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	–	–	–	–
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	–	–	–	–
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	–	–	–	–
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	–	–	–	–
% of adolescent boys (aged 15–19) who have been circumcised	–	–	–	–
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	–	–	–	–
% of young people (aged 20–24) married or in union by age 18	16.7 (2010) [ddd]	–	–	–

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

Peer support groups have been supported to offer adolescents in the field with opportunities for meaningful interaction. The ALL IN initiative has provided the groups with content to help them focus on health and counseling, learning through activities such as training on HIV prevention and control, and interaction with other adolescents. The peer groups are also seen as a mechanism for strengthening social capital and protection of adolescents and are thus seen as a valuable platform for improving social and mental health of adolescents, as well as reducing high risk behavior. Outreach activities target high risk and vulnerable adolescents.

Adolescent-friendly recreational and informal educational centers have been set up for adolescents and youth to support their interaction and learning in a safe and constructive environment, free of judgement and stigma. At the center, adolescents can also access support from professional counselors. The social and recreational benefits, combined with the knowledge, information and counseling that the centers provide access to, make them attractive to adolescents as well as parents.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

In order to improve the implementation of policies and laws that govern adolescents' access to HIV and SRH services, inter- and intra-sectoral collaboration has been strengthened. Under the ALL IN initiative, collaboration between youth and adolescent programme officers from the Ministry of Education and Ministry of Sports and Youth has improved significantly. In addition to that close partnership with Ministry of Health, private addiction treatment and psychological counselling centers, military, police, NGOs and academia have helped to promote youth and adolescent health centers involved in the implementation of the ALL IN in Iran. In addition, clubs were presented in other key neighborhood centers, such as neighborhood councils, offices, religious venues and parent-teacher councils to increase awareness and coordination. In Tehran, the ALL IN programme was introduced to the AIDS Committee of the Tehran governor's office and received the support of member organizations and ministries.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

Iran was the first country to implement ALL IN in the Middle East and North Africa region. An initial assessment was conducted in October 2015 to identify existing services and priorities, as well as the needs of young people across the country. The bottleneck analyses involved adolescents, people living with HIV, health service providers and policy makers. In addition, a stakeholder consultation was conducted in November 2015.

Among the key findings are the following:

1. HIV prevalence among ages 15 to 49 is 0.14 per cent. The low prevalence of HIV in Iran is testament to the success of harm reduction programmes initiated in response to a concentrated epidemic among prisoners in the 1990s.
2. Despite this success, mother-to-child transmission of HIV increased to 2.9 per cent in 2014.
3. Women are less likely to be reached by prevention programmes and less likely to be diagnosed early. Sexual transmission has become as important as injection drug use in the transmission of the disease.
4. The percentage of women infected with HIV has been growing steadily.

The following key priorities have been identified:

1. Establishing youth and adolescent health and counseling clubs in populous and high risk areas.
2. Accurate and complete information on sexual and reproductive health and HIV for adolescents and youth, as well as investment in capacity and a supportive environment for training of adolescents and service providers for better quality delivery.
3. Safe, community-based programmes tailored to the needs of adolescent boys.
4. Partnership with families to ensure access to and engagement of adolescent girls in opportunities for learning and support on HIV and SRH.

Progress in implementation of priority actions identified through assessments
UNICEF and partners have supported the development of a comprehensive community-based minimum service package, targeting the most-at-risk adolescents. The service package has been introduced in five youth and adolescent health and counseling clubs. The one-year implementation survey conducted in pilot sites indicated that training on HIV prevention and changing negative social norms had a significant effect on young people's knowledge and attitude towards HIV and discrimination. In addition, the clubs have also worked to involve parents and, through counseling services and training meetings, have helped parents develop stronger relationships and more effective communication with adolescents.

Impact of the assessments on the use of strategic information on adolescents
ALL IN has helped to strengthen a more collaborative approach to strategic planning and implementation of adolescent health related programmes. Young people and adolescents have actively participated in the assessment as well in conducting activities. Additionally, in the process of the initial assessment, a new collaboration mechanism has been established between main stakeholders, including Ministry of Education, National Youth Organization, the Red Crescent, Ministry of Sports and Youth, Municipality, Prisons' Organization (Juvenile Correction Center), NGOs and international agencies.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

To better communicate with adolescents and transfer educational messages, digital tools such as the Telegram instant messaging application and Instagram have been used. For example, a Telegram channel was launched for awareness-raising purposes and a virtual group has been created, offering online Q&A. A hotline was also launched, along with a website which is currently being piloted.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

1. Partner with the media and private sector to further familiarize the target group with ALL IN and support initiatives at service delivery points for adolescents and youth.
2. Partner with organizations such as the Municipalities and Ministry of Education partners to scale-up safe spaces for adolescents in a cost-effective and sustainable way.
3. Partner with NGOs/civil society to leverage their access to the target population
4. Reinforce the commitment and engagement of organizations and institutes accountable for results in adolescents and youth (such as the Ministry of Education, protection organizations such as the State Welfare Organization, and the Imam Khomeini Relief Foundation).
5. Establish broad public-private partnerships to advocate and put a response in place for vulnerable children and adolescents involved in informal labor and caregiving.
6. Integrate adolescent and youth clubs within the broader health sector strategy to leverage resources for scale up and sustainability

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. The capabilities of adolescents themselves should be considered in certain club activities (e.g. as peer educators), with some responsibilities delegated to adolescent volunteers so they develop a sense of belonging.
2. The most important principle in improving quality and performance of the clubs is having interested, trained and young staff who should go through periodic on-the-job training.
3. It is essential to develop an internal and external monitoring and evaluation tool.
4. Given the variety of activities for different age groups (10-14 years, 15-19 years and 20-24 years) in clubs, such as workshops and games, along with the fact that some need to be carried out externally so that more at-risk groups can benefit, participation in campaigns and financial support are critical to achieving both quality and scale.

5. Inter-country exchange and knowledge management are vital as the adolescent programme is expanded.
6. Parental engagement is essential for a successful adolescent programme.

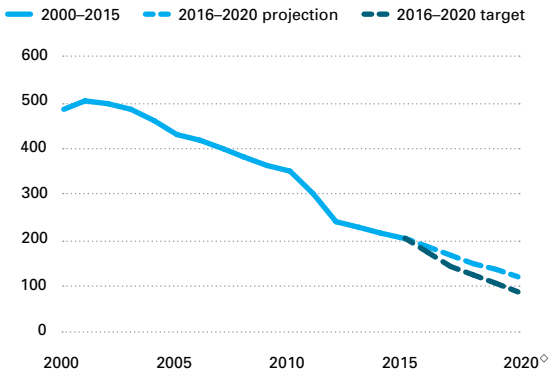
F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. As a result of ALL IN advocacy efforts, the society, parents, officials and policymakers recognize that adolescent health centers are a strategic resource. Therefore, in 2017, scale up of a pilot model to other two provinces is planned. In scaling-up this approach, the social, cultural and economic features of each area will be taken into account.
2. Capacity building for NGO staff in specific areas such as communication skills and working with adolescents with special needs.
3. Advocacy for effective collaboration across all sectors, and development of a long term strategy and plan to ensure sustainability of the outreach and engagement approach.

COUNTRY I **MOROCCO**

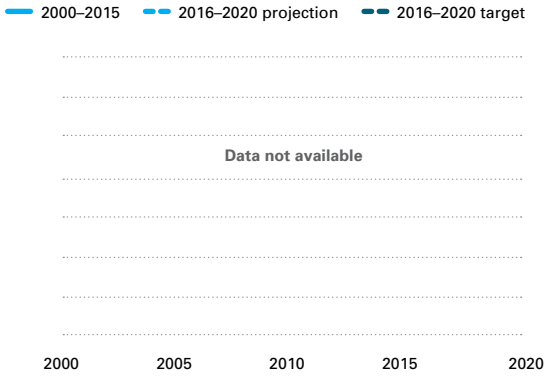
ADOLESCENT HIV TRENDS

New HIV infections among adolescents (aged 15–19), 2000–2020[◇a∞]



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

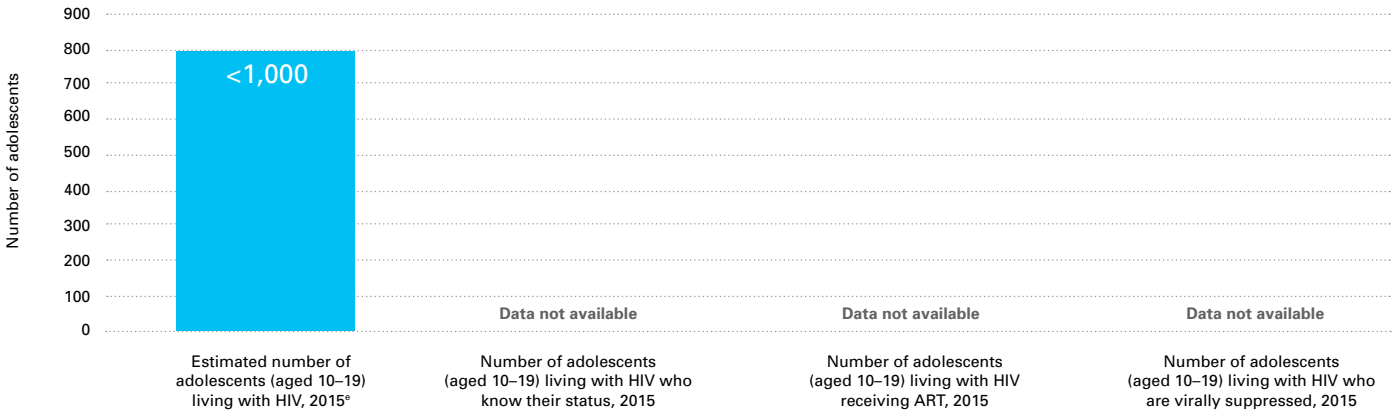
AIDS-related deaths among adolescents (aged 10–19), 2000–2020[λb∞]



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	34,400,000	17,400,000	17,000,000
	Estimated population of adolescents (aged 10–19), 2015[c]	5,800,000	2,800,000	3,000,000
	% of total population that is adolescents (aged 10–19), 2015[d]	17.0%	16.3%	17.6%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	710,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent	–	–	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.0%	0.0%	0.0%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.0%	0.0%	0.0%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	0.0%	0.1%	0.0%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	<1,000	<500	<500
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	<500	<100	<200
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<100	<100	<100
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	12.2 (2004) [eee]	–	–	–
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	–	–	–	–
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	–	–	–	–
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	–	–	–	–
% of adolescent boys (aged 15–19) who have been circumcised	–	–	–	–
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	–	–	–	–
% of youth who have completed secondary school	–	–	–	–
% of young people (aged 20–24) married or in union by age 18	15.9 (2004) [eee]	–	–	–

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

In Morocco, several strategies and national policies exist that promote engagement and integrate the youth population and adolescents in relation to SRH and HIV/AIDS response (the National Strategy for Integrated Youth, the National Strategy for School and University Health, the National Strategic Plan to Fight Against HIV/AIDS).

1. The preparation of a National Strategy for the Promotion of Youth Health is in progress. Priority is given to this vulnerable population with regards to health and social development plans, as well as national education.
2. Government-wide awareness programmes have been developed in schools and community settings, engaging adolescents and youth.
3. Mechanisms such as the Youth Parliament and the National Observatory of the Rights of Children, youth health centers and clubs, as well as peer educational programmes, allow greater opportunities for the involvement of adolescents and youth in HIV response.
4. NGOs also play a key role in the integration of young people in the response.
5. A young person living with HIV has been integrated as a member of the CCM.
6. There are a number of ongoing programmes targeting youth HIV prevention, as well as efforts to raise awareness of this among the population.

In part because of this engagement, youth and adolescents are increasingly at the center of the HIV response. ALL IN efforts in Morocco aim to build on all these initiatives and opportunities to promote and stimulate participation of young people and adolescents in the national response.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

A specific session on the results and recommendations of the ALL IN assessment featured in the meeting on strategies for the new National Strategic Plan (NSP) for the fight against AIDS for the period 2017-2021. As a consequence of these recommendations, the new NSP 2017-2021 identifies adolescents and particularly the most vulnerable as a priority population and sets objectives to strengthen and accelerate their access to SRH and prevention activities. Advocacy efforts are also underway to reduce the legal age for HTC to 15 years and to change the legal framework which prevents young people up to the age of 18 from having access to testing services without parental consent.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

1. Adolescent participation as outlined in the ALL IN initiative, which aims to mobilize and empower youth as leaders and agents of social change, is not yet reflected as such in the operational plan. There are several constraints leading to this:
   a. Lack of specific laws ensuring their right to participation is recognized
   b. Lack of effective interventions for most vulnerable adolescents (from key populations)
   c. Inadequate resource mobilization
   d. Poor coordination in the field
2. The current legal framework does not meet the needs of key populations (stigma and discrimination) and young minors for HIV prevention. It prevents those under the age of 18 from accessing VCT and care services without the consent of their parents.

3. Young people and particularly out-of-school adolescents are completely neglected in planning and delivery of SRH programmes.
4. Information and awareness campaigns are sporadic and programmes do not target the most vulnerable.
5. Service providers and educators lack the capacity to influence social change and behaviors of adolescents and young people.

The priorities defined to address these challenges are the following:

1. Better integrate HIV programmes in the broader context of SRH.
2. Create social and legal environments conducive to the implementation of HIV programmes for adolescents.
3. Improve inclusion and participation of young people as partners in the HIV response.
4. Invest in generating more accurate data.
5. Create specific programs for youth and encourage parental involvement.
6. Support tailored communications with new technologies used by targeted population.
7. Introduce better, comprehensive sexuality education curricula.
8. Advocate for action to address the age of consent to HIV testing, which still serves as a major barrier for adolescents under the age of 18.
9. Create appropriate combination HIV prevention packages and service delivery approaches adapted to adolescents and young key populations.

Progress in implementation of priority actions identified through assessments

The principles of the ALL IN initiative are to foster youth leadership, including adolescents as partners in the HIV AIDS response to reinforcing their access to adapted SRH and HIV services. A 'Test for HIV' campaign, targeting adolescents and young people particularly from key populations, was organized in May and June 2016. Regional mobilization workshops for youth around the testing campaign were also organized and 63,360 young people were tested for HIV. Among them, 20 were found to be HIV positive and linked with care services.

The new NSP 2017-2021 identifies adolescents, particularly the most vulnerable, as priority populations for HIV prevention and sets objectives to strengthen and accelerate their access to SRH and prevention activities. There is strong political will to mobilize and enable this population to become autonomous leaders and actors of social change. While this has not yet translated into concrete progress, young people are being integrated into the decision-making processes.

As part of the new national strategy on immigration and asylum, the Moroccan health system has ensured inclusion of health services for migrants, including minors and adolescents. A joint United Nations programme to support this strategy, including SRH and HIV/AIDS components, was signed with the Government.

Impact of the assessments on the use of strategic information on adolescents

The ALL IN assessment enabled improved access to key strategic information on adolescents. It included the collection and analysis of specific data on adolescents and youth, particularly the estimations of new HIV infections, as well as the analysis of HIV/AIDS reporting cases by age and sex and the use of data on young key populations from the IBBSS studies and 'Stepping- Stones' study. This was complemented by field investigation (interviews and focus groups) and workshops involving various stakeholders and representatives of adolescents and youth. The assessment was complemented with findings from studies on the sexual exploitation of minors and a study on the need for SRH for disabled people.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents.

The internet and social media are widely used, but at the moment no such technological approaches exist in current adolescent HIV programmes. However, in the new NSP the use of technology has been included. The creation of a website specifically for young people, including information on SRH and HIV/AIDS, is underway.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

1. Advocate for access to HTC for unaccompanied youth between the ages 15-18 as part of the Strategy for Human Rights.
2. Expand prevention programmes for adolescent key populations delivered through partnerships with NGOs.
3. Use findings from the assessment to strengthen specific considerations and priorities for youth and adolescents within the national strategy.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. The availability and use of strategic information is very important to emphasize the issues and mobilize stakeholders.
2. The mobilization and participation of youth networks and those from key populations is a key element of success.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. Fast-track prevention programmes for youth and adolescents within the new NSP 2017-2021 and UN Joint Programme of support for the same period.
2. Strengthen comprehensive sexuality education in schools.
3. Advocate for access to context-appropriate combination HIV prevention packages for adolescents and youth from key populations, including access to HTC.
4. Develop innovative approaches to preventing HIV and AIDS among young people, particularly through the use of new technologies.

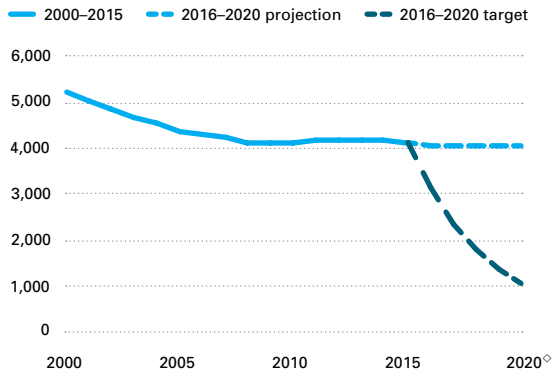
WEST AND CENTRAL AFRICA


Info Sida

COUNTRY I **CAMEROON**

ADOLESCENT HIV TRENDS

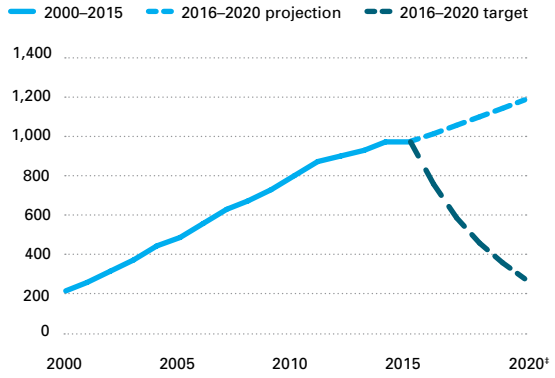
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	23,300,000	11,700,000	11,700,000
	Estimated population of adolescents (aged 10–19), 2015[c]	5,400,000	2,700,000	2,700,000
	% of total population that is adolescents (aged 10–19), 2015[d]	23.2%	23.0%	23.3%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	820,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[fff]	–	27.5 (2014)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.4%	0.4%	0.4%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.7%	0.9%	0.5%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	2.3%	2.9%	1.6%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	29,000	17,000	13,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	4,100	2,900	1,200
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	<1,000	<500	<1,000
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS

ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	26.5 (2004) [ggg]	33.8 (2004) [ggg]	25.7 (2011) [hhh]	29.8 (2011) [hhh]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	5.4 (2004) [ggg]	12.8 (2004) [ggg]	4.0 (2011) [hhh]	9.5 (2011) [hhh]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	47.0 (2004) [ggg]	56.5 (2004) [ggg]	52.0 (2011) [hhh]	69.6 (2011) [hhh]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	3.0 (2004) [ggg]	1.9 (2004) [ggg]	14.5 (2011) [hhh]	6.9 (2011) [hhh]
% of adolescent boys (aged 15–19) who have been circumcised	–	–	–	91.9 (2011) [hhh]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	–	–	22.4 (2011) [hhh]	1.8 (2011) [hhh]
% of youth who have completed secondary school	–	–	12.3 (2011) [hhh]	17.5 (2011) [hhh]
% of young people (aged 20–24) married or in union by age 18	–	–	38.4 (2011) [hhh]	4.5 (2011) [hhh]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

Following the launch of ALL IN in the West and Central African region during the HIV Network meeting and ALL IN regional training, ALL IN was launched in Cameroon in mid-2015, under the leadership of the Directorate of Youth Development (MoY). Four government departments (youth, health, education, family/women/children), civil society – including adolescent and youth movements – and the UN joint team were actively involved.

Under the co-leadership of Ministry of Youth and NAC (MoH), a formal group conducted phase one of the country assessment. This was followed by a national launch with high-level political commitment, as well as media and music celebrities in the framework of 'Holidays without AIDS'.

In-depth analysis, initiated in mid-2016, was undertaken in Douala (economic capital city, coastal), Bamenda (cross-road to Nigeria) and Garoua-Boulai (North region). Reports are currently being compiled.

Adolescent girls and boys were strongly involved in the bottleneck analyses. Part of them were already in partnership with the MoY and this dialogue was strengthened in the framework of ALL IN to influence decisions regarding the recommended actions.

Additional outputs were:

1. At the central level, 15 key adolescent HIV programme managers of ministries were trained to use the Bloomberg BNA Tax and Accounting tool to provide for programming improvement
2. At the regional level, 25 facilitators were prepared to conduct in-depth and BNA exercises in Douala, Bamenda and Garoua Boulai, which led to an assessment of the enabling environment and determinants affecting adolescent and youth interventions. Adolescent participation and Youth Ministry ownership on the process were the strengths of the initiative.

Review of advocacy actions initiating dialogue amongst adolescents

Joint advocacy actions (with UNFPA and UNAIDS) were undertaken, spreading ALL IN messages through a variety of communication strategies and opportunities during:

- International Population Day, celebrated in NGaoundéré (June)
- National Youth Day celebrations (February, with a march by 144 adolescents and young people)
- Holiday without AIDS festival (July) involving Ministers of Health and Youth, the two national champions of ALL IN in Cameroon.

2016 offered also the opportunity to launch U-Report in Cameroon, with surveys on HIV testing and counseling, along with other adolescent and young people concerns such as violence in school and employment.

These surveys generate messages that will be spread through the media (one magazine and two TV channels) to initiate dialogue among adolescents, young people and decision-makers.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

During the phase one validation workshop, stakeholders agreed on three locations for the in-depth analysis:

- Douala (economic capital city, big port, multiple industries, high HIV prevalence in adolescent SW and MSM at 21 per cent)
- Bamenda (transit area, mixed populations, HIV prevalence in adolescents)
- Garoua-Boulai (cross-road region to the East, close to the Central African Republic, with a high number of refugees)

The populations prioritized are:

- Adolescents living with HIV

- Adolescent MSM and SWs
- Adolescents in and out of school

Key bottlenecks from the Douala in-depth analysis:

- On service offer and supply: Few secondary schools offer life skills programmes, HIV prevention, reproductive health and sexuality education, while 60 per cent of youth information centers (CIEE) do not have at least one trained staff member in these areas for adolescents.
- On service quality: A low proportion of adolescents and young people were offered a HIV test in the last 12 months and received their results. Also a low proportion of pregnant adolescent girls who are offered an HIV test and, if positive, have initiated ART in the last 12 months.

Corrective actions that emerged from phase two:

- Expand the model of MCPJ (Multi-functional Centre for Youth Promotion), offering a range of services such as SRH and improving staff competencies and equipment or commodities.
- Work with women's centers on tailored services for girls (promoted by the Ministry of Family and Women).

Progress in implementation of priority actions identified through assessments
Support to HIV/SRH services in priority districts includes:

1. Training of peer educators' supervisors, HIV testing and counseling campaigns
2. Integrated services (HIV, SRH) in University of Yaoundé
3. Leadership and active involvement of regional delegations of Ministries of Youth and Secondary Education, as well as youth associations
4. HPV integration in relation to adolescent girls health (year 2 of HPV Demonstration programme).

Impact of the assessments on the use of strategic information on adolescents
The committee of data custodians, coordinated by the NAC specialist with support from Info-Jeunes (active AYP NGO, Global Fund sub-recipient), MoY and UN, created a strong momentum on adolescent-related data and continues to work using the ALL IN tool to generate advocacy messages and arguments based on the collected and jointly analyzed/validated evidence.

MoY was co-opted as chair of the Adolescent and Young people Technical Group in the SP/CNLS (NAC).

Mapping of AYP vulnerability in the big cities (Douala, Yaounde, Bamenda and Garoua-Boulai) alongside the UNAIDS-supported initiative 'Cities', launched in Cameroon in parallel to ALL IN.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

U-Report Cameroon was initiated at the end of 2015 and identified as an important channel to support ALL IN-related implementation, under the leadership of the Ministry of Youth and the active support of UNICEF-UNAIDS-NAC.

In addition to surveys such as that on HIV testing (joining the global survey on 22 June 2016), a mapping of adolescents and youth-oriented services is being performed in Douala and soon in Garoua-Boulai and Bamenda, in order to be used by the U-Report platform to provide tailored SMS information to U-Reporters on services they need in their geographic location to facilitate adolescent access and increase uptake.

D. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. Participatory aspect of data collection at the 3 in-depth analysis locations, following mobilization and training of key stakeholders including AYP, created a sense of shared ownership at the local level.
2. Cross-sector coordination teams at national and sub-national levels facilitated data collection and access to some difficult to reach data.

3. There is a need to bring together ALL IN and U-Report, and expand access to and uptake of services with other mHealth tools.

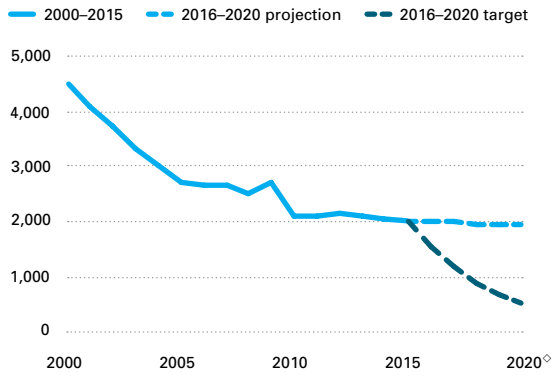
E. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. Phase 3 for adolescent programming and adjustment in early 2017 will generate a plan for advocacy and resource mobilization.
2. Use of opportunities such as the start of USAID/PEPFAR DREAMS programme in Cameroon.
3. Advocacy to use Global Fund non-absorbed funding by removing administrative bottlenecks.

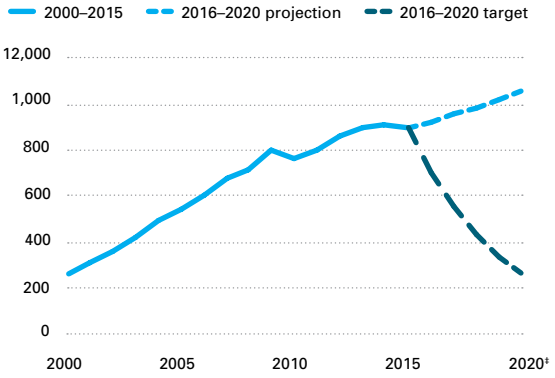
COUNTRY I **CÔTE D'IVOIRE**

ADOLESCENT HIV TRENDS

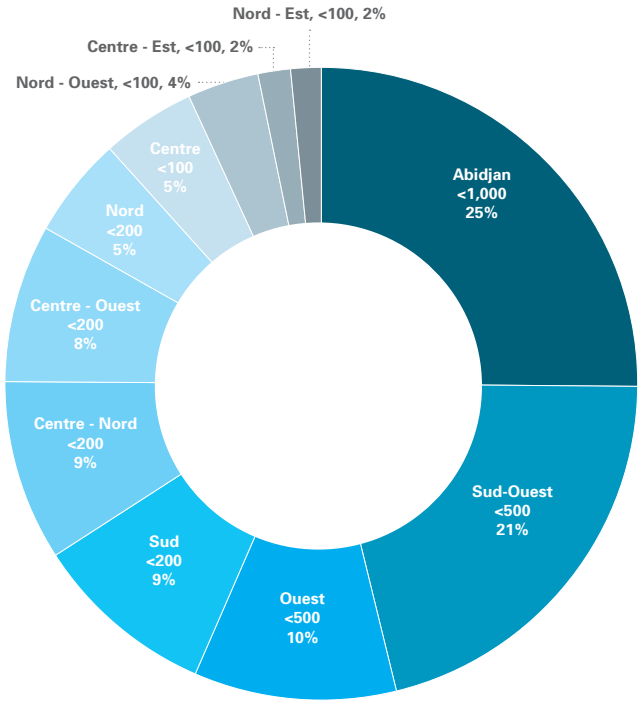
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015e



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015c	22,700,000	11,200,000	11,500,000
	Estimated population of adolescents (aged 10–19), 2015c	5,300,000	2,600,000	2,700,000
	% of total population that is adolescents (aged 10–19), 2015d	23.5%	23.7%	23.3%
	Estimated annual number of live births, 2010–2015 (annual average)c	800,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recentiii	–	31.1 (2012)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015a	0.3%	0.3%	0.3%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015a	0.5%	0.6%	0.4%
	Estimated HIV prevalence among youth (aged 20–24), 2015a	1.4%	1.8%	1.0%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015e	22,000	12,000	9,800
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015e	2,000	1,400	<1,000
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015e	<1,000	<500	<500
Policy	Age of consent for HIV testingf	16	16	16

HIV TREATMENT FOR ADOLESCENTS

ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	18.4 (2005) [iii]	30.0 (2005) [iii]	15.0 (2012) [iii]	20.9 (2012) [iii]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	4.1 (2005) [iii]	13.3 (2005) [iii]	4.3 (2012) [iii]	13.1 (2012) [iii]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	45.3 (2005) [iii]	64.3 (2005) [iii]	31.8 (2012) [iii]	70.1 (2012) [iii]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	2.3 (2005) [iii]	1.8 (2005) [iii]	9.7 (2012) [iii]	5.2 (2012) [iii]
% of adolescent boys (aged 15–19) who have been circumcised	–	–	–	95.7 (2012) [iii]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	–	–	4.7 (2012) [iii]	–
% of youth who have completed secondary school	–	–	11.4 (2012) [iii]	16.5 (2012) [iii]
% of young people (aged 20–24) married or in union by age 18	–	–	33.2 (2012) [iii]	4.0 (2012) [iii]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

ALL IN was launched in October 2015, led by Government (Ministries of Health, Youth, Education, Gender and Social Affairs) with active involvement of civil society, including adolescent and youth movements, and support from UN agencies. With co-leadership between the Ministry of Youth and National School Health Programme (MoH), a country assessment was conducted under the guidance of a multi-stakeholder task force. An in-depth analysis was conducted in San Pedro (industrial and maritime city) and Abidjan (capital city). A third location in the western region of Man was also recently covered.

The exercise in the three different regions provided an opportunity for local authorities and adolescents to discuss, interact and reach a common understanding around key concerns about adolescents' vulnerability.

The bottleneck analyses involved adolescent girls and boys from various networks (ALHIV, Scouts, faith-based groups and young key populations) and their views influenced decisions and orientations during validation meetings.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

Advocacy is underway with the Ministry of Youth to launch U-Report, creating a channel of communication between AYP and the government and enabling adolescents to influence decisions and policies.

Cote d'Ivoire was part of a regional study on legal barriers for adolescent key populations' access and uptake of services (UNFPA-UNICEF-UNESCO-UNAIDS).

The ALL IN initiative in Cote d'Ivoire offered an opportunity to accelerate the validation of the national strategy for adolescents and young people's health 2016-2020. This year, based on the ALL IN analysis, all stakeholders including key populations and adolescent representatives participated in revising communication tools for adolescents and young people.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

Three regions emerged from the rapid assessment as priority for in-depth assessment: Abidjan (capital city, near 20 per cent of the adolescent population), San Pedro (industrial port, transit area, mixed populations, HIV prevalence eight times higher in adolescent girls than the national average) and Man (cross-road region in the west, high levels of migration, close to Liberia/Sierra Leone/Guinea, weak services).

The prioritized populations are:

- Adolescent victims of sexual abuse and exploitation: Multiple partners, non-systematic use of condoms, use of drug and alcohol increasing risky behaviour.
- Adolescents living with HIV: Ignorant of means of prevention and their leading role in the spread of HIV, facing discrimination and stigmatization in different settings including health services and the religious community.
- Adolescent drug users: Insufficient knowledge of the transmission of HIV and STIs, low condom use, exposure to tuberculosis.
- Adolescent girls: Exposure to sexual abuse and exploitation, unsafe abortion, low exposure to prevention programmes, exposure to violence.
- Out-of-school adolescents: Low exposure to prevention programmes, multiple partners, low influence of parents on sexual life, drug use, use of soiled objects (tattoos, piercings), limited access to health information and services.

Key priorities are as follows:

1. Sexual education of adolescents
   - Promote sexual education in family and schools
   - Retain adolescents, especially girls, in schools
   - Promote adolescent responsive sexual health and family planning services
   - Expand sexual and reproductive health education and training programs for both students and their teachers
   - Adopt innovative behaviour-change strategies for adolescents (NICT)
2. Protection
   - Strengthen the fight against all forms of violence in the immediate environment of adolescents, particularly GBV, with emphasis on early marriage and sexual exploitation of minors
   - Promote and strengthen ongoing measures for the protection of children and adolescents
3. Services for adolescents
   - Establish adolescent-responsive spaces that provide holistic services for adolescent health, education and development in a healthy environment
4. Legislative framework
   - Review legislation to allow HIV testing prior to the age 16 without parental consent
   - Prepare the implementing texts of the HIV and AIDS law to combat discrimination
5. Planning, monitoring, evaluation and coordination capacity
   - Strengthen national coordination of interventions for adolescents through the implementation of a national adolescent and youth programme
   - Strengthen the monitoring and evaluation system by adapting it to national and sectoral interventions in favor of adolescents
   - Promote the participation of adolescents in the development, implementation, monitoring and evaluation of programmes targeting them
   - Increase national resources to fight AIDS to end this pandemic by 2030
6. Strengthen, collect and use disaggregated information for adolescent and young people interventions
7. Promote adolescent participation

Progress in implementation of priority actions identified through assessments

1. Preparation and launch of U-Report is underway to address information gaps and links with HIV/SRH services.
2. Piloting integration of HPV vaccination within the school health platform, as part of enhanced programming for broader adolescent health for girls.
3. Validation of the National Adolescent Health strategy is being informed based on the ALL IN analysis.
4. UNFPA and UNICEF are jointly supporting the reorganization of school health services and training of adolescents' health workers to better address adolescent needs.

Impact of the assessments on the use of strategic information on adolescents

A multi-sectoral group involving several ministries, AYP associations/networks and the UN became a 'reference group' on collecting and analyzing data and evidence. In this way, ALL IN has helped introduce a new, stronger approach to strategic planning for adolescents. PNSSU (the national school health programme of the MoH) is taking the lead to 'institutionalize' this approach.

Additionally, following this process of joint analysis, a new collaboration channel has been established between MoH

and MoY as co-leaders of ALL IN. Mutual agreement has been established to improve practices in data reporting and use. As a result, age-disaggregated adolescent data (10-14, 15-19) is now a feature within the national health information system.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

- U-Report will be launched by the Ministry of Youth in the first quarter of 2017.
- Mapping of services is being done in San Pedro, Man and Abidjan to facilitate adolescent access to and increase uptake of services.
- A multi-service platform designed for adolescents and youth in Bouna, a disadvantaged city in the extreme north. UNICEF helped to develop the concept of a multi-services center (sports space, HIV counseling and testing, cyber-center, coffee kiosk). All these activities are managed by adolescents and youth associations or networks based in the city, with collaboration and supervision from the Ministry of Youth, the Mayor and Ministry of Health.
- A national competition between schools on HIV, AIDS and reproductive health innovation and communication was supported by UNICEF in collaboration with the Ministry of Education.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

The Cote d'Ivoire ALL IN strategic group helped develop an advocacy paper for the First Lady of Cote d'Ivoire, who took part in the 7th Africa conference on sexual health and rights, Accra, February 2016.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. Since the political and media launch of ALL IN, adolescent issues have been given more attention in many government ministries and programmes.
2. In-depth analysis in targeted regions helped the key stakeholders, including AYP, to define different strategies relevant to each region. The use of region-specific or local data helps to better indicate local adolescent needs, programme challenges and opportunities.

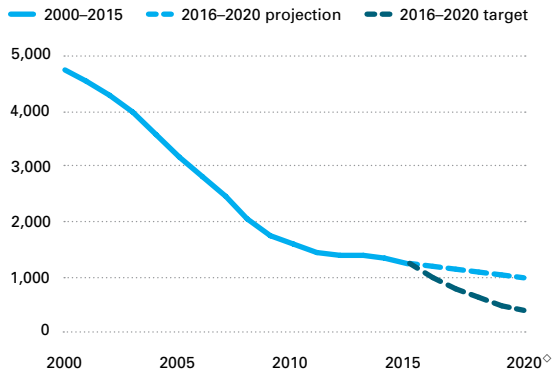
F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. Finalize ALL IN country assessment and planning during the first quarter of 2017.
2. In targeted regions, develop a strong platform for adolescent-responsive health services, with a coordination mechanism for adolescents to oversee the implementation of targeted, context-appropriate packages of combination HIV prevention interventions aimed at adolescents at high risk of infection, as well as the implementation of actions to address bottlenecks identified in assessment.
3. Strengthen comprehensive sexual education in and out of schools

COUNTRY I **DEMOCRATIC REPUBLIC OF THE CONGO**

ADOLESCENT HIV TRENDS

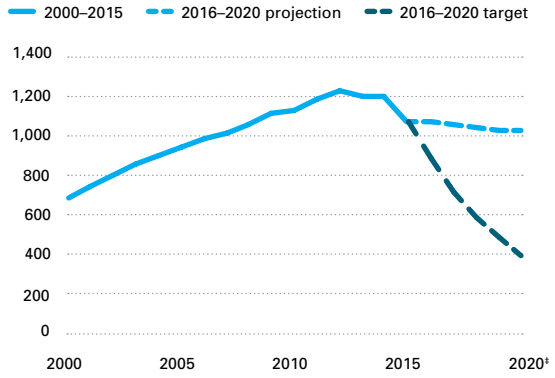
New HIV infections among adolescents (aged 15–19), 2000–2020◇a∞



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

Subnational data not available

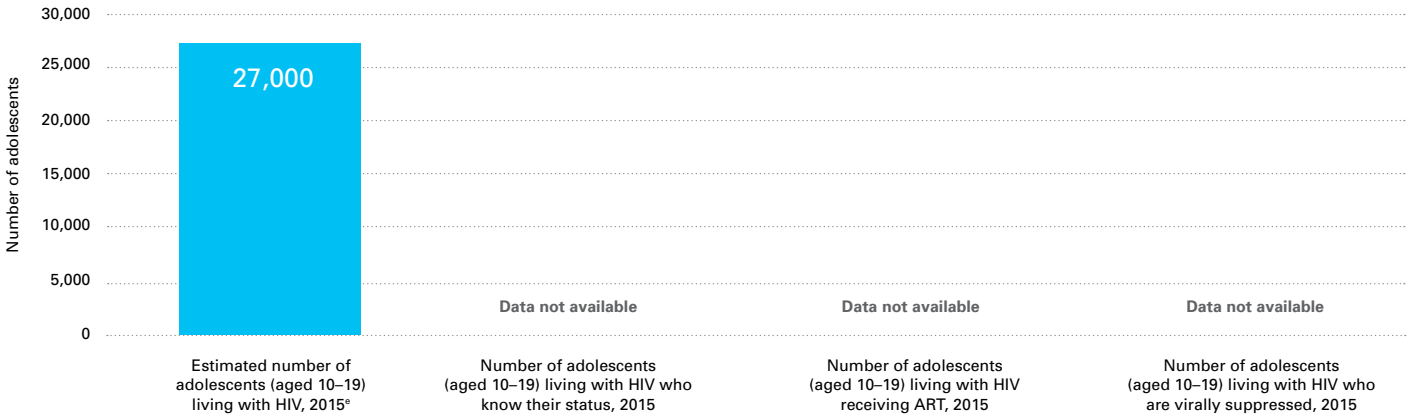
AIDS-related deaths among adolescents (aged 10–19), 2000–2020‡b∞



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	77,300,000	38,700,000	38,500,000
	Estimated population of adolescents (aged 10–19), 2015[c]	18,100,000	9,000,000	9,100,000
	% of total population that is adolescents (aged 10–19), 2015[d]	23.5%	23.3%	23.6%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	3,000,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[kkk]	–	26.7 (2014)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015[a]	0.1%	0.1%	0.1%
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015[a]	0.2%	0.2%	0.1%
	Estimated HIV prevalence among youth (aged 20–24), 2015[a]	0.3%	0.4%	0.2%
	Estimated number of adolescents (aged 10–19) living with HIV, 2015[e]	27,000	14,000	13,000
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015[e]	1,200	<1,000	<500
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015[e]	1,100	<1,000	<1,000
Policy	Age of consent for HIV testing	–	–	–

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	13.7 (2007) [lll]	18.3 (2007) [lll]	17.1 (2014) [kkk]	20.3 (2014) [kkk]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	3.0 (2007) [lll]	9.8 (2007) [lll]	3.0 (2014) [kkk]	8.7 (2014) [kkk]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	7.1 (2007) [lll]	27.7 (2007) [lll]	12.1 (2014) [kkk]	17.3 (2014) [kkk]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	2.3 (2007) [lll]	1.4 (2007) [lll]	4.5 (2014) [kkk]	1.4 (2014) [kkk]
% of adolescent boys (aged 15–19) who have been circumcised	–	96.6 (2007) [lll]	–	–
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	20.8 (2007) [lll]	–	–	–
% of youth who have completed secondary school	–	–	21.2 (2014) [kkk]	29.6 (2014) [kkk]
% of young people (aged 20–24) married or in union by age 18	–	–	37.3 (2014) [kkk]	5.7 (2014) [kkk]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

ALL IN was launched in September 2015, led by Government (PNMLS/NAC, Ministries of Health, Youth, Education, Gender and Social Affairs), with active involvement of civil society including adolescent and youth movements, and support from UN agencies.

With the leadership of PNMLS, support of the UN joint team, and technical and financial support from UNICEF, a country assessment was conducted under the guidance of a multi-stakeholder task force. Following a rapid assessment and validation of the data collection, the in-depth analysis phase is being currently conducted in Kinshasa and 8 selected provinces by consensus.

First data trends were taken into account in the first year of operationalizing the National Adolescent Health Strategy, developed in 2015 by government and partners, with UNICEF support.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

Advocacy is underway by MP, in coordination with the Ministry of Health, to review and adjust the law on adolescent HIV testing, which was identified as one of the bottlenecks.

The ALL IN initiative in DRC has offered an opportunity to accelerate the validation of the national strategy for adolescent and young people's health 2016-2020. This year, based on the ALL IN analysis, all stakeholders including key populations and adolescent representatives participated in revising communication tools for adolescents and young people.

A political momentum helped to attract decision makers' attention on adolescent needs during the national ALL IN launch in July, organized by PNMLS and chaired by the Minister of Health, with UNICEF representation and UNAIDS' country director's active involvement.

Other sexual and reproductive health interventions are being supported by UNFPA and UNESCO to address harmful practices and social norms relating to gender.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

- In DRC, adolescent girls and boys aged 10-19 represent 23 per cent of the national population (16.3 million).
- 36,660 adolescents live with HIV and prevalence is 3.5 times higher in girls aged 15-19 than in boys of the same age (0.7 per cent compared to 0.2 per cent).
- HIV prevalence among adolescent girls who sell sex (5 per cent) is 7 times higher than in adolescent girls in the general population, and prevalence is even higher in young MSM (6 per cent).
- Comprehensive knowledge of HIV is very low (18 per cent in girls and 20 per cent in boys aged 15-19).
- HIV testing is also substantially insufficient (7 per cent in girls and only 2 per cent in boys aged 15-19), while use of condoms among adolescents is as low as 11 per cent in girls and 12 per cent in boys aged 15-19.
- Adolescent pregnancy is at 27 per cent, and malnutrition in adolescents is at 21 per cent.
- Child marriage is at 37 per cent, while 16 per cent of adolescent girls are victims of sexual violence.
- School attendance for adolescents aged 12-18 is 37 per cent in girls and 49 per cent in boys.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents.

U-Report has been promoted, with the active involvement of the Scouts movement. In addition, media partners have been involved in the design and implementation of the National Strategy for Adolescent and Young People's Health, including through weekly radio programmes.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities and action taken on these priorities in 2015 and 2016

Advocate with government institutions and partners to mobilize additional resources.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. Since the political and media launch of ALL IN in July 2016, adolescent issues have been given more attention in many government ministries and programmes. World AIDS Day 2016 is celebrated under the theme of adolescents and youth.
2. Importance of key stakeholders' mobilization for ALL IN activities and involvement in the process stages, including young people and adolescent representatives.

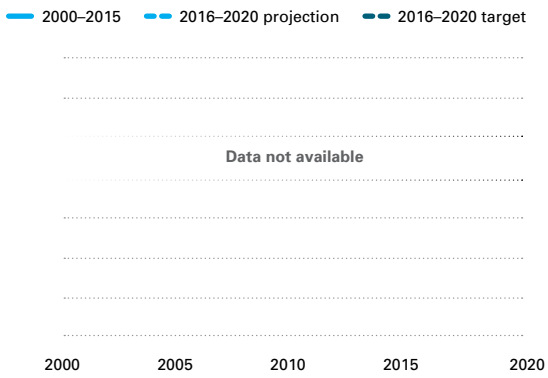
F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. Finalize ALL IN country assessment and planning during the first quarter of 2017.
2. In targeted regions, develop a strong platform for adolescent-friendly health services, with a coordination mechanism for adolescents to oversee the implementation of targeted, context-appropriate packages of combination HIV prevention interventions for adolescents at high risk of infection, as well as implementation of actions to address bottlenecks identified in assessment.

COUNTRY I **NIGERIA**

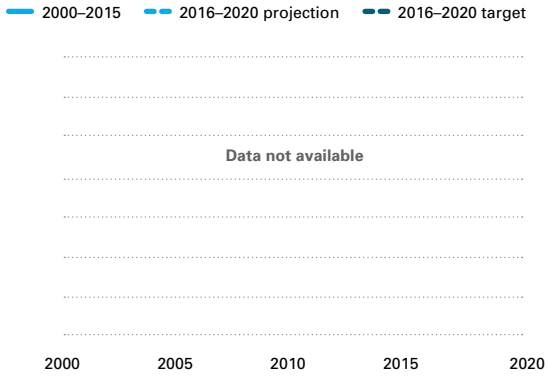
ADOLESCENT HIV TRENDS

New HIV infections among adolescents (aged 15–19), 2000–2020



Subnational distribution of new HIV infections among adolescents (aged 15–19), 2015

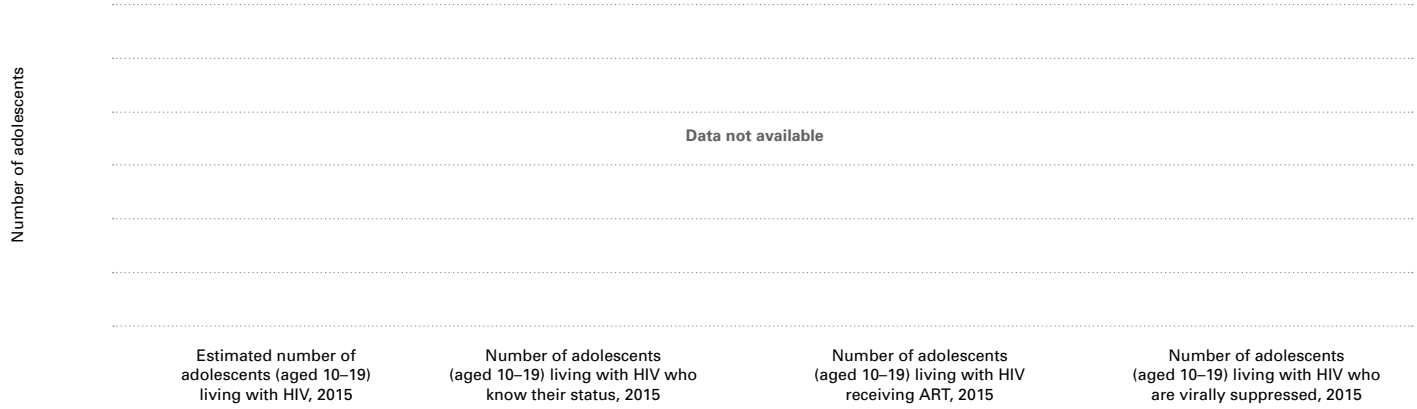
AIDS-related deaths among adolescents (aged 10–19), 2000–2020



BACKGROUND CHARACTERISTICS

	Indicator	Total	Female	Male
Demography	Estimated total population (all ages), 2015[c]	182,200,000	89,400,000	92,800,000
	Estimated population of adolescents (aged 10–19), 2015[c]	41,400,000	20,200,000	21,200,000
	% of total population that is adolescents (aged 10–19), 2015[d]	22.7%	22.5%	22.9%
	Estimated annual number of live births, 2010–2015 (annual average)[c]	6,900,000	–	–
	Percentage of young women (aged 20–24) who gave birth before age 18, most recent[mmm]	–	29.1 (2013)	–
Epidemiology	Estimated HIV prevalence among younger adolescents (aged 10–14), 2015	–	–	–
	Estimated HIV prevalence among older adolescents (aged 15–19), 2015	–	–	–
	Estimated HIV prevalence among youth (aged 20–24), 2015	–	–	–
	Estimated number of adolescents (aged 10–19) living with HIV, 2015	–	–	–
	Estimated number of new HIV infections among adolescents (aged 15–19), 2015	–	–	–
	Estimated number of AIDS–related deaths among adolescents (aged 10–19), 2015	–	–	–
Policy	Age of consent for HIV testing[f]	None	None	None

HIV TREATMENT FOR ADOLESCENTS



ADOLESCENT KNOWLEDGE, TESTING AND BEHAVIOUR RELATED TO HIV

	Baseline		Current	
Indicator	**Girls**	**Boys**	**Girls**	**Boys**
% of adolescents (aged 15–19) with comprehensive, correct knowledge of HIV	19.7 (2008) [xx]	28.2 (2008) [xx]	22.4 (2013) [ww]	29.3 (2013) [ww]
% of adolescents (aged 15–19) reporting multiple sexual partners in the last 12 months	1.0 (2008) [xx]	2.4 (2008) [xx]	0.7 (2013) [ww]	1.1 (2013) [ww]
% of adolescents (aged 15–19) reporting multiple sexual partners who reported condom use at last sex	24.8 (2008) [xx]	61.3 (2008) [xx]	38.1 (2013) [ww]	46.1 (2013) [ww]
% of adolescents (aged 15–19) who were tested for HIV in the last 12 months received the results of the last test	2.2 (2008) [xx]	2.2 (2008) [xx]	4.2 (2013) [ww]	2.3 (2013) [ww]
% of adolescent boys (aged 15–19) who have been circumcised	–	97.5 (2008) [xx]	–	98.5 (2013) [ww]
% of adolescent girls (aged 15–19) who have ever experienced sexual violence	6.6 (2008) [xx]	–	5.6 (2013) [ww]	–
% of youth who have completed secondary school	–	–	42.1 (2013) [ww]	56.6 (2013) [ww]
% of young people (aged 20–24) married or in union by age 18	–	–	42.8 (2013) [ww]	2.4 (2013) [ww]

ADOLESCENT KEY POPULATIONS

Population	Indicator	2010	2011	2012	2013	2014	2015
Adolescent girls (aged 10–19) sexually exploited	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who have sex with men	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Reached by prevention programmes	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
Adolescent boys (aged 10–19) who inject drugs	HIV prevalence (%)	–	–	–	–	–	–
	Tested for HIV	–	–	–	–	–	–
	Used a condom at last sex	–	–	–	–	–	–
	Used sterile injecting equipment at last use	–	–	–	–	–	–

A. SOCIAL CHANGE AND ADOLESCENT ENGAGEMENT

Actions taken to strengthen the meaningful participation of adolescents in decision making

A major action that Nigeria has taken to strengthen the meaningful participation of adolescents and young people (AYP) in decision-making is the establishment of an AYP's subcommittee of the National Prevention Technical Working Group (a high-level group of national stakeholders that provides strategic, technical leadership and serves as the lead advisory body to the national HIV response). The establishment of the AYP sub-group has ensured participation of AYP and AYP-serving organizations at this strategic level. This group was very instrumental in the build up towards strengthening the National Adolescent HIV response. Working with the group, UNICEF supported a study – 'An analysis of HIV epidemiology and Response amongst adolescents and young people in Nigeria 2012/2013'. The study attempted to define the most vulnerable adolescents in Nigeria and recommended high impact interventions for AYP. This provided the required impetus for the development and launch of the first ever National HIV Strategy for AYP in March 2016. While this was going on, UNICEF also supported the implementation of an 18-month pilot in two states (Benue and Kaduna) of comprehensive HIV service delivery for AYP. In addition to working with communities, government and non-governmental mechanisms, AYP (especially ALHIV) participated meaningfully in all stages of the pilot. They contributed to the communication strategy and mapping of HCT campaign sites, and participated as youth advocates, mystery clients and referral guides. The pilot provided a ready platform for a sub-national launch of the ALL IN campaign and the ALL IN assessment in the two pilot states in 2016. The already mobilized AYP groups in the two pilot states were further empowered through the ALL IN assessments. They participated actively in all the phases of the assessment, including contributions to the enabling environment matrix. They understand, own and are utilizing the data that emanated from the analysis for advocacy with policy makers. This process has gone a long way in strengthening AYP in programming and their meaningful participation. In Kaduna state, the leader of the association for AYP living with HIV shared the fact that they now have ready access with policy makers and urged other state groups to learn from them.

Review of policies and laws related to access to services, stigma, discrimination and harmful gender norms

Through support from Population Council, UNICEF and other stakeholders, a guidance document was released by the FMOH to address the policy gap around the age of legal consent for SRH service delivery for adolescents. This is a major milestone and paves the way for further progress that will lead to a law that reduces the age of legal consent for the uptake of SRH services by adolescents.

B. PROGRAMME SCALE UP AND ACCELERATION

Application of the findings of the country assessments to influence HIV response for adolescents, partnerships and resource mobilization

Key findings from assessments

The ALL IN assessment in Nigeria was conducted at the sub-national level in two states (Kaduna and Benue state). Overall, the findings are similar across the two states but do include some specific peculiarities – thus the findings are presented by state. There were a lot of data gaps, especially in the area of service provision coverage. Data is not always disaggregated by 5 years, presenting a challenge in data analysis.

Kaduna State:

Epidemiology

- Adolescent boys and girls aged 10-14 are equally affected by HIV, with prevalence of 2 per cent in girls and 1.7 per cent in boys.
- HIV prevalence among girls and young women is 2 per cent and 3 per cent in 15-19 and 20-24 year age groups respectively, and 1.7 per cent and 1.3 per cent among their male counterparts in the same two age groups. There is substantial variation in prevalence between the state's 23 Local Government Areas (LGAs). Two LGAs, Igabi and Lere, have the highest HIV prevalence among adolescents.

- Out of the 18,800 adolescents living with HIV in Kaduna, 8,800 (47 per cent) are boys and 10,000 are girls.
- Adolescents aged 10-14 constitute 46 per cent of all ALHIV in the state.
- Data on adolescent KPs is very limited, although some state-level population size estimates are available.

Programme coverage

- Reported condom use is higher among adolescents who sell sex (55 per cent) and adolescents who use drugs (65 per cent) than in the general population (40 per cent among boys and 17 per cent among girls). It is lowest among adolescent MSM (30 per cent).
- As with condoms, reported HIV testing is higher among adolescent key populations than it is in adolescents in the general population.
- ART data is not currently reported on for adolescents.
- Child marriage is high (43 per cent). Consequently, Kaduna state has high teenage pregnancy rates (32 per cent) and high STI prevalence in adolescent girls (23 per cent).

Benue State:

Epidemiology

- Adolescent boys and girls aged 10-14 are equally affected by HIV, with prevalence of 3.9 per cent in girls and 3.5 per cent in boys.
- HIV prevalence among girls and young women is 4.2 per cent and 7 per cent in 15-19 and 20-24 year age groups respectively, and 2.1 per cent and 3.7 per cent among their male counterparts in the same two age groups.
- Five LGAs account for 53 per cent of HIV infections in adolescents (Makurdi, Guma, Gboko, Katsina-Ala and Ukum). Makurdi LGA, the state capital, has the highest HIV prevalence.
- Out of the 14,200 adolescents living with HIV in Benue State, 8,500 are girls (60 per cent) while 5,700 are boys.
- New HIV infections in adolescents have more than doubled in Benue since 2000. Current estimates indicate that AIDS-related deaths in adolescents in Benue State have increased by about 700 per cent since 2000. These findings point to significant gaps in programme response.

Programme coverage

- Data on adolescent key populations is very limited in Benue State.
- Condom use is low, particularly among girls. Only 27 per cent of sexually active adolescent girls aged 15-19 report using a condom at last sexual encounter, compared with 61 per cent of boys.
- ART data is not currently reported on for adolescents.
- Gender inequalities and GBV have a significant effect on adolescent girls in Benue:
- 43 per cent of girls are married before the age of 18
- Teenage pregnancy is high at 18 per cent
- Female genital mutilation is also high and 20 per cent of adolescent girls report having experienced sexual violence

Poor demand creation targeting adolescents, weak quality assurance, inadequate support supervision and poor dissemination and use of service guidelines are among the bottlenecks found to affect results in adolescents.

Priority actions defined to address these bottlenecks, improve programme delivery and accelerate progress in HIV prevention, treatment and care in adolescents include:

1. Prioritize targeted scale-up to improve service access for vulnerable adolescent groups
2. Involve adolescents in decision-making, policy formulation and implementation

3. Engagement communities to improve literacy and support for adolescent HIV response
4. Expand innovative communication approaches to reach and engage with AYPs
5. Strengthen capacity for delivery of adolescent and youth-friendly services
6. Improve data collection, reporting and use on adolescents in general and on adolescent key populations
7. Mobilize and ensure sustainable financing for AYP programming

Progress in implementation of priority actions identified through assessments

The assessment generated a huge momentum, knowledge, skills and focus for AYP programming, especially in the two states and in Nigeria generally.

The engagement of key members of two national technical working groups (the Prevention and M/E) and senior-level technical staff of the National Agency for the Control of AIDS (NACA) has served as a capacity-building opportunity and ensured an understanding of the assessment process. This has led to widespread acknowledgement and acceptance of ALL IN assessment tools for data-driven adolescent programming at the national level. NACA leads presented the ALL IN assessment process at a major technical working group meeting. This served as high-level strategic advocacy for the scale-up and leveraging of resources from key stakeholders in the national response. NACA has proposed the replication of the process with its own funding in a few other priority states.

At state level, the State Agencies for the Control of AIDS (SACA) were also fully involved in this process and have taken ownership of the work plans. These are LGA level work plans, involving key staff of local governments in their development. They have full understanding of the process and have built their capacity for adolescent HIV programming. The plans are being utilized for advocacy and mobilization of resources at all levels.

In Kaduna, the data and plans were presented by young people at the national executive council meeting. The data highlighted LGA specificity and generated a lot of response. The state governor directed that the ALL IN plans be integrated into the state priority plan for next year.

In Benue state, the First Lady of the state has tremendous influence on and interest in issues of AYP. She was engaged in the assessment and, after results were presented to her, agreed to become an adolescent HIV champion for the state. To further build her capacity and expand her networks and vision, she participated in the Durban IAS conference in July 2016. There, she presented the results of the Benue ALL IN assessment and shared experiences of supporting the process from a policy maker point of view. UNICEF is working with her and Benue SACA to convene a meeting of sectoral technical and policy leaders at state and LGA level to take ownership of the plans and commit resources for the key priorities identified.

In Kaduna, one of the priority actions is strengthening youth-friendly service provision in facilities. This has been initiated via a TOT at state level, which shall be replicated at LG level to ensure that all high-volume facilities have staff trained to provide youth-friendly services.

Across states, the assessment has had a huge impact on youth groups, especially the children and youth parliament and the association of AYP living with HIV. The assessment process built their capacities on data collection and analysis, with the data and plans providing tangible actions that they own. Thus, they are able to utilize this information to boost sensitization and advocacy with policy makers, religious and traditional leaders. Their participation 'quotient' has increased dramatically and empowered them to demand attention at all levels. Associations of adolescents living with HIV are well organised, generating interest and mobilizing increased membership. Parents of ALHIV are also better engaged and involved in the process.

In view of the increased demand for participation that the ALL IN initiative has created, UNICEF supported a camp for ALHIV from 6 states. The camp was an opportunity to build their capacities for advocacy, meaningful participation, share experiences and to collect data on important themes (such as adherence, disclosure, transition, mental health and sexuality).

At the national HIV prevention conference, an ALL IN presentation was made to young people from various states.

The participants from states where the ALL IN assessment was been conducted were clearly better empowered and able to share experiences on data collection and advocacy.

All of these successes and are being harnessed for improved visibility and programming for adolescents.

Impact of the assessments on the use of strategic information on adolescents
The assessment produced credible local level data. The fact that key stakeholders at sub-national levels were involved in the generation of the data has made it a very powerful tool. This data is being quoted and utilized in key planning processes at all level – by government, UN, NGOs, bilateral and multilaterals.

The findings create demand for more specific adolescent data in key national processes and documents. They have informed the finalisation of the new WHO guidelines and new NSP.

C. INNOVATION

The use of online and mobile technology, social incentives and new programming tools to improve engagement, access, utilization and quality of HIV interventions for adolescents

The assessment has created a niche for adolescent participation. There is an overwhelming consensus that social media is a veritable tool for adolescents and young people – whether for information, advocacy, demand creation, service provision or retention. UNICEF is supporting an initiative to improve the quality and scope of the national call center, with the goal of making it more AYP friendly. An assessment of the center was conducted and a blueprint for the upgrade developed. The blueprint proposes a wide range of platforms, applications and solutions to improve reach, engagement, retention, monitoring and documentation. The center shall serve as a hub for the collation of all call center activities in the country, built with the vision of being a multi-sectoral one stop platform for information and services for adolescents and young people. U-Report and other existing platforms are being linked and aligned to the design of the call center for synergy and effectiveness.

Adolescents and young people also developed various ideas for innovation in the HIV programming space, including a social media blog by an ALHIV to share the daily life and struggles of ALHIV. Social media blogging by celebrities is a very popular with AYP in Nigeria. This presents an opportunity for more acceptance, community support and stigma reduction.

U-Report polls and dialogue have been used to mobilize awareness on ALL IN and adolescents. Results from the polls are analyzed to show AYP participation and views. A very successful Twitter campaign and chat, powered by UNICEF and other UN agencies and youth groups, was organized to increase young people's participation during a visit by the UN Envoy on Youth in August 2016.

D. ADVOCACY AND COMMUNICATION

Advocacy priorities in 2016 included

1. Advocacy on strategic positioning and scale-up of the ALL IN assessment with key members of the National Prevention & M/E Technical Working Groups.
2. Resource mobilization at state and LG level for the implementation of work plans.
3. Advocacy with the UN joint team sub-group for adolescents and young people. This forum has provided an opportunity to provide updates on the assessment level and also leverage partnership opportunities.
4. Support for the upgrade of the national call center, requiring intensive mobilization and awareness-building to position it as an opportunity for scaled-up service delivery. UNICEF ensured that visits by the UN Envoy on Youth in August 2016 and the UNICEF Chief of ICT in November were utilized to achieve this. They visited the call center and pledged support whereever possible.
5. During the visit of the UNSG Youth Envoy, a U-Report poll was conducted to gather the views of young people on

what they envisage as top agendas for young people in Nigeria. HIV came out at number three. The results of the poll were utilized by the UN Envoy on Youth during his advocacy visit with the Vice President.

E. OVERALL LESSONS LEARNED ACROSS THE FOUR ALL IN PILLARS OF WORK AT COUNTRY LEVEL

1. Young people's participation yields great results and generates huge support. However, it is expensive, and requires close supervision and technical support to ensure it yields the desired outputs.
2. Community engagement is important to create an enabling environment and sustain AYP participation.
3. Intensive mobilization of human resources for analysis and documentation is key.
4. State and LG data are very powerful tools in gaining the attention of all stakeholders. It drives the realities closer to home and mobilizes commitment.
5. In spite of commitment by policy makers, it is difficult to get actual resources released for AYP programming due to higher priorities within government.
6. It takes time to get the Government to institutionalize new ways of thinking and budget lines, therefore partner programmes must be patient to allow for the time it needs to take the lead for sustainability.
7. In view of emerging priorities, partners will need to continue to engage with government intensively in order to ensure that the momentum around adolescent programming is not lost.

F. PRIORITIES, KEY MILESTONES AND STRATEGIC OPPORTUNITIES IN 2017

1. Implementation of ALL IN work plans in 8 LGAS.
2. Intensive advocacy for sustainability.
3. Intensive innovative documentation linked to communication for development.
4. A learning collaboration between key stakeholders using the outputs of implementation at state and LGA levels.
5. Implementation of the NACA call center blueprint to scale up and provide linkages for real-time monitoring of services.
6. Demonstration of sustainable adolescent participation models.
7. Intensify cross-sectoral collaboration, particularly around child protection (building on the growing response to findings from a study on violence against children), child marriage and the social media campaign around the Three Frees.
8. Analysis and development of an investment case to support strategic positioning of the HIV response for adolescents.

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◇ 2016-2020 new HIV infections were projected by calculating the HIV incidence rate (infections per uninfected adolescent) and determining the annual rate of reduction (ARR) of the incidence rate between 2010 and 2015 and applying that to the projected population of HIV-uninfected adolescents for 2016-2020.

‡ 2016-2020 AIDS-related deaths were projected by calculating annual rate of reduction (ARR) of the estimated number of AIDS-related deaths between 2010 and 2015 and applying the calculated ARR to project AIDS-related deaths for 2016-2020.

λ Trend data and projections for estimates with values below 50 are not displayed.

∞ There are uncertainty ranges around these point estimates. These uncertainty ranges are available at http://www.aidsinfo.org.