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#EndAdolescentAIDS

SYNTHESIS REPORT OF THE RAPID ASSESSMENT OF ADOLESCENT AND HIV PROGRAMME CONTEXT IN FIVE COUNTRIES:

Botswana, Cameroon, Jamaica, Swaziland and Zimbabwe

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AUDIENCE AND HOW TO USE THIS DOCUMENT

This report is intended to support government technical specialists, development partners, civil society organizations and adolescent and youth groups considering or planning an ALL IN country rapid assessment on adolescents and HIV. The report aims to help this audience:

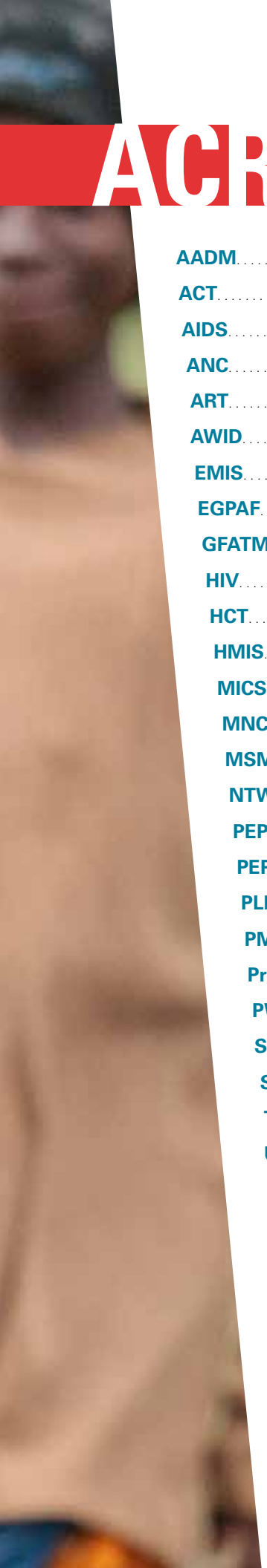
1. Understand the data-driven planning process that was used in Botswana, Cameroon, Jamaica, Swaziland and Zimbabwe to help prioritize adolescent populations, programme interventions and priority geographic areas to accelerate HIV results in adolescents.

2. Identify and discuss key programmatic and other contextual and cross-sectoral challenges and coverage gaps in the delivery of results for adolescents in HIV and related sectors.

3. Understand the cross-sectoral opportunities and linkages to health, education, protection and other relevant areas identified in the five countries as strategic platforms for leveraging improved HIV results in adolescents.

The main body of the report is divided into five main parts: Introduction and Background to the ALL IN agenda, adolescent HIV epidemic and country rapid assessments; Methods describing the process of the synthesis and the rapid assessments; Findings and discussion of main findings of the rapid assessment; Cross-cutting programmatic recommendations drawn from the country rapid assessment results and processes; and Conclusions describing the relevance of this exercise to efforts to end the global HIV epidemic.

Throughout the document there are “Spotlight On” sections that highlight different elements of country assessments. While these aspects may have been done well in all countries, the country in the Spotlight was unique for it in some way.



ACRONYMS

AADM ..... Adolescent Assessment and Decision-Makers' Tool

ACT ..... Accelerating Children's HIV/AIDS Treatment (initiative)

AIDS ..... Acquired Immune Deficiency Syndrome

ANC ..... Antenatal Caret

ART ..... Antiretroviral Therapy

AWID ..... Adolescents who inject drugs

EMIS ..... Education Management Information System

EGPAF ..... Elizabeth Glaser Pediatric AIDS Foundation

GFATM ..... The Global Fund to Fight AIDS, Tuberculosis and Malaria

HIV ..... Human Immunodeficiency Virus

HCT ..... HIV Counselling and Testing

HMIS ..... Health Management Information System

MICS ..... Multiple Indicator Cluster Survey

MNCH ..... Maternal, Newborn and Child Health

MSM ..... Men who have sex with men

NTWG ..... National technical working group

PEP ..... Post-exposure Prophylaxis

PEPFAR ..... The U.S. President's Emergency Plan for AIDS Relief

PLHIV ..... People living with HIV

PMTCT ..... Prevention of Mother-to-child Transmission (of HIV)

PrEP ..... Pre-exposure prophylaxis

PWID ..... People who inject drugs

SRH ..... Sexual and Reproductive Health

STI ..... Sexually Transmitted Infection

TB ..... Tuberculosis

UNAIDS ..... Joint United Nations Programme on HIV and AIDS

UNDP ..... United Nations Development Programme

UNESCO ..... United Nations Educational, Scientific and Cultural Organization

UNFPA ..... United Nations Population Fund

UNICEF ..... United Nations Children's Fund

UNJT ..... United Nations Joint Team on HIV and AIDS

UN Women ..... United Nations Entity for Gender Equality and the Empowerment of Women

VL ..... Viral Load

WHO ..... World Health Organization

VMMC ..... Voluntary Medical Male Circumcision

1. INTRODUCTION AND BACKGROUND

The world has made unprecedented gains in tackling the global HIV epidemic in the last decade.[1] Yet because efforts and progress have not been consistent across all populations, the global HIV epidemic in adolescents has not received adequate focus.[2]

At a time when AIDS-related deaths are declining rapidly in other population groups, AIDS-related deaths among adolescents aged 10–19 are not declining (Figure 1) and AIDS remains the second leading cause of death in adolescents globally. It is the leading cause of adolescent deaths in Africa.

As the world turns its attention to the priorities reflected in the Sustainable Development Goals, it is critical to accelerate efforts to address the global HIV epidemic in adolescents. This is a necessary step towards ending the AIDS epidemic and ensuring that all adolescents have the opportunity to survive and thrive.

1.1 ALL IN agenda

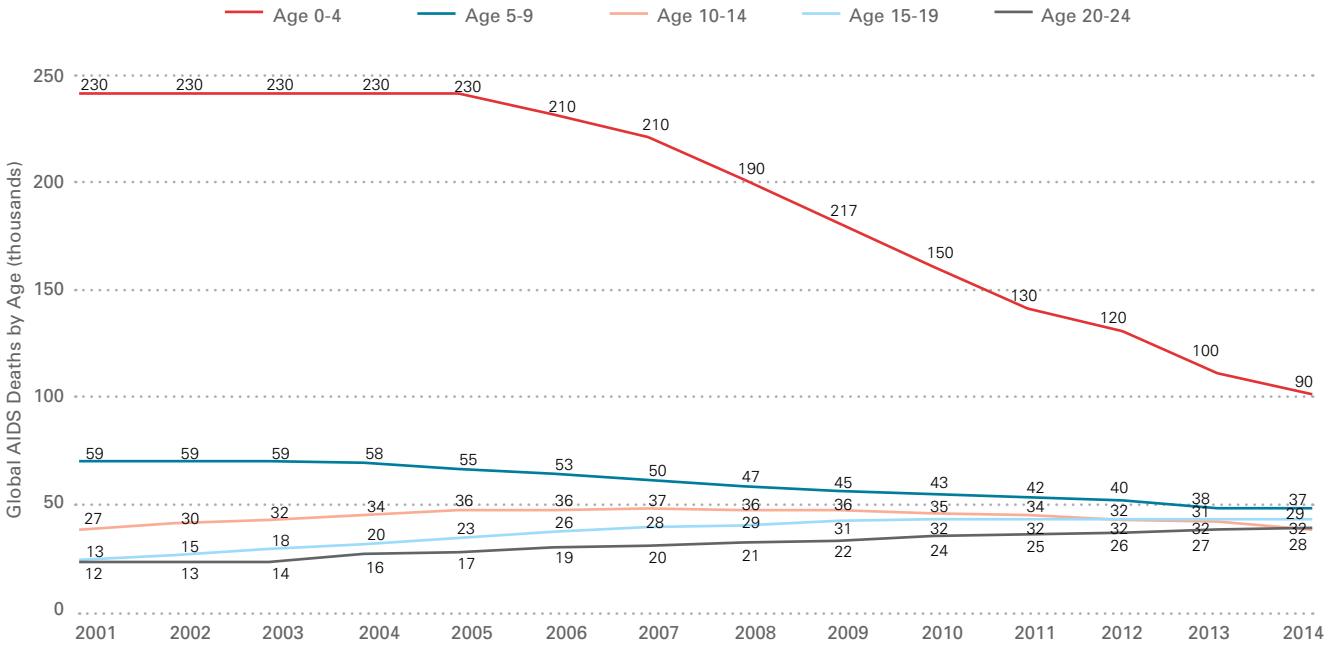
In February 2015, UNICEF and UNAIDS, along with government, international partners and adolescent and youth networks launched The ALL IN agenda[i] (see strategic framework summarized in Figure 2). This aim of this global effort is to catalyze action and collaboration among stakeholders across sectors to drive improved results for adolescents by helping countries make critical changes in programmes and policies. Through these changes, countries will be able to accelerate reductions in new HIV infections and AIDS-related deaths thus getting on track to AIDS epidemic by 2030. The three ALL IN targets for 2020 include a) reducing new HIV infections among adolescents by at least 75 per cent, b) reducing AIDS-related deaths among adolescents by at least 65 per cent and c) eliminating stigma and discrimination.

Four key action areas have been identified for the ALL IN agenda:

1. Engaging, mobilizing and supporting adolescents as leaders and agents of social change.
2. Sharpening adolescent-specific elements of national AIDS programmes by improving data collection and analysis and using to drive programming and results.

i Details about ALL IN agenda are available at http://allintoendadolescentaids.org

FIGURE 1 Estimated number of AIDS-related deaths, globally by 5-year age group, 2001-2014



Source: UNAIDS/UNICEF/WHO Global AIDS Response Progress Reporting and UNAIDS 2014 HIV and AIDS estimates, July 2015.

3. Fostering innovation in approaches that improves the reach of services for adolescents and increases the impact of prevention, treatment and care programmes.

4. Advocating and communicating at the global, regional and country levels to generate political will to invest in adolescent HIV and mobilize the necessary resources.

The ALL IN agenda is happening alongside other global and regional health and HIV-related initiatives, such as the UNAIDS Fast-Track initiative; the UNAIDS Fast-Track Cities Initiative; the UN Secretary General's Global Strategy for Women's, Children's and Adolescents' Health; PEPFAR's Accelerating Children's HIV/AIDS Treatment (ACT) Initiative; the PEPFAR DREAMS Initiative; and the Eastern and Southern Africa (ESA) Ministerial Commitment on sexuality education and sexual and reproductive health services for adolescents and young people.[ii] The ALL IN agenda can leverage these initiatives to achieve further country-level progress in addressing the HIV epidemic in adolescence. At the same time, the ALL IN agenda can enhance the impact of these initiatives by strengthening a country-level cross-sectoral partnership and accountability structure to focus on adolescents.

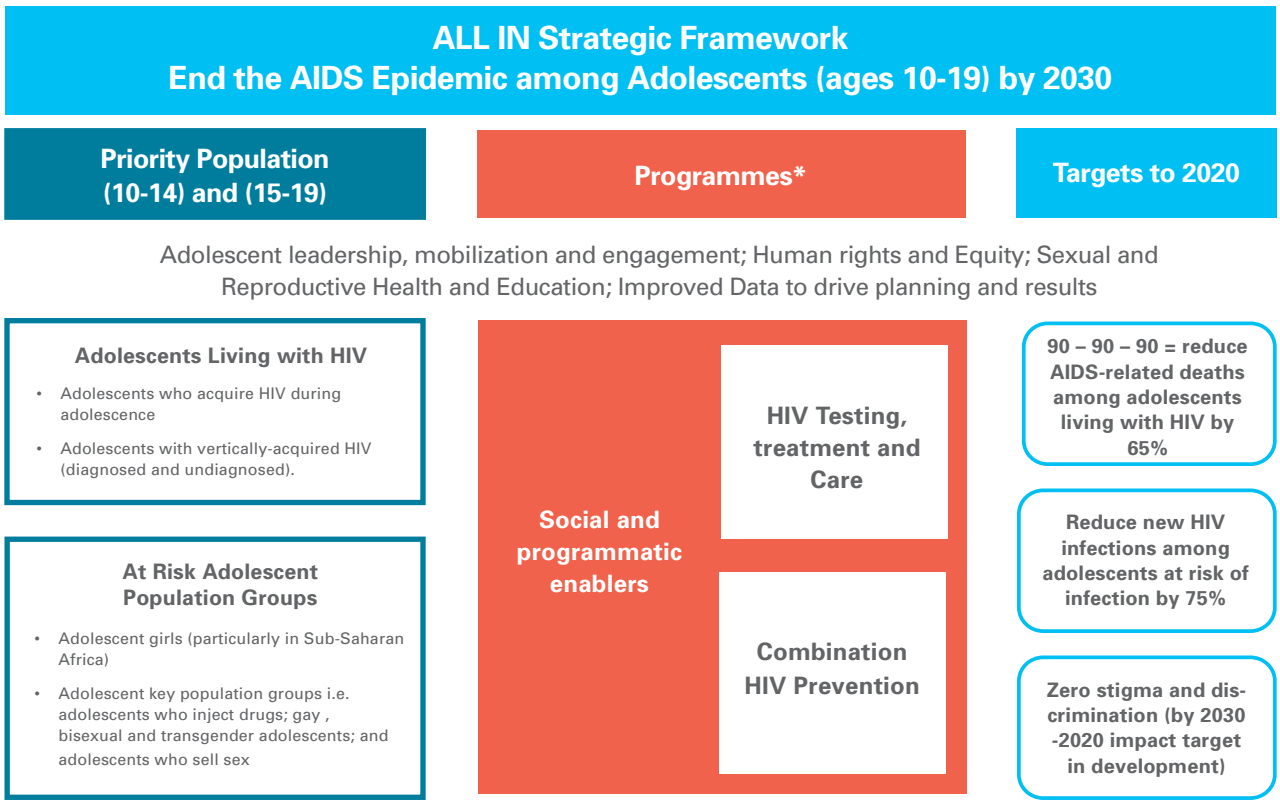
ii For descriptions of these and other initiatives, refer to Annex 1.

1.2 The adolescent HIV epidemic

There are an estimated 1.2 billion adolescents[iii] (aged 10–19) who make up an estimated 18 per cent of the world's population.[3] Millions of adolescents who are becoming sexually active live in countries, communities or networks with a high burden of HIV.[4] An estimated 64% per cent of new adolescent infections in 2014 (140,000 out of 220,000) were among adolescents living in sub-Saharan Africa and seventy-one percent of new adolescent infections in this

iii The United Nations defines adolescents as individuals between the ages of 10 and 19, youth as those between the ages of 15 and 24 and young people as those between the ages of 20 and 24. UNICEF, UNAIDS and WHO. Young people and HIV/AIDS: Opportunity in crisis. The Stationery Office, 2002. UNICEF. Towards an AIDS-free Generation—Children and AIDS: Sixth Stocktaking Report, 2013. New York, NY: UNICEF; 2013:p

FIGURE 2 All In strategic framework



region (98,000) were among girls.[5] Forty percent of new infections in 2014 were in adolescents outside of this region with the largest number (50,000) in Asia, with an equal number of new infections among adolescent girls and boys.

Adolescence is a critical life juncture defined by new experiences and by risk-taking and vulnerability.[6] The experimentation with sexual activity, sexuality and injecting drugs that often occur during this period is accompanied by an increased risk for HIV exposure. Early sexual debut, child marriage and the sexual exploitation of adolescents also increase adolescent risk of HIV infection.[7,8,9,10] Adolescence therefore is an essential period during which to intervene with services and to support adolescents to establish and reinforce HIV prevention and positive health-seeking behaviours. It is also a key time to protect and empower adolescents through social enablers. It is also crucial to ensure survival and quality of life for those adolescents living with HIV by establishing specific ways to identify them, link them to treatment and effectively manage their care.[11]

Understanding adolescent HIV epidemiology, the issues associated with adolescent data, and other structural issues that impact this epidemic are crucial for tailoring a more effective response for HIV prevention and care. Data and trends for the global adolescent HIV epidemic are summarized in Panel 1 (pages 9-12). Key issues associated with adolescent data are highlighted in Box 1. Key structural issues associated with the adolescent HIV epidemic are summarized in Box 2.

BOX 1

Challenges with data on adolescents

Data on adolescent HIV is often characterized by lack of sex- or age-disaggregation, inadequate sample size and poor alignment of indicators across multiple sources.[12] Where adolescent data is collected, data for younger adolescents (aged 10–14) is often unavailable in sentinel surveillance, monitoring systems, surveys and programme and research data. This is often because of challenges in obtaining ethical approval for the inclusion of adolescents in surveys that often lack age-appropriate questions. For adolescent key affected populations, defined as adolescent boys who have sex with adolescent boys (MSM), transgender adolescents, adolescents that are sexually exploited and sell sex and adolescents who inject drugs, these challenges with adolescent data are compounded by discrimination and marginalization. Data for key populations are often scarce or non-existent. These factors make it difficult to measure progress in the adolescent HIV epidemic and HIV-related outcomes in a standard way or constructively use the knowledge that comes from systems to implement the most effective programmes to address HIV in adolescents.[13]

BOX 2

Key structural issues associated with the adolescent HIV epidemic

Access to and quality of education

Duration of schooling and school-based interventions are associated with better health outcomes[14] and positively affect common risk and protective factors for a range of health behaviours, even for marginalized groups of adolescents.[15]

Age of consent policies and laws

Policy and legal barriers related to the age of consent can prevent adolescents from accessing timely HIV testing, care and treatment services.[16]

Broad criminalization laws

Laws that criminalize drug use, sex work or same-sex relationships further marginalize certain populations and inhibit their access to HIV and harm reduction services.[17]

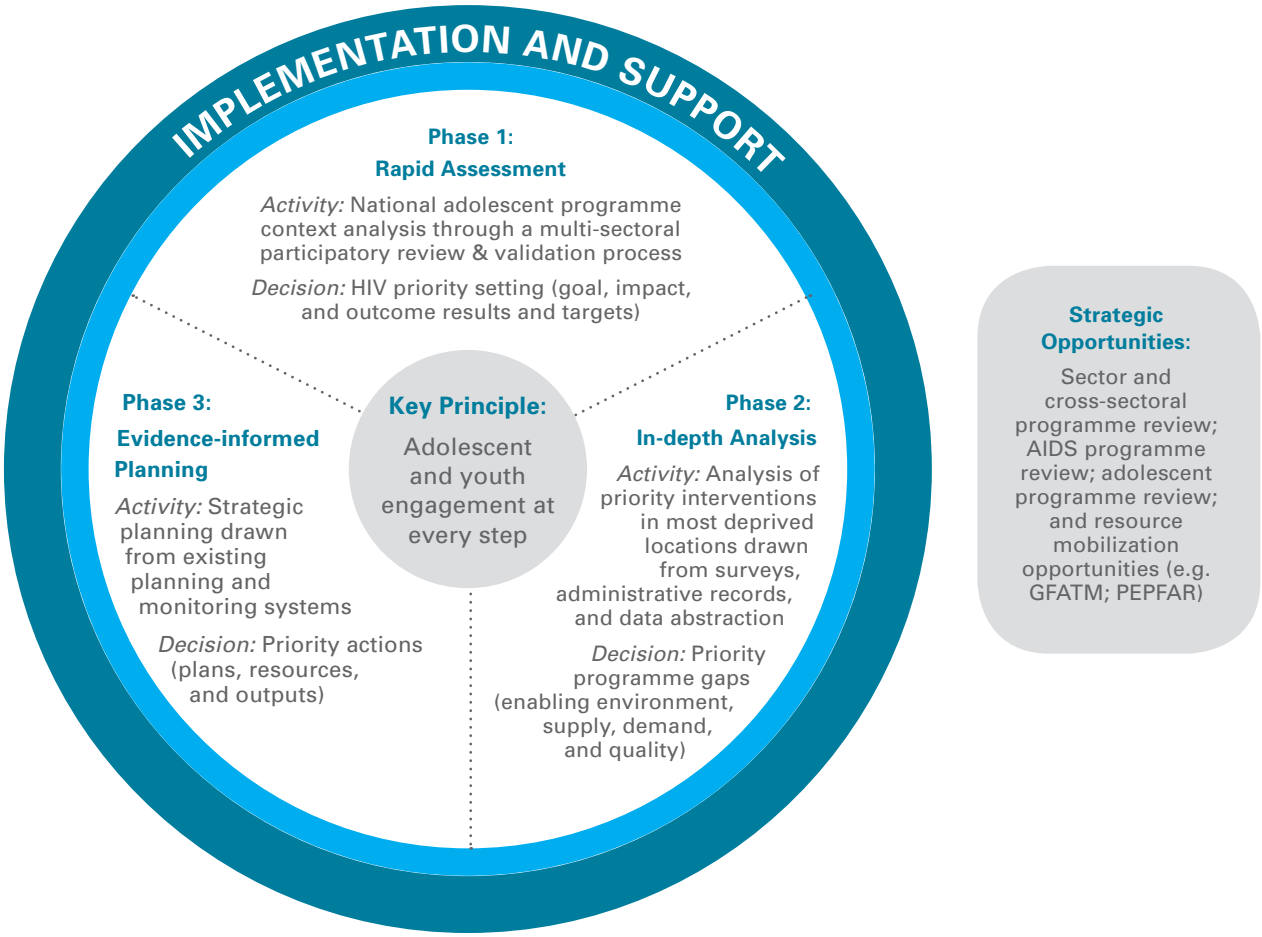
Gender inequality and gender-based violence

Global evidence has attributed disproportionate HIV infection in adolescent girls to gender inequality, inequitable gender norms and intimate-partner violence.[18]

Discrimination and violence

Adolescent girls and adolescents from key populations are at particularly high risk of HIV and often experience social inequality, discrimination and violence.[19,20]

FIGURE 3 All in 3-phase country assessment processes



BOX 3

Rapid assessment objectives

1. Collect, review and validate data on selected indicators related to HIV and adolescent well-being from multiple data sources;
2. Assess national programme enabling environment with partners and adolescents;
3. Synthesize data into a dashboard report; and
4. Identify adolescent sub-populations, interventions and geographic focus areas for programme acceleration.

1.3 Country assessments

UNICEF led the design of a three-phase country assessment process (Figure 3) that builds on the ALL IN strategic framework, the Fast Track Initiative to end AIDS by 2030 and the HIV investment framework.[21] The assessment process supports countries to strengthen the adolescent component of their national HIV programmes (rapid assessment objectives are described in Box 3).

By using an analytic tool – the Adolescent Assessment and Decision-Makers' Tool (AADM) – the assessments are a systematic way to identify equity and performance gaps affecting adolescent HIV programming. They help to define priority actions to improve the effectiveness of the national adolescent HIV response. The process and the tool enable a multi-sectoral team of stakeholders to assess national programme contexts (Phase 1); conduct targeted

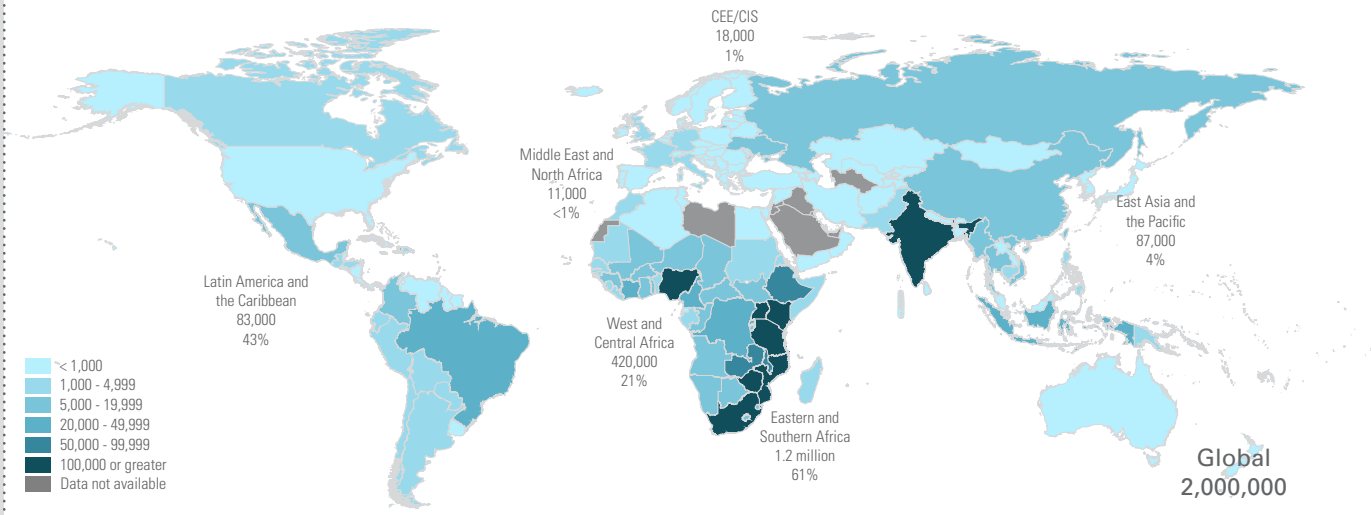
NUMBER OF ADOLESCENTS LIVING WITH HIV

PANEL 1A

Map showing global distribution of number of adolescents (10-19) living with HIV

Key messages: 82% of all adolescents living with HIV are in Sub-Saharan Africa

Estimated number of adolescents living with HIV, 2014



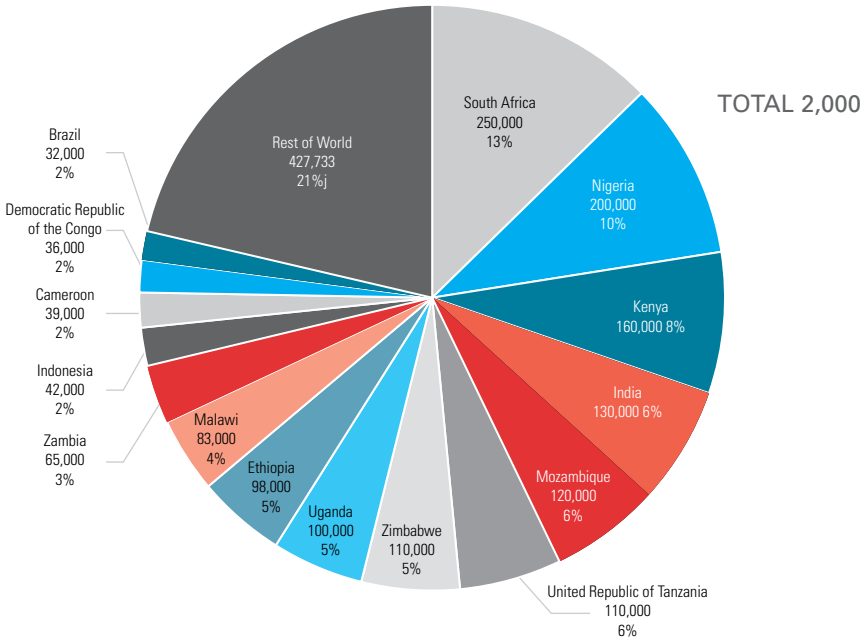
Note: The boundaries and the names shown and the designations used on these maps do not imply official endorsement or acceptance by the United Nations.
Source: UNAIDS 2014 HIV and AIDS estimates, July 2015

PANEL 1B

Pie chart showing the top 20 countries that compromise nearly 50% of adolescents living with HIV globally.

Key messages: Adolescent HIV infections are concentrated in certain countries

Estimated percentage of adolescents aged 10 - 19 living with HIV, by selected high-burden countries 2014



Source: UNAIDS 2014 HIV and AIDS estimates, July 2015.

ADOLESCENT HIV PREVALENCE

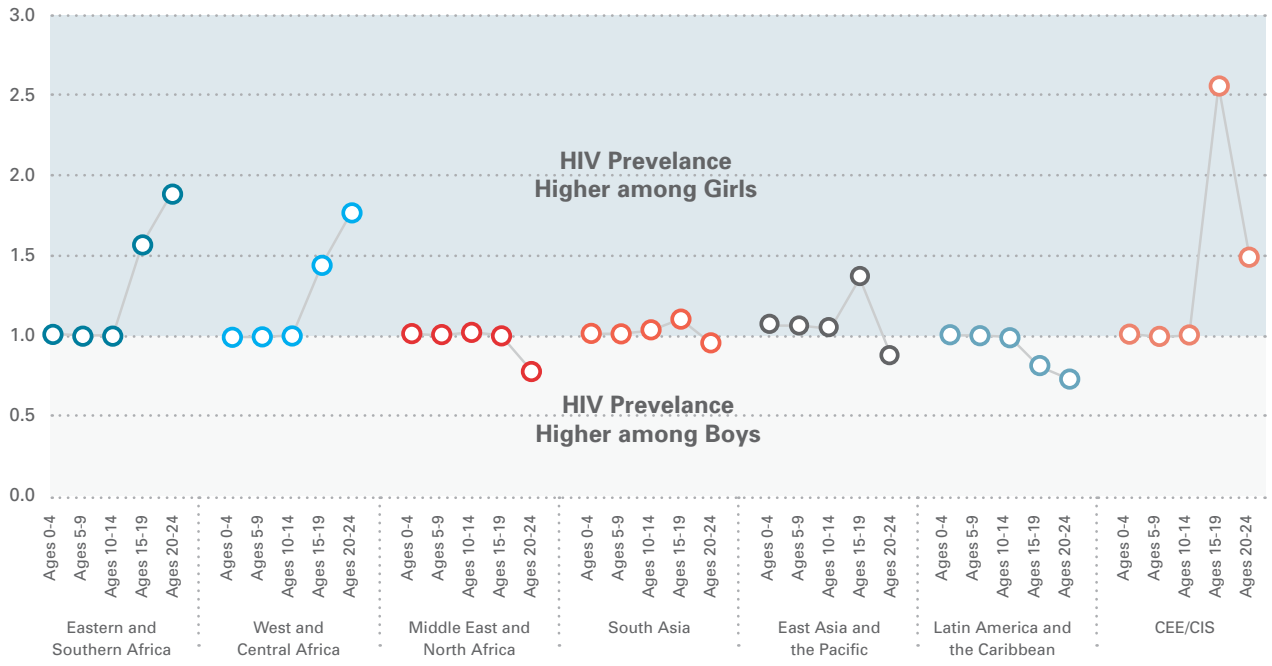
PANEL 1C

Comparison of HIV prevalence in girls and boys of different ages globally

Key messages:

- With increasing age (10-14 to 15-19 and 20-24) gender disparities in HIV prevalence emerge.
- In many places, notably Sub-Saharan Africa, girls are disproportionately infected.
- In Latin America and the Caribbean boys are disproportionately infected.

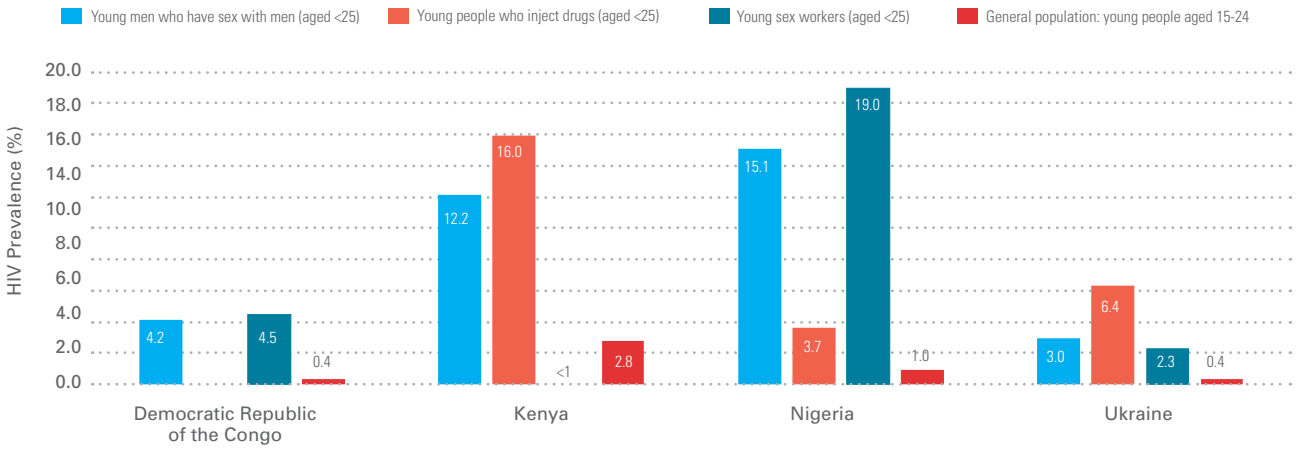
Estimated girl-to-boy ratio in HIV prevalence (%), by age, by UNICEF region, 2014



Source: UNAIDS 2014 HIV and AIDS estimates, July 2015

PANEL 1D

HIV prevalence (%) among various young key population groups and the general young populations, select All In! lead countries, 2011-2014



Source: UNAIDS 2014 HIV and AIDS estimates, July 2015

NEW HIV INFECTIONS IN ADOLESCENTS

PANEL 1E Number of New HIV infections by geographic region

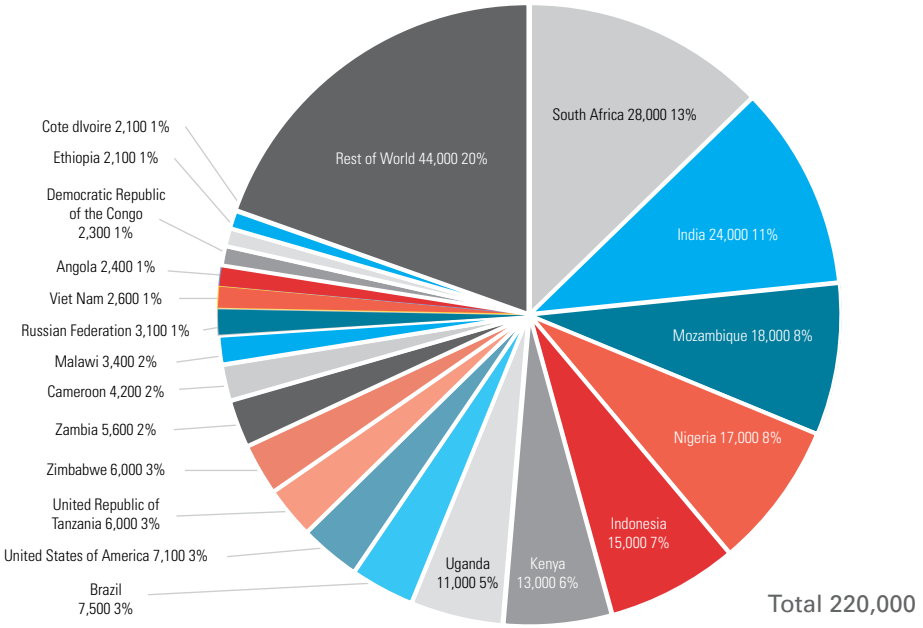
Key messages:

- There are regional and gender disparities associated with global new infection data.
- In Sub-Saharan Africa adolescent girls (ages 15-19) constitute 71% of new infections
- In Latin America and the Caribbean, adolescent boys (ages 15-19) constitute 59% of new infections

	Estimated number of new HIV infections among adolescents (aged 15-19), 2014				
		Girls		Boys	
	Total	Number	Percent	Number	Percent
Africa	140,000	98,000	71%	40,000	29%
Sub-Saharan Africa	140,000	98,000	71%	39,000	29%
Eastern and Southern Africa	100,000	75,000	72%	29,000	28%
West and Central Africa	33,000	23,000	69%	10,000	31%
Middle East and North Africa	2,400	1,100	47%	1,300	53%
Asia	50,000	25,000	51%	25,000	49%
East Asia and the Pacific	25,000	13,000	52%	12,000	48%
South Asia	25,000	13,000	50%	13,000	50%
Latin America and the Caribbean	17,000	7,100	41%	10,000	59%
CEE/CIS	5,200	3,600	69%	1,600	31%
Global	**220,000**	**140,000**	**62%**	**85,000**	**38%**

PANEL 1F Number of new HIV infections in top high burden countries

Key message: New global HIV infections are concentrated in certain countries that contribute the largest number of new HIV infections.



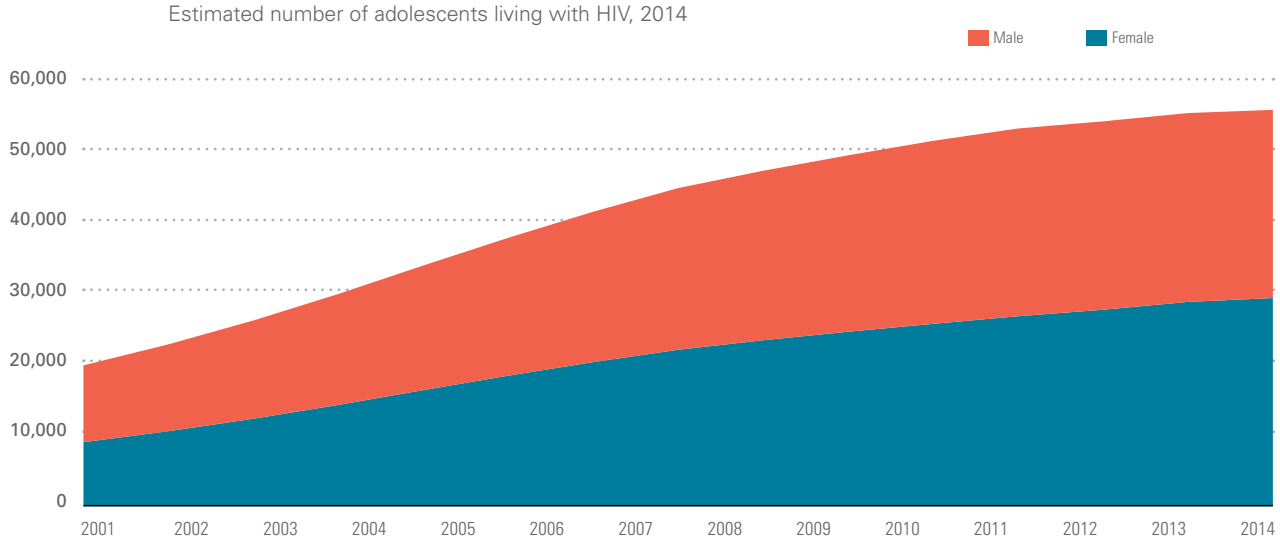
Source: UNAIDS 2014 HIV and AIDS estimates, July 2015

HIV-RELATED DEATHS

PANEL 1G

Graph showing the trends in the gender composition of HIV-related deaths in adolescents

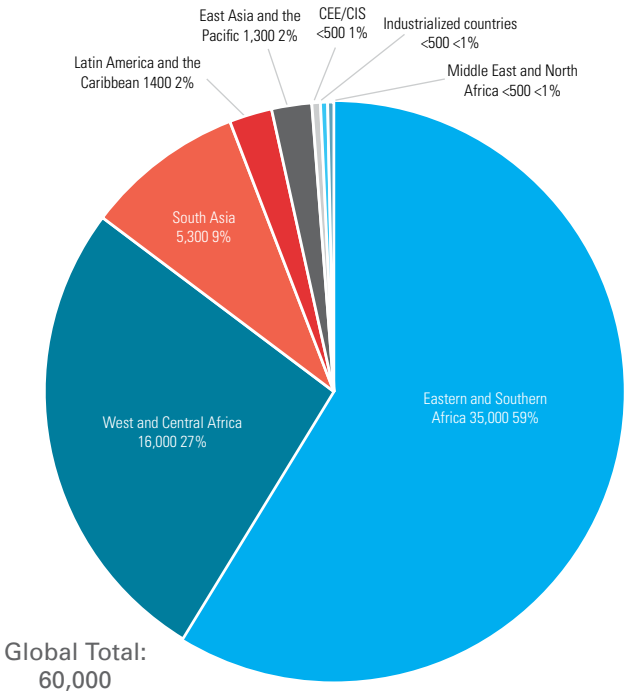
Key messages: In 2014 there was a slightly higher number of AIDS-related deaths in boys, which suggests greater challenges in reaching adolescent boys and linking them to HIV treatment and care.



PANEL 1H

AIDS-related deaths among adolescents (10-19)

Key messages: AIDS is the leading cause of death among adolescence in Sub-Saharan Africa where 85% of the 2014 adolescent AIDS-related deaths occured.



	Estimated number of AIDS-related deaths among adolescents (aged 10-19), 2014				
		Girls		Boys	
	Total	Number	Percent	Number	Percent
Africa	51,000	24,000	48%	27,000	52%
Sub-Saharan Africa	51,000	24,000	48%	27,000	52%
Eastern and Southern Africa	35,000	17,000	48%	18,000	52%
West and Central Africa	16,000	7,400	46%	8,500	54%
Middle East and North Africa	<500	<200	50%	<200	50%
Asia	6,700	3,200	48%	3,500	52%
East Asia and the Pacific	1,300	<1,000	46%	<1,000	54%
South Asia	5,300	2,600	48%	2,800	52%
Latin America and the Caribbean	1,400	<1,000	48%	<1,000	52%
CEE/CIS	<500	<200	56%	<200	44%
Global	**60,000**	**28,000**	**48%**	**31,000**	**52%**

Source: UNAIDS 2014 HIV and AIDS estimates, July 2015

in-depth analysis (Phase 2); and engage in systems-oriented planning (Phase 3). To ensure that the perspectives of adolescents inform the process, their engagement is a crucial component. Finally, the assessment process is an opportunity to align national and global targets and track progress towards these results.

In the first half of 2015, UNICEF, UNAIDS and partners provided technical assistance to Botswana, Cameroon, Jamaica, Swaziland and Zimbabwe to help them conduct rapid assessments on adolescent HIV programming. All five governments requested the support, and they established a multi-sectoral process to coordinate the exercise. Four of the five countries are among the 25 lead countries in the ALL IN agenda; the fifth country, Jamaica, has strong political commitment to address HIV in adolescents and requested the support as an early adopter of the ALL IN agenda.

The experience in these five countries provided initial case studies to inform global lessons on the assessment process and gain insight into mobilizing collective action to address the adolescent HIV epidemic.

This synthesis report focuses on documenting the rapid assessment process, lessons learned from the process as well as the actual findings that emerged from this first phase of the assessments in the five countries.

2. METHODS

A detailed description of the rapid assessment process is presented in the Adolescent Assessment Guidance.[iv] Multiple methods were used to review, synthesize and validate the findings presented in the five country reports.

2.1 Synthesis Process

1. Document and data review
A desk review was conducted to identify literature (peer reviewed articles and published reports as well as programme guidance, tools and country reports) on different aspects of the adolescent HIV epidemic.

2. Collection of stakeholder feedback
A key informant interview questionnaire (Annex 2) was administered online and through a phone or face-to-face interview with stakeholders engaged in the ALL IN country assessment process at the country and global levels. The purpose of the questionnaire was to elicit feedback in relation to the country context, associated processes, key themes and issues that emerged, the perceived benefits of the country assessments and ways to leverage the rapid assessment process going forward.

3. Analysis of the enabling environment in relation to select HIV and cross-sectoral indicators and progress towards ALL IN targets
A summary of lessons emerging from the enabling environment assessment in the five countries is presented in Box 5. As part of the synthesis exercise, we also examined 1) patterns and possible relationships between selected pairs of indicators and 2) possible connections between the enabling environment in each country, selected HIV and other indicators and progress towards ALL IN targets.

4. Thematic analysis of the outputs from the five rapid assessments
Country assessment reports were informed by a review of data gathered on multiple indicators. These indicators were clustered to reflect the situation among adolescents in five domains: Demographics and Epidemiology; HIV Prevention; HIV Testing, Treatment and Care: Protection, Care and Support; and Cross Sectoral Wellbeing (adolescent sexual and reproductive health, education, nutrition, etc). Outputs from country data entry were reflected in a dashboard that was structured based on these themes. This dashboard structure was used as the frame for each of the country reports as well as the frame for the thematic analysis in this synthesis report.

5. Collection of information on adolescent and youth engagement in the rapid assessments
Documentation on adolescent and youth engagement in the rapid assessments was reviewed and interviews were conducted with in-country stakeholders to ascertain the processes and key findings from the adolescent and youth engagement .

6. Thematic analysis of key informant interviews on the rapid assessment process
Stakeholder interviews were analyzed to identify key themes related to lessons learned from the assessment process and the perceived value of the assessment process to countries.

iv UNICEF, Guidance document on Adolescent Assessment and Decision Makers Tool (AADM).

7. Identification of recommendations
Data from the methods mentioned in 1–6 were analyzed to generate suggested programmatic recommendations to accelerate HIV results in adolescents and process recommendations to strengthen future ALL IN assessments. The suggested recommendations were presented to regional and country teams and partners to gather further feedback.

2.2 Data use and limitations

Data on new HIV infections and AIDS-related deaths were pre-populated in the AADM tool for each of the countries based on the most recent global estimates available at the time of the country assessment exercise. For the five countries that conducted their assessments between March to June 2015, the analysis was based on either 2013 or 2014 HIV estimates.

There are significant data-related limitations to the analyses presented in this report.

a) Data collected and analyzed for each country assessment were often from different sources [v]

b) There are multiple instances where data were only available for one or some of the countries for a particular indicator.

c) Wherever it was available, data were reported showing sex- and age-disaggregation; however, such age- and sex-disaggregated data were not consistently available for all indicators in all the countries.

d) In many cases, countries used proxy data that were only available for certain age groups or specific to certain sub-populations.

e) There were instances where small sample sizes were included in the studies and surveys from which data were obtained.

f) Data on adolescent key affected populations were scarce or unavailable in all five countries. Where data were included in assessments, it was obtained from small studies, often representing select geographic areas, certain key affected populations. In some cases, studies on adult populations were used to extrapolate estimates in the adolescent population.

In light of these limitations, some results presented in this report require cautious interpretation, and this is noted wherever applicable. The companion document to this report includes a summary of standard indicator definitions, the sources for data used in each country and descriptions of proxy indicators in cases where they were used.

Efforts were made in this synthesis exercise not only to point out the gaps, but also to consolidate the data and identify patterns to inform decision-making. Statistical analysis was not conducted on these data and therefore the observations pointed out might not be statistically significant. While direct comparison between countries is not feasible, it is possible to observe some patterns that emerge within the five countries. This was done particularly in our analysis of data patterns in light of the enabling environment. Further investigation is necessary to explore and confirm the significance of any patterns and connections noted.

v Data sources and the use of proxy indicators are noted in accompanying figures where this information was available.

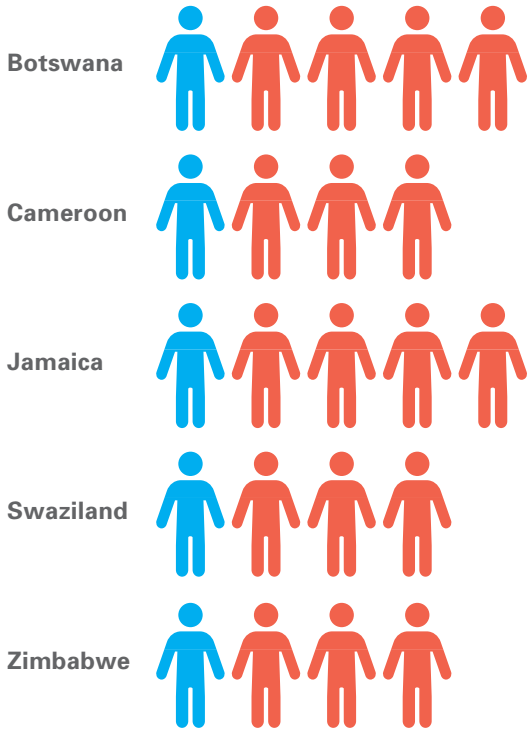
3. SYNTHESIS FINDINGS AND DISCUSSION

3.1 Analysis of the rapid assessment findings

3.1.1 Demographics

Adolescents comprise approximately one fifth (Botswana and Jamaica) to one fourth of the total population (Cameroon, Swaziland and Zimbabwe). Adolescents are therefore a significant population group in terms of planning for responses to end the AIDS epidemic in all five of these countries (Figure 4).

FIGURE 4 Proportion of the population of countries that are adolescents



Sources: Botswana (Census 2011), Cameroon (3è RGPH, Projections démographiques), Jamaica (no source provided), Swaziland (CSO, Population Census projections for 2014, Swaziland) and Zimbabwe (ZIMSTAT 2013 and 2014 Population Projections).

3.1.2 HIV epidemic in adolescents and young people

3.1.2.1 HIV prevalence (%) in adolescents (aged 10–19) and young people (aged 20–24)

In all five countries, HIV prevalence increases in the older cohorts (from 10–14 to 15–19 and from 15–19 to 20–24). This increase is more pronounced for girls in all countries but Jamaica (Figure 5), where it is more evident for boys.[vi] This increase in HIV prevalence with successive age cohorts is consistent with increased sexual behaviour. However, it is also the result of adolescents living with HIV surviving into their early adult years. In the four countries where increase by successive age cohort is more pronounced in girls (Botswana, Cameroon, Swaziland and Zimbabwe) the gender disparities reflect earlier sexual activity among adolescent girls with older, higher-risk sexual partners. In Jamaica, the gender disparity illustrates the significant risk of HIV among adolescent boys and the contribution of sexual transmission in adolescent boys and young men to the overall epidemic. In Botswana and Swaziland the gender disparity in HIV prevalence narrows among the 15–19-year-old cohort in 2014 compared to 2011.

Country teams noted a number of contextual factors driving higher HIV prevalence in older adolescents and young people, including:

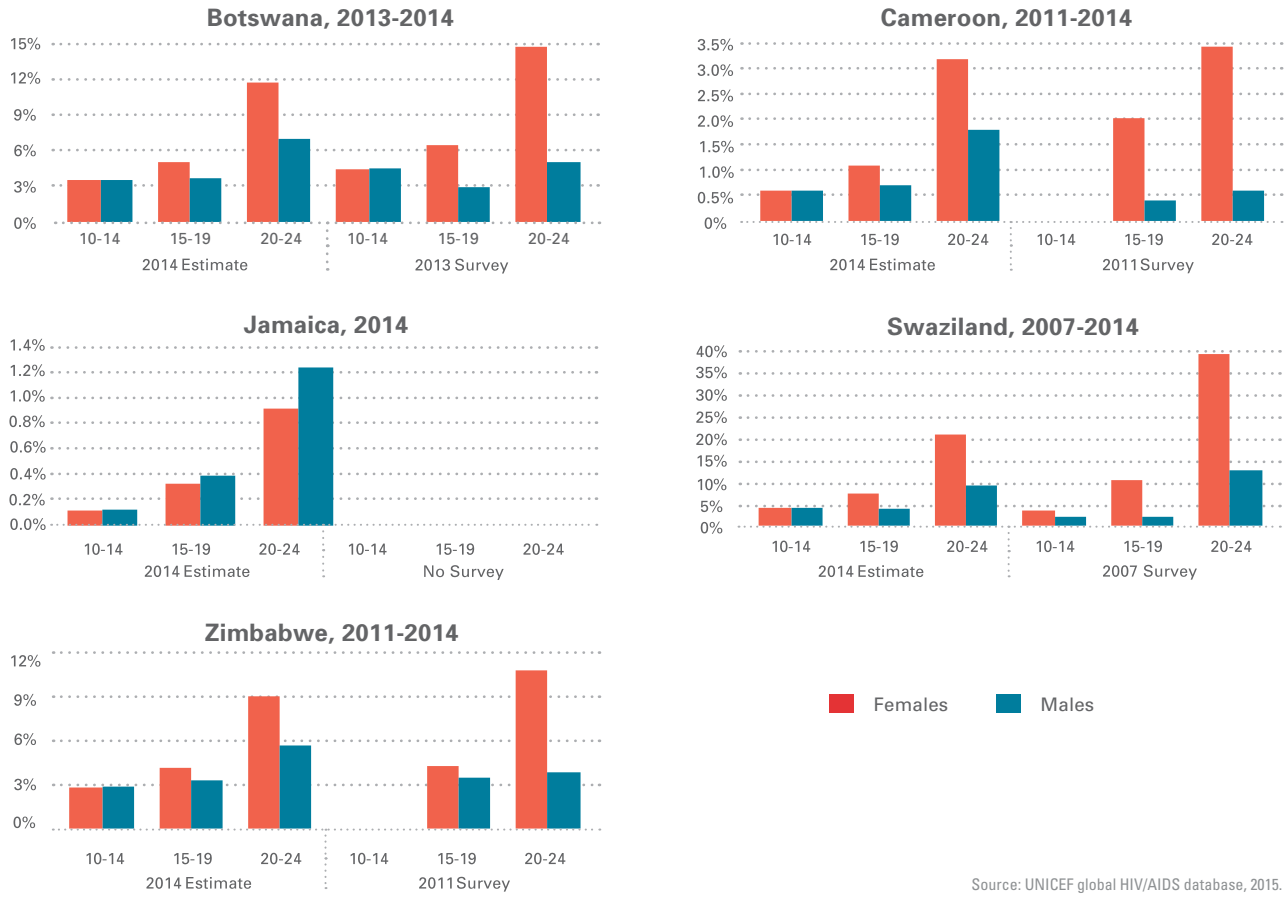
- Decreasing condom use among sexually active young people (aged 15–24) (Botswana);
- Low levels of comprehensive knowledge of HIV (Botswana and Zimbabwe);
- High reported occurrence of transactional sex (Botswana and Jamaica);
- Age-disparate sexual relationships (Jamaica and Swaziland); and
- Child sexual exploitation and gender-based violence (Jamaica).

vi The exception to this is Swaziland, where HIV prevalence decreased slightly in boys from ages 10–14 to 15–19.

KEY MESSAGES

- Data from the five countries shows that reveals a pattern of increasing HIV prevalence from younger adolescents (aged 10–14) to older adolescents (aged 15–19) that becomes more pronounced in young people (aged 20–24).
- Gender disparities in HIV prevalence emerge with increasing age in girls in four countries and in boys in one country.

FIGURE 5 Global estimates and country survey estimates of age and sex-disaggregated HIV prevalence among adolescents and young people



Source: UNICEF global HIV/AIDS database, 2015.

3.1.2.2 Looking ahead to 2020: Projected Trends in New HIV infections in adolescents (aged 15–19)

Projections[vii] for new adolescent HIV infections for 2015 to 2020 (Figure 6) can provide an indication of whether countries can potentially meet the target of reducing new infections by 75 per cent by 2020.[viii] These projections suggest that Jamaica is extremely close to meeting this target and could meet it with effective targeting and acceleration of HIV programming. Botswana and Swaziland can potentially meet the target with acceleration in HIV prevention, care and treatment. To meet the target, Cameroon and Zimbabwe would have to substantially accelerate HIV prevention, treatment and care efforts in adolescents; they would also need to address social factors that contribute to increased HIV risk in adolescents.

vii Projected progress towards ALL IN targets is based on a global analysis where 2015–2020 values have been projected based on applying the average annual rate of decline (%) between 2012–2014 and applying that to calculate 2015–2020 values. Projected rates of decline are calculated based on comparing the 2010 baseline to the projected 2020 value.

viii Targets are based on if investments in adolescent prevention and treatment programmes stay the same, and if HIV incidence stays at the same rate as observed in the last five years.

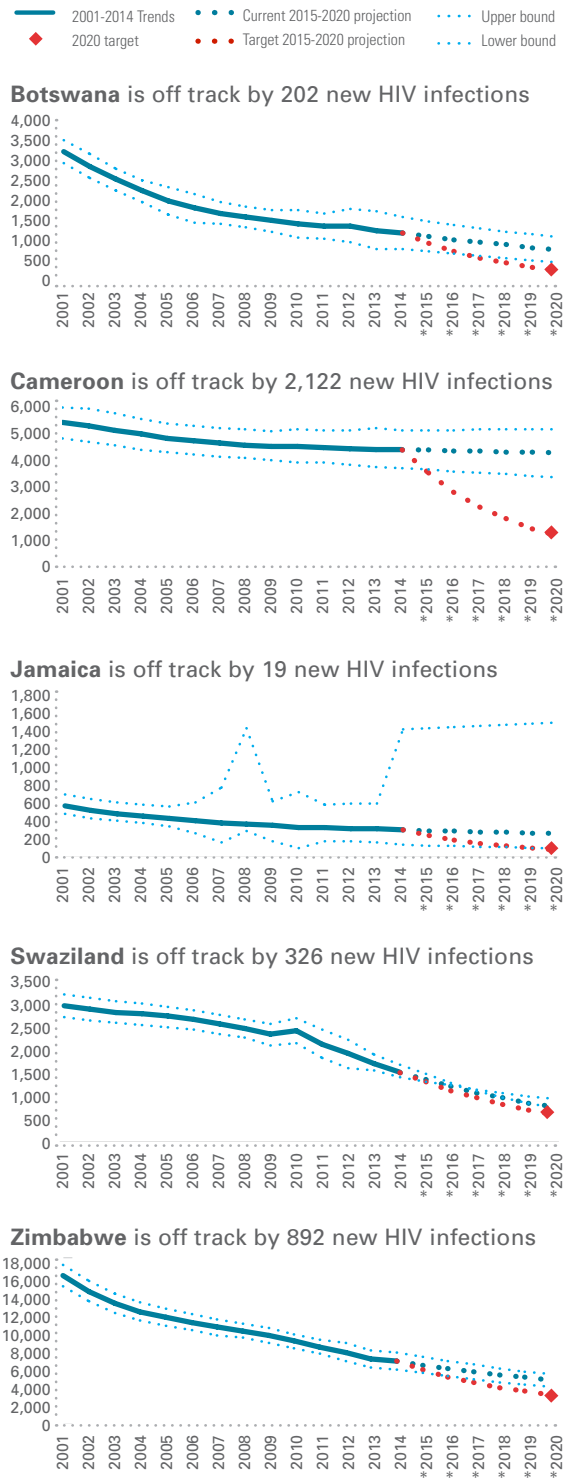
3.1.2.3 Looking ahead to 2020: Projected Trends in AIDS-related deaths among adolescents (aged 10–19)

Projections[ix] for adolescent AIDS-related deaths for 2015–2020 (Figure 7) can provide an indication of whether countries can potentially meet the target of reducing new AIDS-related deaths by 65 per cent by 2020.[x] Projections suggest that Jamaica will likely meet the target with even minimal acceleration of HIV treatment and care. Botswana and Swaziland can potentially meet this target by accelerating scale-up of ART coverage. However, Cameroon and Zimbabwe require even more substantial scale-up of ART in order to meet this target.

ix Projected progress towards ALL IN targets are based on a global analysis where 2015–2020 values have been projected based on applying the average annual rate of decline (%) between 2012–2014 and applying that to calculate 2015–2020 values. Projected rates of decline are calculated based on comparing the 2010 baseline to the projected 2020 value.

x Targets are based on the assumption that investments in adolescent prevention and treatment programmes stay the same each year, and that HIV incidence stays at the same rate as observed in the last five years.

FIGURE 6 Trends in estimated number of adolescents newly infected with HIV (ages 15-19)



Source: UNICEF analysis of UNAIDS 2014 HIV and AIDS estimates, July 2015.
*2015-2020 values have been projected based on applying the average annual rate of decline (%) between 2012-2014 and applying that to calculate 2015-2020 values

Botswana

Stakeholders in Botswana rated the enabling environment with an average score of 5.2/10, denoting a supportive enabling environment, with some areas for improvement. Botswana has relatively low levels of child marriage (6.1 per cent) and adolescent pregnancy (9 per cent) reflecting empowerment of girls and commitment of families and communities to protection of children. Botswana used secondary school enrolment as an alternative definition of net secondary school attendance; this was moderate (52 per cent in girls and 48 per cent in boys). However, there are high levels of sexual violence towards girls (17 per cent) and boys (10 per cent), which indicates an important area for programme and policy attention that can influence social change.

Botswana's enabling environment results are consistent with the observed progress in coverage gaps for HIV-related interventions. There is good progress in ART and condom coverage reflecting levels of awareness, demand, empowerment and strength of ART and condom service availability. The moderate coverage gaps in HIV testing and HIV knowledge in adolescents mirror the moderate secondary school enrollment and missed opportunities to empower adolescents through knowledge and health-seeking skills and build demand. Laws around the age of consent could also play a role in the observed HIV testing coverage gaps, because they limit the proportion of adolescents that are able by law, to seek services independently.

Projections of new HIV infections and AIDS-related deaths in Botswana for 2015–2020 provide an indication of whether Botswana is on track to meet the ALL IN 2020 targets for reductions in new HIV infections and AIDS-related deaths in adolescents (Figure 7 and Figure 8). Projections suggest that with acceleration of adolescent programming, particularly coverage of HIV testing and HIV knowledge where there are moderate gaps, Botswana has the potential to meet the 2020 ALL IN targets.

Cameroon

Stakeholders in Cameroon rated the enabling environment with an average score of 4.5/10, reflecting some progress across the eight domains. There are substantial challenges associated with the social context in Cameroon that could potentially impact HIV risk and adolescent HIV service access. Cameroon has high prevalence of child marriage (38%) and sexual violence towards adolescent girls (22 per cent) with data unavailable for boys. The country also has a high prevalence of adolescent pregnancy (25 per cent) and low net secondary school attendance for both sexes (37 per cent for girls and 42 per cent for boys).

Coverage gaps in HIV-related services observed in Cameroon are consistent with this challenging environment. While there are only moderate coverage gaps in HIV testing in both sexes (18 per cent for girls and 25 per cent for boys), the national targets for HIV testing are low (32 per cent for both sexes). High prevalence of teenage pregnancy could play a role in the observed lower HIV testing coverage gaps in girls compared with boys. In light of the gaps in HIV testing coverage, there is also a significant gap in ART coverage (47 per cent). While condom coverage gaps are low for boys (10 per cent), there are significant gaps for girls (28 per cent). High levels of sexual violence and the unequal power dynamics associated with child marriage could play a role in this condom coverage gap in girls and hinder girls' access to HIV services. Given the role of education in HIV knowledge, the significantly low secondary school attendance could account for the observed significant gaps in HIV knowledge (54 per cent in girls and 50 per cent in boys).

Projections of new HIV infections and AIDS-related deaths in Cameroon for 2015–2020 provide an indication of whether Cameroon is on track to meet the ALL IN 2020 targets for reductions in new HIV infections and AIDS related deaths in adolescents (Figure 7 and Figure 8). Projections suggest that Cameroon has the potential to meet the 2020 ALL IN targets only with substantial acceleration and improved focus on and quality of HIV programming, including HIV prevention and treatment; it will also require addressing factors inherent in the social context that put adolescents – and particularly adolescent girls – at increased risk of HIV.

Jamaica

Stakeholders in Jamaica rated its enabling environment with an average score of 2.7/10, which corresponds with no or very little progress. Examination of cross-sectoral and HIV-related data, however, suggests that stakeholders might have been more critical of their country's enabling environment because the low rating of the enabling environment did not reflect the relatively good progress shown in the indicators measured in the assessment. Jamaica's social context features relatively low rates of child marriage (8 per cent) and teenage pregnancy (9 per cent) reflecting empowerment of adolescent girls and relatively strong social or family support for the rights of adolescent girls. Jamaica has very high levels of secondary school attendance (92 per cent for girls and 91 per cent for boys). This indicates an excellent opportunity to convey knowledge about HIV. On the other hand, 21 per cent of girls in Jamaica experience sexual violence, which is significant, and much greater than the percentage of boys who experience such violence (5 per cent), which are still high.

The largely supportive social context in Jamaica does not consistently translate into

progress in HIV-related indicators. Jamaica has no condom coverage gap in boys and only a moderate gap in girls (19 per cent), which could be attributed to high secondary school enrollment and adolescents' extensive access to Jamaica's long-running Health and Family Life Education programme. While Jamaica has made good progress in building HIV knowledge in both sexes (gaps of only 13 per cent in girls and 9 per cent in boys), the national targets for this indicator were low (52 per cent for girls and 43 per cent for boys).

There are significant gaps in HIV testing (45 per cent among girls and 57 per cent among boys) and in ART coverage (50 per cent). These gaps could be attributed to additional factors that were not explored in this analysis, including stigma preventing uptake of testing. Also, as noted in the country assessment report, there is inadequate age-disaggregation of monitoring data and poor reporting on use of services by adolescents, particularly those aged 10–14.

Swaziland

Stakeholders in Swaziland did not conduct the enabling environment assessment looking at the same eight domains as the other countries did. The pilot experience in Swaziland informed the development of a more comprehensive tool to assess the enabling environment. Analysis of cross-sectoral indicators, however, suggests there are numerous challenges and areas for urgent improvement in the enabling environment of Swaziland.

- While Swaziland has low prevalence of child marriage (4 per cent), which suggests empowerment of girls, it has moderate levels of adolescent pregnancy (17 per cent) and very high levels of sexual violence perpetrated against girls (33 per cent). Data on sexual violence against boys were not available.
- While there was moderate secondary school attendance in girls (52 per cent), there was low secondary school attendance in boys (42 per cent).

Swaziland found moderate gaps in HIV knowledge in both girls (18 per cent) and boys (20 per cent). The roughly equal levels of knowledge among adolescent girls and boys – despite lower secondary school attendance among boys – suggests that other sources of information may play a significant complementary role in building knowledge among boys.

With respect to services, condom coverage gaps were notably low in boys (10 per cent). These data were not available for girls. There is a significant gap in ART coverage (39 per cent) in Swaziland. As seen elsewhere, HIV testing gaps were substantially lower in girls (8 per cent) compared to boys (25 per cent). Interestingly, HIV testing coverage targets in Swaziland were low and different for each sex (65 per cent for girls and 55 per cent for boys). This suggests both a recognition of the relatively more challenging task of reaching adolescents boys compared to adolescent girls; it also reflects the priority in reaching adolescent girls – given indications of their early vulnerability due to earlier age at first sex – and the opportunity to reach the most vulnerable, pregnant adolescent girls through ANC and SRH services.

Projections of new HIV infections and AIDS-related deaths in Swaziland for 2015–2020 provide an indication of whether Swaziland is on track to meet the ALL IN 2020 targets for reductions in new HIV infections and AIDS related deaths in adolescents (Figure 7 and Figure 8). Projections suggest that with acceleration of adolescent programming, Swaziland has the potential to meet the 2020 ALL IN targets, particularly coverage of HIV testing, where there are moderate gaps; and ART, where there are significant gaps. Swaziland will also have to address factors in the social context that put adolescents – and particularly adolescent girls – at increased risk of HIV.

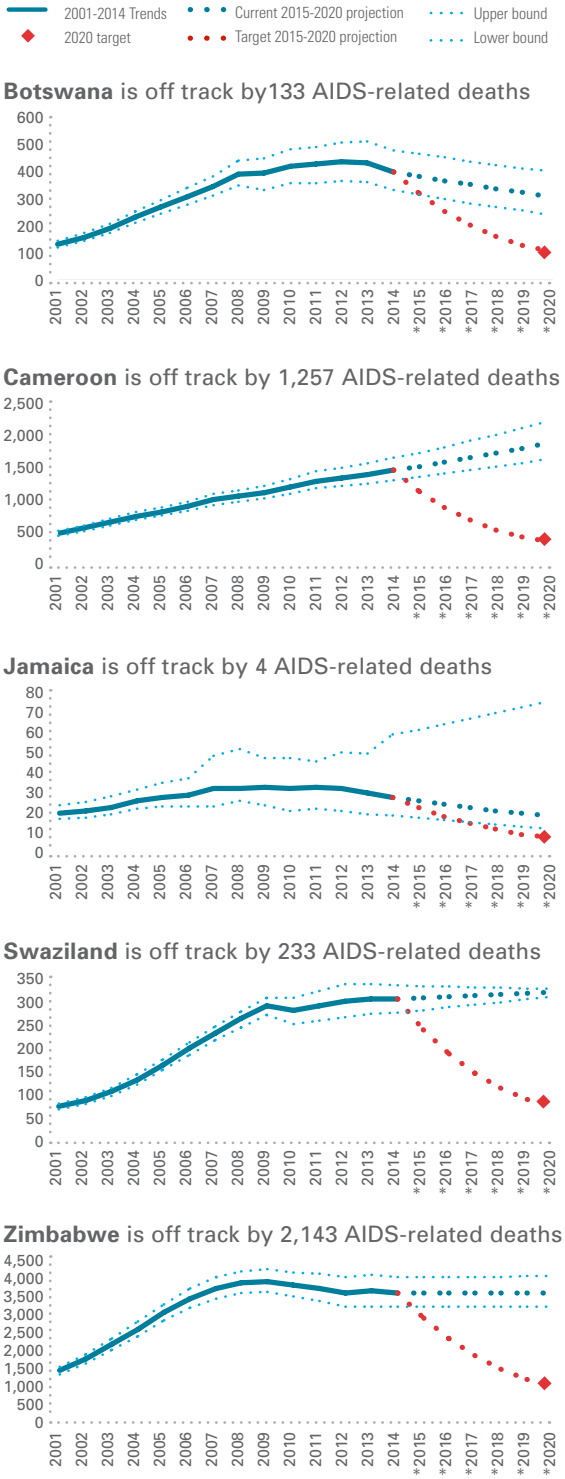
Zimbabwe

Stakeholders in Zimbabwe assessed their enabling environment as relatively good with a score of 6/10. Yet data reveal challenges including high rates of child marriage (25 per cent) and sexual violence (41 per cent among girls and 39 per cent among boys). These contribute to HIV risk and could potentially hinder access to HIV services. In addition, there are high rates of adolescent pregnancy (24 per cent), which could be linked to the high rates of child marriage. There is moderate school attendance that is higher in girls (60 per cent) than boys (51 per cent).

Zimbabwe has significant coverage gaps in HIV testing (55 per cent in girls and 66 per cent in boys) and ART (36 per cent). In addition, the data showed high rates of child marriage, adolescent pregnancy (24 per cent) and gender-based violence despite high rates of secondary school enrollment. While condom coverage was moderate among boys (13 per cent), these data were not available for girls.

Projections of new HIV infections and AIDS-related deaths in Zimbabwe for 2015–2020 provide an indication of whether Zimbabwe is on track to meet the ALL IN 2020 targets for reductions in new HIV infections and AIDS related deaths in adolescents (Figure 7 and Figure 8). Projections suggest Zimbabwe has the potential to meet the 2020 ALL IN targets only with substantial acceleration of HIV programming, including HIV prevention and treatment; it will also require addressing factors inherent in the social context that put adolescents – and particularly adolescent girls – at increased risk of HIV.

FIGURE 7 Trends in estimated number of AIDS-related deaths among adolescents (ages 10-19)



Source: UNICEF analysis of UNAIDS 2014 HIV and AIDS estimates, July 2015.
*2015-2020 values have been projected based on applying the average annual rate of decline (%) between 2012-2014 and applying that to calculate 2015-2020 values

3.1.3 Adolescent key affected populations

KEY MESSAGES

- Data on adolescent key populations are scarce and of limited quality in all five countries.
- The data that were available reflected higher HIV prevalence among adolescent key populations. This suggests higher HIV risk within these populations compared to the general adolescent population.
- Where behavioural data were available for key populations, it reflected low levels of HIV testing and variable levels of coverage of condom use across the five countries.
- These findings underscore the urgent need for more targeted HIV prevention, care, treatment and support efforts for adolescent key populations.

Globally, adolescent key populations, including gay and bisexual adolescent boys, transgender adolescents, adolescents who are sexually exploited and sell sex and adolescents who inject drugs, have been found to have higher risk for HIV infection than the general adolescent population.[22] Adolescent key populations also experience substantial barriers in access to care, mostly because of stigma and discrimination reinforced through country laws and policies, negative attitudes encountered during contact with health services, social isolation, violence as well as self-stigmatization.[23,24]

In all five countries, no data were available on injection drug use among adolescents. Only Jamaica had estimates related to transgender adolescents. Zimbabwe had no official data on these key populations. More general issues associated with data on adolescent key affected populations are described in Section 2.2 (data limitations and implications).

Data on HIV prevalence among sexually exploited adolescents, as well as older adolescents who sell sex, and on adolescent boys who have sex with boys (MSM) were available in Botswana, Cameroon, Jamaica and Swaziland. Data on transgender adolescents in Jamaica were also available (all shown in Table 1a). Available behavioural data on adolescent key populations included condom use in sexually exploited females who sell sex and among adolescent MSM (Botswana, Cameroon, Jamaica and Swaziland), and on HIV testing (Botswana and Cameroon); these are shown in Table 1b. These data were from varying age cohorts, populations and samples, so it is not possible to make any comparison among countries. Collectively, however, the adolescent key population data from all five countries reflect higher risk within these populations compared to the general adolescent population.[xi]

Stakeholders in all countries acknowledged the need to generate much better data on key populations in general, including on adolescents, in order to inform planning and implementation of an evidence-informed and human-rights based response to address these adolescents' HIV risk. The limited data on key adolescent populations that were available in four of the rapid assessment countries underscore the urgent need to scale up HIV prevention, care, treatment and support efforts to focus on these adolescent populations – particularly for condom promotion among adolescent MSM in all of these countries and HIV testing in key populations in Botswana.

3.1.4 HIV testing, treatment and care

HIV testing services are the essential entry point to HIV treatment and care. Table 2 summarizes the data available across the five countries on the status of HIV testing, treatment and care.

In all five countries, coverage levels for HIV testing in adolescents were below country targets. There were consistently lower coverage gaps in HIV testing coverage in girls vs. boys[xii] in four countries (all but Botswana, where there was only a 1 percentage point difference between sexes).

xi Integrated Bio-Behavior Surveys often include questions on sexual debut and earlier experiences that shed light on adolescent vulnerabilities among key populations

xii Jamaica used an alternative indicator for HIV testing (percentage of sexually active adolescents (aged 15-19) who were tested and received results in the last 12 months).

KEY MESSAGES

- Adolescent HIV testing and ART coverage levels fell short of national targets in all countries except Botswana.
- Data for coverage of ART for PMTCT and viral suppression in adolescents aged 10–19 years were only available in Botswana and Jamaica.

Integration of HIV testing for pregnant women and girls into antenatal care (ANC) programmes has been scaled up substantially to support elimination of mother-to-child transmission of HIV. In both Botswana and Jamaica – the only two countries with age disaggregated data on coverage of ART for PMTCT – coverage among pregnant adolescents living with HIV exceeded national targets. A significant proportion of adolescent girls in the other four countries have experienced pregnancy and thus likely benefited from ANC-based HIV testing leading to the observed lower coverage gaps in HIV testing for girls in these countries compared with boys.

In Cameroon, Jamaica,[xiii] Swaziland and Zimbabwe, ART coverage levels in adolescents were substantially below national targets; in Botswana, ART coverage in adolescents exceeded the national target. No country had sex-disaggregated data on ART coverage, so differentia patterns in ART coverage between boys and girls could not be assessed. However, given the potential for a significant number of sexually active adolescent girls who become pregnant to access HIV testing through ANC, ART coverage may be greater in adolescent girls than in adolescent boys. This would have to be assessed through age- and sex-specific analysis of ART coverage data. If verified, specific strategies would need to be defined to improve identification of adolescents, particularly adolescent boys, living with HIV who may not be diagnosed and linked to treatment and care.

xiii Jamaica reported that estimates for adolescent ART coverage may not be accurate because of challenges tracking behaviorally infected adolescents.

Only Botswana and Jamaica had reliable data to report on viral suppression, and sex-disaggregated data were available only in Botswana. National targets for this indicator were exceeded in Botswana, while in Jamaica data showed current levels of viral suppression substantially below national targets. Jamaica reported that viral suppression estimates are affected by low uptake of viral load testing (26 per cent in adolescents in 2014). Botswana reported that the data suggesting high levels of viral load suppression in this context should be considered with caution as viral load monitoring had only recently been introduced and the sample size associated with these data is small.

These data highlight the need in the five countries to scale up and improve uptake of testing, particularly by better targeting efforts to improve self-assessment of risk and promote demand-creation strategies among adolescents. Analysis of data on new infections and AIDS deaths in adolescents to understand better where HIV risk and the need for access to testing, ART and other HIV services is greatest can promote improved strategies to reach adolescent populations at higher risk. This will build demand and improve linkage to ART and prevention. Country teams also pointed to early experiences with and the need to improve the innovative use of mobile phones and media to support programmes. They also highlighted the need for cross-sectoral approaches such as partnerships between health facilities and schools, to build knowledge, risk awareness and demand – and also to expand and maintain ART coverage among adolescents.

TABLE 1A: Country assessment adolescent key population HIV prevalence

	Female sex workers	MSM	Transgender
Botswana	62% (aged 18+)	13% (aged 18+)	
Cameroon	21%* (aged 11-19)	21% (Douala) and 52% (Yaounde) (aged 18-24)*	
Jamaica	2%* (aged 15-24)	14%[7] (aged 10-19)	27% (aged 15-19)*
Swaziland	83%* (aged 18+)	46%* (aged 18+)	

Standard indicator definitions:
HIV prevalence female sex workers: HIV prevalence among adolescents (aged 10-19 years) who sell sex
HIV prevalence MSM: HIV prevalence among gay and bisexual adolescents (aged 10–19 years)
HIV prevalence transgender: HIV prevalence among transgender adolescents (aged 10-19 years)

Data Sources:
HIV prevalence female sex workers: Botswana (2012 Mapping, Size Estimation & BBSS of HIV/STI among Select high risk sub-populations in Botswana); Cameroon (Rapport de l'enquete seroepidemiologique et comportementale sur le VIH et la syphilis chez les travailleurs de sexe au Cameroun, GVFI, 2010), P.46),; Jamaica ((National HIV/STI Programme, 2014); Swaziland (Baral, S et al. 2013. Examining prevalence of HIV infection and risk factors among female sex workers (FSW) and men who have sex with men (MSM) in Swaziland. USAID Project SEARCH)
HIV prevalence MSM: Botswana (2012 Mapping, Size Estimation & BBSS of HIV/STI among Select high risk sub-populations in Botswana.); Cameroon (Report of Integrated biological and behavioral surveillance (IBBS) among men who have sex with men (MSM) in Cameroon, 2012); Jamaica ((National HIV/STI Programme, 2014); Swaziland (Baral, S et al. 2013).
HIV prevalence transgender: Jamaica (National HIV/STI Programme, 2014).

***Proxy Indicators Used:**
HIV prevalence female sex workers: Cameroon (HIV prevalence (%) among adolescent girls who sell sex (aged 11 - 19); Jamaica (HIV prevalence (%) among young females (aged 15-24) who sell sex); Swaziland (HIV prevalence among female sex workers older than 18 years)
HIV prevalence MSM: Cameroon (HIV prevalence (%) among MSM aged 18-24 years); Swaziland (HIV prevalence among men who have sex with men older than 18 years)
HIV prevalence transgender: Jamaica (HIV prevalence among adolescent transgender aged 15-19 (%)

TABLE 1B: Country assessment adolescent key population HIV prevention behavior prevalence

	Condom use		HIV testing	
	Female sex workers	MSM	Female sex workers	MSM
Botswana	90% (aged 10-19)	84% (aged 10-19)	48% (aged 10-19)	61% (aged 10-19)
Cameroon	73% (aged 15-35)	55% (Douala) and 38% (Yaounde) (aged 18-24)	90% (aged 18-65)	89% (aged 18-65)
Jamaica	90% (aged 15+)	76% (aged 15-19)		
Swaziland	83% (aged 18+)	46% (aged 18+)		

= Poor coverage = Moderate coverage = Good coverage

Standard indicator definitions:
Condom use/ female sex workers: Percentage of adolescents who sell sex (aged 15- 19 years) using a condom at last sex
Condom use/ MSM: Percentage of gay and bisexual adolescent boys (aged 15-19 years) using a condom at last sex
HIV Testing/female sex workers: Percentage of adolescents who sell sex (aged 15-19) who received a HIV test in the past 12 months and know their results
HIV testing/ MSM: Percentage of young men who have sex with young men (aged 15-19) who received a HIV test in the past 12 months and know their results

Data Sources:
Condom use/ female sex workers: Botswana (2012 Mapping, Size Estimation & BBSS of HIV/STI among Select high risk sub-populations in Botswana); Cameroon (Rapport de l'enquete seroepidemiologique et comportementale sur le VIH et la syphilis chez les travailleurs de sexe au Cameroun, GVFI, 2010), P.31); Jamaica (National HIV/STI Programme, 2014); Swaziland (Baral, S et al. 2013).
Condom use/ MSM: Botswana (2012 Mapping, Size Estimation & BBSS of HIV/STI among Select high risk sub-populations in Botswana); Cameroon (Report of Integrated biological and behavioral surveillance (IBBS) among men who have sex with men (MSM) in Cameroon, 2012, P. 29); Jamaica (National HIV/STI Programme, 2014); Swaziland (Baral, S et al. 2013).
HIV Testing/female sex workers: Botswana (2012 Mapping, Size Estimation & BBSS of HIV/STI among Select high risk sub-populations in Botswana); Cameroon (Final report of HIV prevention for population at risk in Cameroon, 2013, P. 31); Jamaica (National HIV/STI Programme, 2014)
HIV testing/ MSM: Botswana (2012 Mapping, Size Estimation & BBSS of HIV/STI among Select high risk sub-populations in Botswana); Cameroon (Final report of HIV prevention for population at risk in Cameroon, 2013, P. 19); Jamaica (National HIV/STI Programme, 2014)

***Proxy Indicators Used:**
Condom use/ female sex workers: Cameroon (Percentage of FSW (aged 15 - 35) who used condom at last sex); Jamaica (Percentage of female sex workers 15+ years who sell sex reporting use of a condom at last sex); Swaziland (Reported use of condom with regular clients among female sex workers ages 18 and older)
Condom use/ MSM: Cameroon (Percentage of MSM (aged 18-24) who reporting condom use at last sex in Douala and Yaounde); Swaziland (Reported use of condom with casual sexual partners of men who have sex with men ages 18 and older).
HIV Testing/female sex workers: Botswana (Percentage of female sex workers who had been tested in the last 12 months); Cameroon (Percentage of FSW (aged 18 - 67) who received HIV test in the past 12 months and know their results)
HIV testing/ MSM: Botswana (Percentage of men who have sex with men who had been tested in the last 12 months); Cameroon (Percentage of MSM (aged 18 - 65) who received HIV test in the past 12 months and know their results).

3.1.5 Combination HIV prevention

Current coverage of selected HIV prevention interventions is compared with national targets in Table 3.

Condoms: Data on condom use was available for both sexes in Botswana, Cameroon and Jamaica, but only for boys in Swaziland and Zimbabwe. In Botswana, condom use was high and exceeded national targets for both sexes. In Cameroon and Jamaica, condom use was moderate, but higher in boys than in girls. Condom use fell short of national targets for both sexes in Cameroon, for girls in Jamaica and for boys in Swaziland and Zimbabwe.

PAIRED INDICATOR REVIEW: Condom coverage gaps and adolescent pregnancy
Adolescent pregnancy is a good indicator of condom use and unprotected sex.

KEY MESSAGES

- In all five countries, with the exception of condom coverage in boys (and girls in Botswana), coverage of different combination HIV prevention interventions fell below national targets.
- There were also multiple gaps in the data related to these interventions. No countries had data on drug use or harm reduction programmes; and there were multiple challenges with data on post-exposure prophylaxis (PEP), including lower coverage of PEP among boys.

TABLE 2: Five-country dashboard outputs for coverage of key HIV testing, treatment and care interventions among adolescents

Table of compiled data of coverage of Key HIV testing, care and treatment interventions among adolescents

	HIV testing coverage value	HIV testing coverage target	ART Coverage for ALHIV	ART Coverage for ALHIV target	Pregnant adolescents receiving ARVs for PMTCT	Pregnant adolescents receiving ARVs for PMTCT target	Viral suppression of ALHIV	Viral suppression of ALHIV target
Botswana	Girls 64% Boys 64%	83%	10-19 96% 10-14 90% 15-19 96%	85% 85% 85%	95%*	?	All 92%* Boys Girls	90%
Cameroon	All Girls 15% Boys 7%	32%	10-19 5-14 6% 15-19 13%					
Jamaica	Sexually active girls ages 15-19 years* 30% Adolescent boys* 18%	75%	15-19 31%	81%	98% (ages 15-19)*	95%	All 11% Girl 8% Boy 14%	73% 73% 73%
Swaziland	Girls 57% Boys 30%	65% 55%	10-19 52% 10-14 51% 14-19 51%					
Zimbabwe	SA girls (15-19) 58% SA boys (15-19) 35% All girls (15-19) 35% All boys (15-19) 24%	90%	10-19 51% 10-14 48% 15-19 54%	90%				

Indicator definitions:

HIV Testing: Percentage of adolescents (aged 15-19 years) who received an HIV test in the last 12 months and know their results

ART Coverage for ALHIV: Percentage of adolescents and young people (aged 15-19 years) living with HIV receiving antiretroviral therapy for treatment

Pregnant adolescents receiving ARVs for PMTCT: Percentage of pregnant or breastfeeding adolescents (aged 15-19) living with HIV who received anti-retroviral drugs (ARVs) for PMTCT

Viral suppression of ALHIV: Percentage of adolescents (aged 10-19 years) living with HIV on ART who are virologically suppressed (viral load (VL) below 1000 copies)

Data Sources:

HIV Testing: Botswana (BAIS IV, 2013); Cameroon (EDS-MICS IV 2011); Jamaica (National HIV/STI Programme, 2012); Swaziland (MICS 2010): Zimbabwe (MICS 2014)

ART Coverage for ALHIV: Botswana (Department of HIV & AIDS Prevention & Care; HIV/AIDS Information Management Division, M & E Unit, MoH, December 2014); Cameroon (Data Base NACC, 2014 & EPP-SPECTRUM, 2016); Jamaica (JAAPAIDS); Swaziland (ART Patient Management Information System, 2014); Zimbabwe (Numerator (DHIS, 2014): Actual number on ART; Denominator (Spectrum): All those living with HIV)

Pregnant adolescents receiving ARVs for PMTCT: Botswana (PMTCT Programme Update, April to June 2014); Jamaica (JAAPAIDS)

Viral suppression of ALHIV: Botswana (The Voice of the HIV Infected and Affected School age Children in Botswana. A cross-sectionanl psychology study among 10-19 year olds. 2011); Jamaica (JAAPAIDS)

***Proxies noted:**

HIV testing: Jamaica (Percentage of sexually active adolescents (aged 15-19) who were tested and received results in the last 12 months)

Pregnant adolescents receiving ARVs for PMTCT: Botswana (% of HIV positive pregnant women who received anti retroviral drugs during the past 12 months for PMTCT, by December 2014.); Jamaica (Percentage of pregnant adolescents 15-19 years living with HIV who received ARVs for PMTCT)

Viral suppression of ALHIV: Botswana (System used in Botswana has a cut-off of 400 copies. Data is based on a study that was conducted by Baylor among 10-19 year olds)

- Botswana defined adolescent pregnancy and condom coverage differently from other countries, as the percentage of adolescents who reported ever being pregnant, and condom use with non-regular partner. Botswana had a low rate of adolescent pregnancy (9 per cent) with little to no condom coverage gaps in males or females.
- The other countries used the standard definition for these indicators.[xiv] Jamaica had low rates of teenage pregnancy (9 per cent) with no condom coverage gaps in boys but moderate condom coverage gaps in girls (19 percentage points).
- Moderate rates of adolescent pregnancy in Swaziland (17 per cent) corresponded to relatively low gaps in condom coverage in boys (10 percentage points), but there was no data on condom coverage for girls.
- For countries with high rates of adolescent pregnancy, including Cameroon (25 per cent) and Zimbabwe (24 per cent), there were inconsistent links to condom coverage with relatively low condom coverage gaps in boys in Cameroon (10 percentage points), but high gaps in girls (28 percentage points). In Zimbabwe, there were moderate condom coverage gaps for boys (13 percentage points), with condom coverage data unavailable for girls.

Voluntary medical male circumcision (VMMC): Of countries with VMMC programmes for HIV prevention (Botswana, Swaziland and Zimbabwe), only Zimbabwe reported age-disaggregated data on VMMC coverage among adolescents. In all countries, adolescent coverage was substantially below targets.

Harmonized social cash transfers (HSCT): Only Botswana, Jamaica and Zimbabwe collected data on HSCT. While Botswana did not report a target for this indicator, HSCT coverage in the other two countries was below national targets.

Pre-exposure prophylaxis (PrEP): As expected given the very recent release of the global guidelines on PrEP, none of the five countries had national data on adolescent PrEP use.[xv] Botswana and Zimbabwe stressed the

xiv Standard indictor for pregnancy used in the assessment: Percentage of adolescent girls (aged 15-19 years) who have had a live birth or who are pregnant with their first child (began child bearing). Standard indictor for condom use in the assessment: Percentage of adolescents (aged 15-19 years) reporting multiple partners in the last 12 months who used a condom at last sex

xv Since the country rapid assessments, WHO released new guidelines on PREP, which can facilitate its scale-up. (WHO. Guideline on when to start antiretroviral therapy and pre-exposure prophylaxis for HIV. 2015. Accessed at http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565_eng.pdf?ua=1)

TABLE 3: Coverage of Key Combination HIV Prevention Interventions Among Adolescents in 5 countries

	Adolescent condom use				Adolescent male circumcision (15-19)		Ado-lescent PREP	Harmonized Social Cash transfers		Adolescent PEP Coverage				Harm reduction	
	Girls		Boys							Girls		Boys		Girls	Boys
	value	target	value	target	value	target	N/A	value	target	value	target	value	target		
Botswana	94%*	90%	93%*	90%	23%	55%	N/A	26%*	N/A	N/A				N/A	N/A
Cameroon	52%	80%	70%	80%	92%	100%	N/A	N/A	N/A	82%	80%	33%	80%	N/A	N/A
Jamaica	56%	75%	75%	75%	N/A	N/A	N/A	63%	80%	N/A	N/A	N/A	N/A	N/A	N/A
Swaziland	N/A	N/A	75%	80%	18%	70%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Zimbabwe	N/A	N/A	62%	75%	18% (10-14) and 15% (15-19)	80%	N/A	11%*	30%	62%*	80%	37%*	80%	N/A	N/A

Standard indicator definitions:
Adolescent condom use: Percentage of adolescents (aged 15-19 years) reporting multiple partners in the last 12 months who used a condom at last sex
Adolescent VMMC: Percentage of adolescent males (aged 10- 19 years) who are circumcised
Adolescent PReP: Percentage of eligible9 sexually active adolescents (aged 10-19 years) who self-report usage of pre-exposure prophylaxis
Harmonized Social Cash transfers: Percentage of poorest households receiving cash transfers in the last three months
Adolescent PEP Coverage: Percentage of adolescents eligible10 for post-exposure prophylaxis (PEP) for HIV who were provided PEP within 72 hours of sexual violence
Harm reduction: Percentage of adolescents (aged 15-19 years) who inject drugs reporting use of sterile injecting equipment the last time they injected

Data Sources:
Adolescent condom use: Botswana (BAIS IV, 2013); Cameroon (EDS-MICS IV 2011); Jamaica (PIOJ, 2012); Swaziland (Analysis of MICS 2010 for 2013 GARP Report); Zimbabwe (MICS, 2014)
Adolescent VMMC: Botswana (BAIS IV, 2013); Cameroon (EDS-MICS IV 2011); Jamaica (No info provided); Swaziland (MICS 2010); Zimbabwe (MICS, 2014)
Harmonized Social Cash transfers: Botswana (World Bank, 2013); Jamaica (PIOJ, 2012); Swaziland (SHAPMoS); Zimbabwe (No info on source provided).
Adolescent PEP Coverage: Cameroon (2014, Base de données CNLS); Jamaica (no information provided); Zimbabwe (DHIS, 2014)

***Proxy indicators used:**
Adolescent condom use: Botswana (Condom use with non-regular partner)
Harmonized Social Cash transfers: Botswana (Poorest households receiving any government assistance); Zimbabwe (Percentage of HH receiving cash transfer in targeted districts)
Adolescent PEP Coverage: Zimbabwe (Percentage of adolescents (aged 11 - 16) eligible for PEP that reported usage within 72 hours of sexual violence).

importance of developing national policy guidelines on PrEP delivery to adolescents for effective introduction of PrEP within their national AIDS programmes.

Harm reduction: None of the five countries had data sources for harm reduction among adolescents.

Post-exposure prophylaxis (PEP): Across the five countries, reporting on sexual violence is incomplete, and this affects data on PEP. Only Cameroon and Zimbabwe collected sex-disaggregated data on PEP coverage among adolescents. In Zimbabwe, data for this indicator were available for adolescents aged 11–16 and obtained through sexual abuse cases reported to a health facility within 72 hours. This data showed coverage below targets among boys and girls. In Cameroon, PEP coverage for girls exceeded the target, while PEP coverage for boys was below the target. PEP coverage was substantially lower for boys than girls in both countries, which is potentially linked to lower reporting of sexual abuse among boys. While Botswana has adopted guidelines for PEP, there were no data on PEP coverage because PEP is distributed through pharmacies – a different contact point from the point where sexual violence is reported, which is through the police. Discussions of these data in Botswana revealed that the country had no designated focal point to coordinate data on PEP among the different agencies involved in providing this service.

The overall findings related to combination HIV prevention underscore the need to establish and scale up quality combination HIV prevention interventions with gender-differentiated strategies to address gaps in coverage between girls and boys. Also needed are better-defined strategies to reach those at greatest risk of HIV infection. Strategies that incorporate the use of traditional and new media, community-based approaches, public-private partnerships and school platforms can strengthen delivery of prevention services, targeted programming and data collection and monitoring. Better and continued monitoring and analysis of the epidemic and of programme performance for adolescents aged 10–19 will enable countries to fill gaps in core programme intervention areas and achieve greater impact.

3.1.6 Social and programmatic enablers

Social and programme enablers assessed in adolescent populations include comprehensive, correct knowledge of HIV, access to media and health care decision-making. Coverage compared to country targets is shown in Table 4.

Comprehensive, correct knowledge of HIV: All five countries reported data on comprehensive, correct knowledge of HIV among adolescent girls and boys aged 15–19. Rates of comprehensive, correct knowledge of HIV were low in all countries, with slightly higher rates among girls in every country. In Botswana, the only country with data on both the 10–14 and 15–19 cohorts, there was greater HIV knowledge in the older group. Botswana, Cameroon, Swaziland and Zimbabwe had targets ranging from 70 to 80 per cent for this indicator; Jamaica's were substantially lower (see below).

KEY MESSAGES

- Coverage of HIV-related social and programmatic enablers of adolescents was poor in all the five countries.
- Rates of comprehensive, correct HIV knowledge were low in the rapid assessment countries, with slightly higher levels among girls than among boys.
- All countries but Jamaica were below national targets for adolescent access to media.
- Countries did not have data on mobile phone use and access to Internet, but noted that such data would be useful.
- Only Cameroon collected data on adolescent participation, and it showed extremely low levels of participation.

PAIRED INDICATOR REVIEW: HIV knowledge gaps and secondary school attendance

Secondary school attendance can enhance adolescents' HIV knowledge because it provides them with greater exposure over time to comprehensive information on HIV through school-based health and sexuality education programmes. In all five countries, there are connections between secondary school attendance and HIV knowledge gaps.

- Jamaica reported high secondary school attendance rates for both sexes (92 per cent in girls and 91 per cent in boys) and low gaps in HIV knowledge for both sexes compared with their targets (13 percentage point gap in girls and 9 percentage points in boys). However, it must be noted that national targets for HIV knowledge in Jamaica were low, and were different for boys and girls (the targets were 52 per cent for girls and 43 per cent for boys).
- In contrast, Cameroon reported low secondary school attendance in both sexes (37 per cent in girls and 42 per cent in boys) and significant HIV knowledge gaps for both sexes (54 percentage points in girls and 50 percentage points in boys).

TABLE 4: Coverage of HIV-related social and programmatic enablers of adolescents in five countries

	Comprehensive, correct knowledge of HIV among adolescents								Adolescents with access to media				Adol. health care decision making
	Girls 10-14		Boys 10-14		Girls 15-19		Boys 15-19		Girls 15-19		Boys 15-19		Both sexes
	value	target	value	target	value	target	value	target	value	target	value	target	value (no target)
Botswana	24%	80%	22%	80%	48%	80%	46%	80%					
Cameroon					26%	80%	30%	80%	66%	80%	77%	80%	8%
Jamaica					39%	52%	34%	43%	96%	80%	96%	80%	
Swaziland					52%	70%	50%	70%	26%	80%	27%	80%	
Zimbabwe					51%	80%	49%	80%	64%	80%	66%	80%	

Standard indicator definitions:
Comprehensive, correct knowledge among adolescents: Percentage of adolescent (aged 10- 19 years) who have comprehensive knowledge of HIV
Adolescents with access to media: Percentage of adolescents (aged 15-19 years) who, at least once a week, read a newspaper or magazine, listen to the radio, or watch television
Adolescent's health care decision making: Percentage of adolescents (aged 15-19 years) who usually make healthcare decisions for themselves

Data Sources:
Comprehensive, correct knowledge among adolescents: Botswana (BAIS IV, 2013), Cameroon (EDS-MICS IV 2011); Jamaica (National HIV/STI Programme, 2012), Swaziland (SDHS 2007); Zimbabwe (MICS, 2014)
Adolescents with access to media: Cameroon (EDS-MICS IV 2011); Jamaica (National HIV/STI Programme, 2012); Swaziland (SDHS 2007); Zimbabwe (MICS, 2014)
Adolescent's health care decision making: Cameroon (2014, Situation des jeunes et des adolescents en matière de santé de reproduction et de lutte contre les IST/VIH/SIDA au cameroun (MINSANTE, Janvier 2014); Swaziland (HIV Guidelines 2013)

***Proxy indicators used:**
Adolescent's health care decision making: Swaziland (Availability of policy statement reducing age of consent for HIV testing below 18 years) (no data provided)

- Zimbabwe reported moderate levels of secondary school attendance (60 per cent in girls and 51 per cent in boys) with corresponding moderate HIV knowledge gaps in girls and boys.
- Both Botswana and Swaziland used alternative definitions for net secondary school attendance that differed from the standard definition. In Botswana, secondary school enrollment was used as a proxy indicator and this was moderate in both sexes (52 per cent in girls and 48 per cent in boys). Swaziland reported net secondary school attendance among adolescents aged 10–14 and had moderate levels in girls (52 per cent) and low levels in boys (42 per cent).

Access to media: Cameroon, Jamaica, Swaziland and Zimbabwe had data on the percentage of adolescents with access to media (TV, radio and newspapers). In Jamaica, 96 per cent of girls and boys had access to media; the other three countries were below the 80 per cent target for this indicator. Swaziland had low rates of adolescent access to media (26 per cent for girls and 27 per cent for boys). Both Zimbabwe, at 64 per cent for girls and 66 per cent for boys, and Cameroon (66 per cent for girls and 77 per cent for boys) had moderate to high coverage for this indicator. With the exception of Jamaica, boys had more access to media than girls in the other countries with data. These rates of adolescent access to media are indicative of the potential outreach to adolescents that can be achieved by programmes using multi-media channels, mobile and the internet.

Internet and mobile phone use: Countries acknowledged the potential value of these media and engagement platforms. Feedback from adolescent focus group discussions in Botswana revealed that the two main sources of information for adolescents in Botswana are Internet-based media (e.g., Facebook) and radio. However, the assessment did not seek to capture data on use of these modalities.

Adolescent participation in decision-making: Only Cameroon included data on adolescent decision-making. Cameroon reported that 8 per cent of adolescents make healthcare decisions for themselves; the data, however, were not disaggregated by sex or age.

In Botswana and Jamaica, the working groups considered the potential use of age of consent as a proxy to measure the "percentage of adolescents that have a final say in their health care". However, given the multiple and at times contradictory legal provisions on age of consent in these countries, the assessment teams could not identify a clear, single value for the age of consent.

As a whole, data on social and programmatic enablers in the five countries highlighted challenges in adolescent participation in decision-making and in comprehensive, correct knowledge of HIV among adolescents. These data also highlight the need to enhance correct, comprehensive HIV knowledge through traditional and innovative forms of media and through schools.

3.1.7 Cross-sectoral programmes

KEY MESSAGES

- Data on sexual and reproductive adolescent health in the five countries revealed high rates of sexually transmitted infections (STIs) and teenage pregnancy. In Cameroon and Zimbabwe, there was low uptake of family planning services. In Botswana and Jamaica, there were disturbingly high rates of adolescent suicide attempts and alcohol use, although the data on suicide attempts came from smaller-scale surveys.
- These data underscore the need for integrated delivery of services for adolescents through a core package of services that best addresses adolescent needs in each country context. Also needed is a delivery approach that optimizes the reach offered through multiple platforms (schools, health facility platforms, community and media).

a. Adolescent sexual and reproductive health and other health issues

The rapid assessments attempted to document adolescents' health and well-being using data on sexual and reproductive health and other health issues among adolescents. However, there were numerous gaps in data for these indicators, and the exercise revealed a lack of standardized reporting for similar themes. This makes cross-country assessments of patterns in these data particularly challenging. These data and their gaps are summarized in Table 5. Annex 7.2 contains a brief summary of evidence associated with these cross-sectoral adolescent health and well-being indicators along with sources for further reading.

STIs: Countries used differing indicators and sources to report on STIs. However, all of them noted high rates of STIs. The most recent data on self-reported prevalence of STI in adolescents aged 15–19 showed 3 per cent each for both girls and boys in Cameroon, 3 per cent in girls and 4 per cent in boys in Swaziland and 9 per cent in girls and 8 per cent in boys in Zimbabwe. Botswana measured STI prevalence through the percentage of sexually active students aged 10–19 years who reported STI symptoms (29 per cent for girls and 25 per cent for boys), whereas Jamaica measured it through the percentage of adolescents aged 15–19 who have ever been told by a health care worker that they have an STI (5 per cent in girls and 6 per cent in boys).

Adolescent pregnancy: See 'Paired indicator review: condom coverage and adolescent pregnancy'.

Family planning: Only two countries, Cameroon and Zimbabwe, reported data for this indicator. Cameroon reported that 12 per cent of adolescents have access to any contraceptive methods. In Zimbabwe, recent data indicate that 66 per cent of sexually active adolescent girls aged 15–19 have their family planning needs met through modern methods.

Maternal health: To capture this outcome, some countries reported on the percentage of adolescents with a live birth attended by a skilled health provider (in Jamaica 85 per cent and in Swaziland 68 per cent). Other countries reported on the percentage of adolescents with a live birth who attended antenatal care at least four times: In Botswana this was 73 per cent and in Zimbabwe 63 per cent. Cameroon reported on the percentage of pregnant girls aged 15–19 who attended at least one ANC visit (18 per cent).

Anaemia: Only two countries reported on anaemia prevalence in adolescent girls aged 15–19: Cameroon (40 per cent) and Zimbabwe (26 per cent).

Mental health: Botswana and Jamaica were the only two countries with data on adolescent mental health. Although the data in both countries were from limited sample surveys and must be interpreted with caution, they both indicated disturbingly high rates of attempted suicide in the adolescent populations in their studies, which merits further examination. Data from a national youth risk behavioural survey that included all education sub-districts in Botswana found an attempted suicide rate of 35 per cent for both girls and boys aged 10–19 years. Data on attempted suicide among adolescents in Jamaica was covered in a national school health survey among adolescents aged 13–15. This survey found that 23 per cent of girls and 21 per cent of boys aged 13–15 had attempted suicide one or more times in the last 12 months.

Alcohol use: Three countries were able to report data on adolescent alcohol use. In Zimbabwe, 1 per cent of girls and 8 per cent boys aged 15–19 reported having at least one alcoholic drink in the last 30 days. In Botswana, this indicator was only available for adolescents aged 10–19 in school and it showed that 9 per cent of boys and 6 per cent of girls had at least one alcoholic drink in the last 30 days. In Jamaica, the national school health survey was limited to students aged 13–15; it found that 74 per cent of girls and 85 per cent of boys had ever had a drink of alcohol before age 14.

The data on sexual and reproductive health and other health issues among adolescents reveal numerous data gaps. They also underscore the need to establish,

TABLE 5: Coverage of sexual and reproductive health and other health issues among adolescents in five countries

	STI prevalence		Adolescent pregnancy	Maternal Health (ANC coverage 4+ visits)	FP covergae	Iron Folate	Malnutrition prevalence	Anemia	Adolescent TB prevalence		Mental health/ suicide			HPV vacc coverage in girls	Alcohol use	
	Girls	Boys							Girls	Boys	All	Girls	Boys		Girls	Boys
Botswana	29%*	25%*	9%	73%*					2%	2%	35%	35%	35%	98%	6%*	9%*
Cameroon	3%	3%	25%*	18%* (1 visit only)	12%		26%	40%								
Jamaica	5%*	6%*	9%	85%*				28%*			22%*	23%*	21%		74%*	85%*
Swaziland	3%	4%	17%	68%*		31%*										
Zimbabwe	9%	8%	24%	66%	66%			26%							1%	8%

Standard indicator definitions:
STI prevalence: Self-reported prevalence of STIs and/or symptoms of an STI in the last 12 months among adolescents (aged 15–19 years) who ever had sexual intercourse
Adolescent pregnancy: Percentage of adolescent girls (aged 15-19 years) who have had a live birth or who are pregnant with their first child (began child bearing)
Maternal health: Percentage of adolescents (aged 15-19 years) with a live birth in the last two years who attended antenatal care (ANC) with any provider during their last pregnancy at least four times; or percentage of live births to adolescent girls aged 15-19 years attended by a skilled health provider (doctor, nurse, midwife or auxiliary midwife) in the last two years
FP coverage: Percentage of adolescents (aged 15-19 years) who are sexually active who have their need for family planning satisfied with modern methods
Iron Folate: N/A
Malnutrition prevalence: N/A
Anemia: Percentage of adolescent girls (aged 15-19 years) with anemia
Adol TB Prev: Prevalence of tuberculosis (TB) among adolescents (aged 10-19 years)
Mental health: Prevalence of suicide attempts among adolescents (aged 10-19) in the past 12 months14
HPV vacc coverage in girls: Percentage of 10-15 year old adolescent girls who have received the full dose15 of the human papilloma virus (HPV) vaccine
Alcohol consumption: Proportion of adolescents (aged 15-19 years) who had at least one alcoholic drink at any time during the last one month

Data Sources:
STI prevalence: Botswana (First Botswana Youth Risk Behavioural Surueillance Survey, November 2012); Cameroon (2011, EDS-MICS IV); Jamaica (National HIV/STI Programme, 2012); Swaziland (SDHS 2007); Zimbabwe (ZDHS, 2010-11).
Adolescent pregnancy: Botswana (First Botswana Youth Risk Behavioural Surueillance Survey, November 2012); Cameroon (2011, EDS-MICS IV); Jamaica (MICS, 2011); Swaziland (MICS 2010); Zimbabwe (MICS, 2014)
Maternal health: Botswana (Botswana Family Health Survey (2007)); Cameroon (Sentinel Surveillance Report, 2012); Jamaica (no info provided); Swaziland (MICS 2010); Zimbabwe (MICS, 2014).
FP coverage: Botswana (Botswana Family Health Survey (2007); Cameroon (2011, EDS-MICS IV)
Iron Folate:) Swaziland (SDHS 2007).
Malnutrition prevalence: Cameroon (2011, EDS-MICS IV); Zimbabwe (ZDHS, 2010-11).
Anemia: Cameroon (2011, EDS-MICS IV); Jamaica (No info provided); Zimbabwe (ZDHS, 2010-11)
Adol TB Prev: Botswana (BAIS IV, 2013)
Mental health: Botswana (First Botswana Youth Risk Behavioural Surueillance Survey, November 2012); Jamaica (NCDA, 2010)
HPV vacc coverage in girls: Botswana (no source provided)
Alcohol consumption: Botswana (First Botswana Youth Risk Behavioural Surueillance Survey, November 2012); Jamaica (2010); Zimbabwe (MICS, 2014)

***Proxy indicators used:**
STI prevalence: Botswana (Percentage of sexually active students who reported STI symptoms).
Adolescent pregnancy: Botswana (Percentage who reported ever being pregnant or pregnant)
Maternal health: Botswana (attended more than four times); Cameroon (Percentage of pregnant girls (aged 15-19) that attended at least one ANC visit); Jamaica (Percentage of adolescent girls (under 20 yrs) with a live birth in the last 2 years who attended ANC during their last pregnancy at least four times by any provider, most recent data); Swaziland (Percentage of adolescent girls (aged 15-19) with a live birth in the last 2 years who attended ANC during their last pregnancy at least four times by any provider, most recent data available)
FP coverage: None
Iron Folate: Swaziland (Mean BMI)
Malnutrition prevalence:
Anemia: Jamaica (Percentage of ANC clinic attendees aged 15-19 who are anaemic)
Adol TB Prev:
Mental health: Jamaica (Percentage of students aged 13-15 years who actually attempted suicide one or more times in the last 12 months)
HPV vacc coverage in girls: None
Alcohol consumption: Botswana (Percentage of students 10-19 who have had at least one alcoholic drink in the last 30 days); Jamaica (Percentage of students aged 13-15 who had ever had a drink of alcohol for whom their first drink was before age 14)

strengthen and scale up integrated age- and context-specific sexual and reproductive health services and increase demand for these programmes among adolescents, families and communities. The data also point to the need to establish or strengthen data collection for these programmes to better feed into the design of programmes and services.

STI detection and treatment should be a core part of integrated health programmes and HIV prevention efforts for adolescents.[25] Adolescent pregnancy data point to the need for interventions to empower adolescent girls and address the needs of those who are at high risk of early marriage and pregnancy. The data also suggest that more must be done to scale up access to oral and barrier contraceptive methods.

Among the more striking data in this review are those on mental health and alcohol use. These data strongly suggest the need for further investment in more

systematic assessment, monitoring and preparedness to respond to both mental health issues and alcohol abuse in adolescents.

STI, contraceptive and family planning services and ANC and PMTCT services all offer strategic access to girls at high risk for HIV infection, STIs, unplanned or unwanted pregnancy and sexual violence and exploitation, including child marriage. These girls may be otherwise hard to find in the community due to their age or because of the presence of stigma and secrecy around sexual exploitation and violence. The sexual and reproductive health service platforms are therefore a unique opportunity to reach, retain and provide these girls with a comprehensive package of support that addresses more than the immediate service for which they present. Definition of such a core package for vulnerable girls, its standardization across platforms and providers and the clarification of protocols for its management and delivery will improve quality of care, support and outcomes in adolescents.

3.1.8 Child protection, gender-based violence, social protection, education and life skills

The rapid assessments explored country progress in relation to selected measurable social norms (child marriage and gender-based violence), education and social protection – all areas that influence adolescent health, well-being and HIV risk (Figure 14). Annex 7.1 contains a brief summary of evidence associated with these sectors as well as sources for further reading.

PAIRED INDICATOR REVIEW: Child marriage and gender-based violence

Analysis of data on child marriage and sexual violence can offer potential insight into family and community factors that affect adolescent HIV risk. The links between child marriage, violence, early pregnancy and HIV risk[26] are documented in the literature (see Annex 7 for further reading). Zimbabwe, which uses an alternative definition of child marriage (percentage of adolescent girls (15–19) who are currently married or in union), had a high prevalence of child marriage (25 per cent).[xvi] Among the other countries, which use the standard definition (percentage of young women aged 20–24 who were first married or in a union before age 18) there was a high prevalence of child marriage in Cameroon (38 per cent) and low prevalence in Jamaica (8 per cent), Botswana (1 per cent) and Swaziland (4 per cent).

The assessment proposed an indicator on intimate partner violence as proxy measure for gender-based violence in adolescents.[xvii] All countries chose to use alternative measures. Cameroon, Jamaica and Swaziland defined gender-based violence as the percentage of adolescents aged 15–19 who have ever experienced sexual violence. All three countries had high levels of sexual violence, notably Cameroon (22 per cent in girls, 26 per cent in boys), which also has high levels of child marriage.

Like Cameroon, Zimbabwe also had high levels of gender-based violence (41 per cent in girls and 39 per cent in boys) as well as a high prevalence of child marriage. Zimbabwe, however, used a broader age range and definition of violence in its measure of gender-based violence (percentage of adolescents aged 13–17 who have ever experienced physical and/or sexual violence). Where child marriage was high, gender-based violence was also high, illustrating the importance of efforts to strengthen the protective environment for children and the importance of engaging families and communities in changing the social norms that enable gender-based violence. Investment in these efforts creates important synergies for HIV prevention outcomes linked to the direct and indirect risk of infection associated with child marriage and gender-based violence.

Adolescents whose households received external economic support: Social protection programmes, including measures to provide vulnerable households with economic support, increase access to essential social service (e.g., health, education, nutrition) and decrease HIV vulnerability and risk behaviors.[27,28]

KEY MESSAGES

- High rates of child marriage were reported in Cameroon and Zimbabwe.
- High levels of sexual violence in relation to girls and boys were reported in all five countries.
- Given the links between child marriage and HIV risk as well as between and sexual violence and HIV risk, these findings point to areas that require urgent action.
- School attendance was moderate to high in all five countries. This provides an opportunity to reach adolescents and complement school and education-sector programmes with initiatives that empower, build social networks, engage adolescents in social change and build health-seeking behaviour.
- The proportion of schools with teachers trained to deliver life-skills-based and comprehensive sexuality education was extremely low in all countries.

xvi Other countries used the standard indicator: Percentage of young women aged 20–24 who were first married or in a union before age 18

xvii Proposed assessment indicator on gender-based violence: Percentage of adolescent girls aged 10-19 who experienced physical or sexual violence from a male intimate partner in the past 12 months

An increasing number of countries are investing in strengthening social protection programmes. However, there are still variations within and among countries in how they monitor and report on the coverage and quality of these programmes. None of the countries were able to report national data specifically on adolescents (10 – 19) whose households received external economic support. Botswana did have recent data showing that 14 per cent of households with orphans and vulnerable children aged below 18 years live in households that received external economic support.

Secondary-school attendance: This has been discussed previously. See "Social and Programmatic Enablers" for discussion on HIV knowledge and secondary education.

Life skills-based education: Only two countries, Swaziland and Zimbabwe, reported on data related to implementation of life skills-based education curricula and each used different, alternative indicators to assess this. Swaziland reported that 3 per cent of secondary schools currently implement comprehensive life skills education. Zimbabwe reported that only 1 per cent of teachers had been trained (in-service & pre-service) in the previous academic year to deliver a quality comprehensive sexuality education curriculum. Although no specific programme data were reported on teacher training or coverage in schools, in Jamaica there is a comprehensive national Health and Family Life Education Programme that schools are mandated to provide to all students in grades 1 through 9. The assessment team there credited this programme for the high levels of knowledge and condom use reported in the assessment, particularly among adolescent key populations.

Data on child protection, gender-based violence, social protection, education and life skills from the five countries reveal challenges in the adolescent HIV response related to social norms, child and social protection systems and monitoring. They also point to opportunities for response. Two countries (Cameroon and Zimbabwe) reported high levels of child marriage and in both of these countries a large proportion of adolescents reported that they had experienced sexual violence. Education and empowerment of children and adolescents as well as community engagement are key to mobilizing collective action to challenge and change social beliefs that maintain the practices of child marriage and gender-based violence. Opportunities to act on this exist through the moderate-to-high secondary school attendance rates and in programmes in place in multiple sectors that reach out to and engage communities and adolescents themselves. Both countries also have provisions in law that aim to create and protect an enabling environment in which girls can thrive in society.[29,30]

BOX 5

Summary of qualitative feedback from assessments of country enabling environments

1. National situation analysis
There is limited data on adolescents within existing situation analyses, especially with respect to age-, location- and sex-disaggregated data and data on adolescent key populations. This limits the capacity of these analyses to serve as instruments for decision-making and to guide effective national prioritization and planning for adolescents. Gaps in data on adolescents are evident in the analysis of selected indicators, e.g., lack of data on condom coverage gaps in girls, sex-disaggregated data on ART coverage gaps, and data on the prevalence of sexual violence towards boys.

2. National policies, strategies or plans of action
There are conflicting positions and understandings of policies that affect adolescents, particularly policies dealing with the age of consent for HIV service delivery.

3. Coordination mechanisms
Adolescent coordination mechanisms are not well-defined and lack strong linkages to other coordination mechanisms. As a result, adolescent programming is fragmented and weak.

4. Consultative processes
Ministries of Health and National HIV/STI Programmes are the established coordination mechanisms for adolescent HIV responses in most countries. They bring together multiple sectors and development partners to support the response. The coordination of action for broader adolescent health and development beyond HIV is less well defined. Government departments often work in silos and are not necessarily familiar with broader adolescent issues.

5. Legislation
Laws that criminalize key populations prevent access to critical services, perpetuate discrimination and violate fundamental rights. At the same time, laws that enforce age of consent in relation to HIV services, particularly for adolescents aged 10–14, also hinder timely access to these services. Such laws could play a role in the high coverage gaps for HIV testing and ART observed in Table 5.

6. Adolescent participation
National coordination mechanisms and development processes have limited adolescent participation, particularly for adolescents living with HIV and from key populations. Greater efforts are necessary to enhance the continuity, quality and diversity of adolescent representation and participation in coordination mechanisms. There is a need for more adolescent- and youth-driven advocacy on key policy and legal issues affecting adolescents and youth.

7. Resources allocation and mobilization
Resource mobilization efforts have neglected adolescent-specific issues. It is critical to strengthen and better target investments in adolescent-focused HIV, health and social interventions. It is crucial to optimize synergies with current programmes and funds targeting adolescents and youth, through joint review and planning.

8. Monitoring and evaluation
Data and evidence gaps limit perspective on programme needs and equity gaps affecting adolescents.

TABLE 5: Enabling environment assessment scores and select HIV and cross-sectoral indicators[λ◇]

	Average enabling environment score	Sex	Select HIV-related intervention progress gaps												Prevalence of select enabling environment social phenomena			
			HIV testing coverage gap			ART coverage gap			Condom coverage gap			HIV knowledge gap			Pregnancy	Child Marriage	Gender-based violence	Net secondary school attendance
			Gap	Current	Target	Gap	Current	Target	Gap	Current	Target	Gap	Current	Target				
			Ages 15-19												Age groups vary			
Botswana	5.2	F	20%	63%	83%	0%	96%	85%	0%	94%	90%	32%	48%	80%	9%	6%	17%	52%
		M	19%	64%	83%				0%	93%	90%	34%	46%	80%			10%	48%
Cameroon	4.5	F	17%	15%	32%	47%	13%	60%	28%	52%	80%	54%	26%	80%	25%	38%	22%	37%
		M	25%	7%	32%				10%	70%	80%	50%	30%	80%			26%	42%
Jamaica	2.7	F	45%	30%	75%	50%	31%	81%	19%	56%	75%	13%	39%	52%	9%	8%	21%	92%
		M	57%	18%	75%				0%	75%	75%	9%	34%	43%			5%	91%
Swaziland	N/A	F	8%	57%	65%	39%	51%	90%	N/A			18%	52%	70%	17%	4%	33%	52%
		M	25%	30%	55%				5%	75%	80%	20%	50%	70%			N/A	42%
Zimbabwe	6	F	55%	34%	90%	36%	54%	90%	N/A			29%	51%	80%	24%	25% (no target)	41% (no target)	60%
		M	66%	24%	90%				13%	62%	75%	31%	49%	80%			39% (no target)	51%

Legend	Poor coverage/progress (high gaps)	Moderate (medium gaps)	Good (low gaps)	Low national target
HIV testing, ART, condom and HIV knowledge gaps	coverage gap >35%	coverage gap between 11%-35%	coverage gap <10%	Target less 65%
Prevalence of pregnancy and child marriage	prevalence >20%	prevalence 11-20%	prevalence 1-10%	
Sexual violence	prevalence >1%	N/A	prevalence 0%	
Secondary school attendance	<45%	46-70%	>80%	

Note: The coverage gap and prevalence values in Figure 4 are color-coded using subjective interpretation of the severity of the gap or social phenomena. As shown in the legend above, red indicates poor coverage or progress, orange indicates moderate coverage or progress, green indicates good coverage or progress and yellow denotes where targets are low. Coverage gaps represent the percentage point difference between the actual coverage values and current targets for each country. For example, the HIV testing coverage gap for females for Botswana is 20 percentage points. This is the difference between the actual coverage value (63 per cent) and the target coverage value (83 per cent) for this indicator.
λ Sex-disaggregated data are presented the data is presented where available.
◇National AIDS Strategies and their timing upon which gaps toward HIV-intervention targets were measured include: Cameroon: (NO RESPONSE RECEIVED TO REQUEST FOR THIS INFORMATION); Botswana: Revised Second Botswana National Strategic Framework for HIV and AIDS 2010 – 2017 Note: Targets in Botswana were not aligned to global targets); Jamaica: (NO RESPONSE RECEIVED TO REQUEST FOR THIS INFORMATION); Swaziland: Extended National HIV/AIDS Framework (E-NSF) 2014-2018 and Zimbabwe: National HIV/AIDS Strategy 2015 to 2018; Zimbabwe: (NO RESPONSE RECEIVED TO REQUEST FOR THIS INFORMATION) (Zimbabwe's performance was measured toward global HIV targets.

Standard indicator definitions:
HIV Testing: Percentage of adolescents (aged 15-19 years) who received an HIV test in the last 12 months and know their results
ART Coverage for ALHIV: Percentage of adolescents and young people (aged 15-19 years) living with HIV receiving antiretroviral therapy for treatment
Adolescent condom use: Percentage of adolescents (aged 15-19 years) reporting multiple partners in the last 12 months who used a condom at last sex
Comprehensive, correct knowledge of HIV among adolescents: Percentage of adolescent (aged 10- 19 years) who have comprehensive knowledge of HIV
Adolescent pregnancy: Percentage of adolescent girls (aged 15-19 years) who have had a live birth or who are pregnant with their first child (began child bearing)
Child marriage: Percentage of young women aged 20-24 years who were first married or in a union before age 18
Gender-based violence: Percentage of adolescent girls aged 10-19 who experienced physical or sexual violence from a male intimate partner16 in the past 12 months
Net Secondary school attendance: Secondary school **net attendance ratio:** (net secondary school attendance of secondary school age children currently attending secondary school or higher)

Data Sources:
HIV Testing: Botswana (BAIS IV, 2013); Cameroon (EDS-MICS IV 2011); Jamaica (National HIV/STI Programme, 2012); Swaziland (MICS 2010); Zimbabwe (2014 MICS)
ART Coverage for ALHIV: Botswana (Department of HIV & AIDS Prevention & Care; HIV/AIDS Information Management Division, M & E Unit, MoH, December 2014); Cameroon (Data Base NACC, 2014 & EPP-SPECTRUM, 2016); Jamaica (JAAPAIDS); Swaziland (ART Patient Management Information System, 2014); Zimbabwe (Numerator (DHIS, 2014): Actual number on ART; Denominator (Spectrum): All those living with HIV)
Adolescent condom use: Botswana (BAIS IV, 2013); Cameroon (EDS-MICS IV 2011); Jamaica (PIOJ, 2012); Swaziland (Analysis of MICS 2010 for 2013 GARP Report); Zimbabwe (MICS, 2014).
Comprehensive, correct knowledge of HIV among adolescents: Botswana (BAIS IV, 2013); Cameroon (EDS-MICS IV 2011); Jamaica ((National HIV/STI Programme, 2012): Swaziland (SDHS 2007); Zimbabwe (MICS, 2014).
Adolescent pregnancy: Botswana (First Botswana Youth Risk Behavioural Surueillance Survey, November 2012); Cameroon (2011, EDS-MICS IV); Jamaica (MICS, 2011); Swaziland (MICS 2010); Zimbabwe (MICS, 2014)
Child marriage: Botswana (Census, 2011); Cameroon (2011, EDS-MICS IV); Jamaica (National HIV/STI Programme, 2012); Swaziland (2010, MICS); Zimbabwe (MICS, 2014)
Gender-based violence: Botswana (First Botswana Youth Risk Behavioural Surueillance Survey, November 2012); Cameroon (2011, EDS-MICS IV); Jamaica (National HIV/STI Programme, 2012); Swaziland (2007, UNICEF Violence Against Children Report); Zimbabwe (NBSLEA, 2011).
Net Secondary school attendance: Botswana (Secondary Education Statistics Brief - 2012, Statistics Botswana); Cameroon (Rapport d'analyse des donnees statisticques du MINESEC 2012/2013); Jamaica (MICS 2011); Swaziland (MICS 2010); Zimbabwe (MICS, 2014).

***Proxy Indicators Used:**
HIV Testing: Jamaica (Percentage of sexually active adolescents (aged 15-19) who were tested and received results in the last 12 months)
ART Coverage for ALHIV: Cameroon (Ages 5 – 14 (this was noted as an adapted indicators in excel, but not sure what it means)
Adolescent condom use: Botswana (Condom use with non-regular partner)
Adolescent pregnancy: Botswana (Percentage who reported ever being pregnant or pregnant)
Child marriage: Zimbabwe (Percentage of adolescent girls (15-19) who are currently married or in union)
Gender-based violence: Botswana (Percentage of sexually experienced students who were raped the first time they had sexual intercourse); Cameroon, Jamaica and Swaziland (Percentage of adolescents (aged 15-19) who have ever experienced sexual violence, most recent data available); Zimbabwe (Percentage of adolescents (13-17) who have ever experienced physical and / or sexual violence)
Net Secondary school attendance: Botswana (Secondary school enrollment) and Swaziland (Net secondary school attendance among adolescents (aged 10-14), most recent data available)

3.2 Adolescents and youth during the rapid assessment

All country assessments used various methods to engage adolescents and youth from different populations. These included interactive and participatory consultations, meetings and workshops. In each country, different stakeholders took the lead in organizing and mobilizing adolescents and youth.[xviii] These fora featured discussion of issues and review of data and policies that affect adolescents and youth in language that they could understand; they did this through interactive presentations, completion of simplified tools, focus group discussions and drama. The various forums also collected qualitative feedback and perspectives from adolescents and youth on their access to services, their inclusion in decision-making and their recommendations moving forward.

In each country, adolescent and youth representatives provided feedback from the fora, along with their testimonies, at meetings of the rapid assessment national technical working groups. Consistent themes emerged. In multiple countries there was emphasis on limited or non-existent adolescent and youth participation in the decision-making, planning and implementation processes associated with adolescent and HIV and other health programmes that affect them. Adolescent and youth in multiple countries also reported limited access to adolescent- and youth-friendly HIV and sexual and reproductive services. Other themes that emerged from individual countries included concerns about adolescent health-seeking and HIV-risk behaviors, absence of adult role models, lack of data on younger adolescents, confusion and non-enforcement of protective laws and policies and policies around age of consent and poor parent-adolescent communication on sexual and reproductive health information. Adolescents were also concerned about sexuality and discrimination which, along with shame and stigma perpetuated by some healthcare providers, prevented uptake of HIV testing and counselling and ART.

Recommendations coming from adolescent and youth engagement forums in the different countries were often similar. They centred on ensuring the creation of more accessible and adolescent- and youth-friendly HIV and SRH services; strengthening meaningful adolescent and youth engagement in existing HIV platforms and policy processes; and educating, empowering and strengthening the capacity of vulnerable populations via networks of adolescent girls and adolescent key populations. Recommendations that were unique to individual countries included recommending use of more innovative ways to communicate and engage adolescents on key issues, and advocating for inclusion of adolescents aged 10–14 in the next DHS and in other reliable sources of data. They also included such recommendations as involving families, communities, dancehall artists and media personnel in efforts to strengthen HIV prevention, treatment and care; and addressing family attitudes and norms, poverty and teenage pregnancy as key factors behind child marriage.

3.3 Country opportunities, innovations and priorities based on rapid assessment results

Due to the rapid assessment process, countries have identified opportunities to advance the focus on adolescents, innovative ways to enhance adolescent participation and priorities for addressing the adolescent HIV epidemic.

3.3.1 Opportunities to advance focus on adolescents

Four core opportunities were identified in the majority of the rapid assessment countries:

1. Fostering political will to ensure continued prioritization of adolescents and to meet commitments;
2. Using findings from assessments to inform and influence laws, policies and guidelines;
3. Strengthening national M&E systems and data on adolescents; and
4. Strengthening adolescent programming and response through improved coordination and innovative partnerships.

3.3.2 Innovative ways to enhance adolescent participation

Country teams recommended the following approaches to enhance adolescent engagement:

- Complement the use of traditional media sources with the use of mobile and Internet technology to improve communication and engagement and to improve programme quality;
- Create space and support for engaging adolescents and define active roles for them related to programme planning, monitoring, communication and service delivery;

xviii Organizations that mobilized, coordination and supported the participation of adolescents and youth in the rapid assessments included: UNICEF, NACA, the Ministries of Health, Education, and Local Government and four youth organizations, including BOFWA, Young 1ove, YOHO and Baylor (Botswana); The Ministry of Youth and Civic Education and youth networks and civil society (Cameroon), civil society and youth advocacy networks (Jamaica); Organizations working with young people, including the Family Life Association of Swaziland, the Baylor Teens Club and the National Youth Organization (Swaziland); and The National Young People's Network on Sexual Reproductive Health and HIV (NYPNSRHH) (Zimbabwe).

- Harness the full potential of the education sector to complement opportunities for learning with initiatives to mobilize and drive social change; and
- Strengthen the capacities of family and community networks to engage and support positive adolescent outcomes.

3.3.3 Priority populations, interventions and geographic locations

At the end of the rapid assessment, Botswana, Cameroon, Jamaica and Swaziland identified priorities for in-depth exploration for the Phase 2 assessment with agreements on WHO (which populations), WHAT (which interventions) and on how to determine WHERE (geographic locations). These priorities are summarized in Box 6.

BOX 6

Summary of priorities at end of rapid assessments for Botswana, Cameroon, Jamaica and Swaziland

Botswana

Who: Priority populations include adolescent girls and young women, adolescents living with HIV and adolescents who are vulnerable, including adolescent key populations (MSM and sexually exploited adolescents selling sex), adolescent mothers, adolescents engaged in transactional sex, adolescents living with disabilities and adolescents out of school.

What: Priority interventions include:

- HIV testing and counselling
- Antiretroviral treatment
- Condom use among sexually active adolescents
- Comprehensive sexuality education – both in and out of school
- Prevention of adolescent pregnancy
- Prevention of gender-based violence
- Medical male circumcision
- Substance abuse prevention and response

Where: Four to six districts were identified as focus geographic areas.

Cameroon

Who: Priority populations include adolescent girls, adolescents living with HIV and adolescents who are vulnerable, including adolescent key populations (MSM and sexually exploited adolescents selling sex), adolescents living with disabilities, adolescents and young people in prison, adolescents living in the street, and infected/affected orphans and vulnerable children).

What: Priority interventions include:

- HIV testing and counselling
- Antiretroviral treatment
- Condom programming
- Comprehensive knowledge and sexuality education
- Simplified models for adolescent sexual and reproductive health (ASRH) including expansion of school-based ASRH
- Protection and legislation

Where: Six subregions were identified as focus geographic areas

Jamaica

Who: Priority populations include adolescents living with HIV, sexually active adolescent girls and boys and adolescents who are vulnerable, including adolescent key populations (adolescent MSM, bisexual adolescent boys, transgender adolescents and sexually exploited adolescents selling sex).

What: Priority interventions include:

- HIV testing and counselling,
- Antiretroviral treatment,
- Condom programming among sexually active adolescents and key populations
- Community and family-based psychological support

Where: The discussion about where is ongoing.

Swaziland

Who: Priority populations include adolescent girls and young women, adolescents living with HIV, children affected by AIDS and orphans and vulnerable children.

What: Priority interventions include:

- HIV testing and counselling,
- Antiretroviral treatment,
- Condom use among sexually active adolescents,
- Comprehensive sexuality education,
- VMMC
- Economic strengthening for vulnerable households

Where: Geographic locations for subnational assessment of bottlenecks to be focused on areas to complement PEPFAR DREAMS and Global Fund projects for adolescents and youth.

3.4 Key lessons learned about the rapid assessment process

Analysis of global and country-level stakeholder interviews and country rapid assessment reports revealed eight key lessons about the assessment process.

3.4.1 Early engagement and preparation with countries

Adequate time in countries is necessary to cultivate understanding about ALL IN, connect it to ongoing country, regional and global processes and enlist the participation of key partners in the national rapid assessment. The earlier assessments, such as the pilot assessment in Swaziland, did not have adequate advance preparation in terms of data collection, communication and engagement with a variety of stakeholders. In all five countries, the quality of in-country preparation and engagement also depended on the strength of the in-country coordination mechanism on adolescents and on the consultants hired by different countries to support the process.

Data collection, analysis, discussion and consensus can take longer than originally planned and should happen in advance of the country support mission and prior to broad stakeholder engagement. It is important to factor the release date of global HIV data estimates into decisions on timing a national rapid assessment to avoid extra work.[xix]

3.4.2 Multi-sector and donor participation

The rapid assessments were participatory processes that re-engaged a range of stakeholders from various sectors involved in adolescent programming to take stock of programme progress, challenges and opportunities. Through their cross-sectoral review of data and solutions, the assessments have helped strengthen coordination and multi-sectoral engagement within national technical working groups on adolescents.

The rapid assessment process presents an opportunity to mobilize a broad multi-sectoral range of stakeholders, including donors. Donors such as PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria participated in some of the rapid assessments, enabling the country team to identify potential synergies. As a result, the Global Fund, for example, made funding decisions following assessments in Jamaica and Swaziland. In Zimbabwe, the findings were incorporated into the concept note for special incentive funding from the Global Fund.

xix The timing of the annual release of new global estimates was a challenge for the rapid assessment exercises. In this first experience, the revised annual estimates were released after the countries had concluded their rapid assessments, and there was unclear guidance on interpreting the broad assessment findings and priority actions in light of the new estimates. Some countries proceeded to re-enter and re-analyse the data, which took significant amounts of additional time.

SPOTLIGHT ON BOTSWANA – Discussion of bottlenecks for the Phase 2 assessment

In Botswana, the stakeholder meeting engaged implementing partners with programme knowledge and experience in a discussion of priority subnational areas for Phase 2 (in-depth analysis). They also spoke about potential bottlenecks. Working groups filled out prioritization matrices for each intervention to identify target populations and priority districts. Criteria used to select priority geographic areas included:

- High burden of HIV,
- Small but defined locations that allow for easy measurement of indicators,
- Areas with programme implementation capacity,
- Geographic spread and location diversity (e.g., rural and urban) and presence of key affected populations, and
- Availability of data for priority interventions.

Based on their programme experience, implementing partners discussed bottlenecks to each intervention using a framework that examined four determinants of coverage including the enabling environment, supply and demand factors and quality of services. Delivery and uptake of the selected interventions will be analysed in four to six priority districts in Phase 2 of the assessment to provide more detailed insight into the bottlenecks affecting intervention delivery and impact of these interventions on adolescents.

3.4.3 The important role of champions

Champions in the form of high-level representatives of government (mostly ministries of health and national coordinating authorities) and the UN played an instrumental role in securing political support and effective participation in the assessment exercises.

In Botswana, The National AIDS Coordinating Agency (NACA) was the key champion. In Jamaica, the National HIV/STI Programme convened stakeholders and led the process. In Swaziland, the National Emergency Response Council on HIV and AIDS (NERCHA) served as a champion in the process of mobilizing government ministries. In Zimbabwe, the ministry of health championed and led the effort. In all countries, UNICEF and UNAIDS teams provided strong support to these in-country champions, mobilizing the UN family and other donors and helping assessment efforts link to other ongoing initiatives.

3.4.4 Adolescent engagement

Adolescents and young people played a prominent role in the rapid assessments by helping to convey the issues through their powerful testimonies. They provided perspective on their needs and challenges and engaged in and informed decision-making. Yet there are outstanding questions about how to optimally engage adolescents and young people, including questions on how to ensure representation that reflects the diversity of adolescents, and how to sustain their involvement. Some adolescents from key populations, including adolescents who inject drugs and sexually exploited adolescents who sell sex, were not represented in the national stakeholder discussions. Taboos and social norms, as well as legislation that criminalizes same-sex behaviour, sex work and drug use made it difficult to engage openly with these populations.

It is important to strengthen the capacities of assessment teams to engage adolescents effectively. Some key actions to enhance adolescent and youth engagement include: provide more dedicated time and support to orient adolescents and youth to the issues, concepts and methodologies; translate the assessment content to make it more accessible to them; and enlist the participation of a broader representation of adolescents and young people, including adolescent girls and adolescents from key populations. These approaches can help ensure that crucial perspectives are incorporated.

3.4.5 Gaps in data on adolescents

There were a number of common data-related challenges that emerged in the ALL IN country assessments. These included substantial data gaps, lack of age- and sex-disaggregated data for adolescents, multiple conflicting data sources and various issues with data related to key adolescent populations. For the most part, age disaggregation is not routinely required in national reporting. As is the case in the most popular population-based surveys (e.g., DHS), most survey-based information reviewed for the assessments was not typically available for adolescents aged 10–14 years; where it was collected, sample sizes in this age group were too small to give any meaningful coverage value.

SPOTLIGHT ON CAMEROON – Rapid assessment integrated into Cameroon's national action plan to strengthen the adolescent HIV response

In Cameroon, the UNICEF regional team initiated political engagement for the ALL IN agenda with a number of government line ministries, UN agencies and implementing partners weeks in advance of the rapid assessment. These efforts enlisted support for the ALL IN agenda and led to the development of a national action plan to strengthen the response to HIV among adolescents.

The rapid assessment and the subsequent use of its findings were included as components of this plan. The political engagement resulted in the establishment of a truly cross-sectoral coordination team led by the Ministry of Youth in collaboration with the Ministry of Health and the National AIDS Commission. The involvement of the Ministry of Youth, which has a coordination mandate for adolescents and young people, facilitated access to data and fostered multi-sectoral participation in the rapid assessment.

Discussions with partners such as UNAIDS led to access to additional disaggregated adolescent data for the rapid assessment from the UNAIDS Fast-Track Cities Initiative. Finally, advance political engagement led to immediate application of the rapid assessment findings in the context of the national action plan.

Review of adolescent data brought multiple insights for countries. For some countries, the rapid assessment was the first time national partners looked together at cross-sectoral data and appreciated the relevance of gaps in multiple sectors for adolescent HIV outcomes. Prior to this exercise, adolescents were often viewed as a single homogeneous age group or were lost in data that focused either on children aged 0–14 or youth aged 15–24. The rapid assessment process shed light on how HIV affects adolescents of different ages. This exercise prompted countries to recognize that adolescent data are weak and lacking in specificity. This was a also therefore a catalyst for national Statistics managers to acknowledge that they could be doing so much better for adolescents; it will hopefully motivate the collection of more data on adolescents, which will then be used to address gaps in programming and data systems. Adolescent data sometimes revealed striking insights – such as high levels of attempted suicide and alcohol use in adolescents – that triggered emotional discussions that in turn motivated additional data review and discussions about a potential response.

In many countries, the assessments highlighted data gaps and opportunities to strengthen national data collection. The rapid assessment process served to reinforce the value of data-driven programming.

3.4.6 AADM tool

The AADM tool is a major component of the rapid assessments. It is designed to help countries consolidate data and improve their understanding of the adolescent HIV epidemic, HIV risk, HIV response, and overall adolescent health and well-being. Countries appreciated many aspects of the tool, such as its comprehensiveness and its ability to generate of a summary dashboard to convey findings. In some countries, there was the perception that the tool should be modified to allow more room for countries to redefine some of the indicators and to expand its capabilities to analyse more of the non-HIV-related health and social sector indicators for example indicators in social protection, violence and education.

As more countries implement rapid assessments, revisions to the AADM should continue to allow countries more flexibility to redefine indicators to more meaningfully assess the status of non-facility-based interventions that are critical to understanding HIV risk for adolescence. Revisions could also encompass ways to better examine the status of key populations, particularly in concentrated epidemic contexts.

3.4.7 Capacity built in countries

The rapid assessments were a powerful exercises that built the capacity of countries to conduct a rapid assessment and collect, analyse and use data on adolescents. They served as a starting point for people to triangulate data on adolescents from different sectors. While many of the country teams were not accustomed to looking at adolescent data across sectors, for some people the rapid assessments were the first time they saw comprehensive data or reports on adolescents. The assessments also provided many participants with a first opportunity to examine potential entry points for more targeted approaches for improving adolescent outcomes and to identify opportunities to optimize available resources.

3.4.8 Advocacy and resource mobilization for adolescents and HIV

At least 25 countries will have initiated country assessments by mid-2016. This will present challenges to global, regional and country teams to keep up with the demand for technical support and funding for the assessments. In many countries, there are questions related to continued and long-term funding of country as-

SPOTLIGHT ON ZIMBABWE – Regional learning and capacity-building

The Zimbabwe rapid assessment served as a learning and capacity-building exercise for other countries in the region, including Lesotho and Malawi. Zimbabwe was able to share the rapid assessment process directly with these countries and enable them to move quickly to plan rapid assessments of their own.

Having people on the ground throughout the ALL IN process, particularly at the data validation exercise and stakeholders' meeting, enabled representatives from Lesotho and Malawi to go back to their countries with clear, concrete plans on how to adapt the ALL IN process to their own country context. Participants reported that they were able not only to explain to their counterparts what an ALL IN rapid assessment entailed, but also to better articulate the value of that exercise. The same learning and capacity-building approach has been used in other country rapid assessments.

sessments and how other adolescent-focused initiatives might be coordinated with on linked to ALL IN efforts.

The definition of clear targets in the ALL IN strategy for HIV prevention and treatment in has helped address a higher-level gap that limited the advocacy focus and potential for resource mobilization for the adolescent response. With these targets now defined, countries are able to have focused discussions on what it will take to achieve them.

The rapid assessments increased attention and drive for the adolescent HIV epidemics in all five countries. Strategic information generated from the assessments has helped generate advocacy materials that raise awareness about adolescents and their reproductive and sexual health and about HIV, and which make a case for investing resources in these areas. The next round of funding proposals or internal budgeting can take the country into more specifics on adolescents in terms of programming and priority setting. The timing of future country assessments should be strategized to inform funding opportunities, such as Global Fund concept notes, proposals and financial reprogramming opportunities.

3.4.9 Sustain the momentum of the ALL IN rapid assessments in countries

Concerns emerged within countries related to sustaining the momentum achieved by the rapid assessment processes. At the end of the assessment processes, some assessment teams felt a lack of clarity on the next steps for taking forward the dialogue and work that had been initiated. This makes the lasting impacts of the assessments uncertain. Sustained engagement, clear guidelines and continued coordination and dissemination of findings will play an important part in maintaining the momentum around the work approach. An important example of this effort at sustainability and mobilization of programme action are the webinars that have been held to profile country experiences and findings.

Existing national coordination bodies should be convened to ensure strengthening of coordination systems for adolescent programming across sectors and agencies. The assessment methodology should be integrated within routine national, subnational and sectoral planning and review cycles to allow for timely commitment of the necessary financial and technical support to implement the assessment.

SPOTLIGHT ON JAMAICA – Rapid assessment results used for resource mobilization

For the past several years, Jamaica's National HIV response has been steadily losing funding for programmes targeting adolescents and youth. Donors kept pointing to the dearth of epidemiological data to support prioritization of adolescents and young people. The ALL IN Rapid Assessment facilitated a much-needed age- and gender-specific analysis of data from bio-behavioural surveys and existing surveillance systems. This provided further insight on the issue of HIV among adolescents and youth and forced partners and stakeholders to take a closer look at the comprehensive situation among adolescents and young people aged 10–24.

Jamaica's ALL IN rapid assessment was well-timed, because Global Fund negotiations were also in progress. Data from the rapid assessment was included in the Global Fund proposal, which helped spark new interest in reaching vulnerable young people. The Global Fund has since considered providing funding for interventions targeting young key affected populations and young people living with HIV. These include cash transfers to maintain school attendance, income generating grants for families, support for adolescent support groups and family support groups. The Global Fund will also consider supporting psychosocial support by providing much-needed adolescent psychologists. The areas of need highlighted above have previously been significantly underfunded, a situation that limited the capacity of national programmes to respond adequately to some of the underlying drivers of the epidemic among Jamaica's young people.

SPOTLIGHT ON SWAZILAND – Pioneer of the rapid assessment process launched a global webinar to share its experience and mobilize other countries to conduct rapid assessments

Swaziland shared its experience as the first country to conduct a rapid assessment through a global webinar that featured high-level leadership engagement. At least 92 people logged in to participate in the webinar, with many logging in and participating in teams. At least 16 country teams and several regional teams participated in the webinar including individuals and teams from Botswana, Chad, Côte d'Ivoire, Jamaica, Kenya, Lesotho, Namibia, the Niger, Nigeria, Rwanda, Swaziland, Togo, the United Arab Emirates, Uganda, United Republic of Tanzania and Zimbabwe. Through this platform, Swaziland was able to share highlights of the rapid assessment process, findings, successes and lessons learned.

Among the lessons learned in Swaziland that were highlighted by different speakers in the webinar were:

a) The importance of government leadership and ownership across sectors;

b) The necessity of engaging a diverse range of adolescents and youth in programme design, review and implementation;

c) The need for early action by the country teams to gather, review and enter data to make the most of time committed from external support sources for validation and priority-setting;

d) The importance of building the adolescent assessment into the work of existing coordinating groups in order to make the process more cost-effective, help strengthen these mechanisms and integrate adolescent priorities more systematically into ongoing strategic planning initiatives and resource mobilization efforts; and

e) The crucial contribution of the assessment to improved data, tracking, monitoring and programming for adolescents.

The webinar can be viewed at the following link: https://www.youtube.com/watch?v=jixc42-AqZE&feature=youtu.be

4. CROSS-CUTTING PROGRAMMATIC RECOMMENDATIONS

This section contains eight programme recommendations based on key findings from the data collected through the five country assessments. A summary of evidence and citations associated with programme recommendations is included in Annex 7.

4.1 Prioritize adolescents in efforts to end the HIV epidemic

Prioritize adolescents, who constitute between one fifth and one fourth of the population in the five countries, in efforts to address and end the HIV epidemic in each country.

4.2 Use data on the adolescent HIV epidemic to tailor the response to the epidemic

Expand access to HIV prevention, care and treatment for the adolescent population in general, with particular focus on strategies to reach adolescents who may be harder to reach and disproportionately affected in each country. Use age and gender patterns shown in data on the adolescent HIV epidemic – including adolescent HIV prevalence, incidence and deaths – to inform targeted and gender-specific strategies to more effectively address the adolescent HIV epidemic.

4.3 Strengthen data collection in relation to adolescents and adolescent key affected populations

Strengthen the capacity of national and sub-national information management systems to collect age- and sex-disaggregated data on adolescents, along with accurate and representative data on adolescent key populations. Include stronger representation of adolescents and key populations within national surveys. Address multiple conflicting sources of data on adolescents and HIV that exist within countries. Strengthen systems to monitor adolescent HIV interventions and sort out major data collection challenges associated with such interventions as PEP. Establish data collection for interventions where data do not exist, for example harm reduction prorgammes and adolescent PrEP.

4.4 Improve HIV knowledge, awareness and capacity to make health-related decisions among adolescents by using school programmes, the media and community-based approaches

Expand coverage of HIV-related social and programmatic enablers of adolescents in all five countries. Harness secondary school enrollment across countries, use media and community-based approaches to reach adolescents with comprehensive, correct knowledge of HIV, especially in boys, as well as build adolescent health decision-making capacity. Conduct awareness and advocacy efforts, and address relevant laws and policies that limit adolescent participation to enhance adolescent decision-making.

4.5 Scale up integrated and multi-disciplinary health service delivery for adolescents

Scale up quality and context-specific integrated and multi-disciplinary approaches for health service delivery for adolescents, particularly programmes for STI screening and prevention, family planning and mental health. Build the capacity and awareness of health, education and law enforcement and other professionals who interact with adolescents to understand the connections between HIV and other aspects of physical and emotional health, and how HIV is linked to such social issues such as child marriage and sexual violence.

4.6 Use innovative strategies to scale up accessible quality interventions for adolescents, and to generate demand for and monitor coverage of these key interventions

Develop innovative strategies that harness mobile technology and media to reach adolescents, including key populations – with the aim of achieving better coverage, more access, greater demand and better monitoring of adolescent HIV interventions. Key interventions include adolescent combination HIV prevention, HIV testing, PMTCT and ART.

4.7 Address harmful policies and laws

Sensitize and conduct advocacy with relevant stakeholders to:

a) Modify policies and laws around the age of consent. This is crucial for timely access among adolescents to HIV testing, care and treatment services and necessary for stronger adolescent participation in decisions related to their health;

b) Clarify conflicting positions and varying understanding of policies relevant to age of consent;

c) Change broad criminalization laws that perpetuate discrimination against adolescent key populations and hinder their access to key HIV services; and

d) Ensure that laws and policies protect adolescent girls from child marriage and both girls and boys from sexual violence.

4.8 Define research agendas

Define operational, epidemiological and social research priorities based on the rapid assessment findings.

5. CONCLUSION

It is important to prioritize adolescents as the international community mobilizes efforts to end the global HIV epidemic by 2030. Adolescents constitute a significant proportion of the population, and global data on the adolescent HIV epidemic demonstrate an urgent need to accelerate efforts for adolescents and the key affected populations among them.

The rapid assessment process looked at adolescents aged 10–19 in a way that has not been done previously: by assessing demographics, HIV epidemiology, HIV programme delivery and the overall health and well-being of adolescents aged 10–14 and 15–19.

The rapid assessment process brought Botswana, Cameroon, Jamaica, Swaziland and Zimbabwe closer to defining action to accelerate adolescent responses and meet global targets. The assessments in these five countries have illustrated how the assessment process itself can help situate programmatic priorities for adolescents within ongoing Fast Track discussions. Ultimately, the success of the assessments supported through ALL IN will depend on how well the approach influences allocation and mobilization of current resources for adolescents in the short term – and on how countries integrate the approach into regular review and planning mechanisms to ensure funding in the long term. The latter is a process that can clearly lead to national programmes that are more effective and efficient, and which are better able to deliver on national commitments for adolescents.

Scaling up resource mobilization efforts for the ALL IN agenda will be critical to generating funding for governments to conduct rapid assessments and strengthen their responses to the adolescent HIV epidemic. Implicit in resource mobilization efforts is the need to more concretely define what it will take for countries to achieve ALL IN prevention and treatment targets. To this end, dialogue involving global, regional and national initiatives and partners should continue to strive for consistent understanding of the key components necessary to address the global adolescent HIV epidemic – and on how to ensure complementarity, improved efficiency and synergy between initiatives around adolescent HIV.

ANNEXES

ANNEX 1: GLOBAL AND REGIONAL INITIATIVES

Global initiatives

The Fast Track 90/90/90[31]

The Fast Track Initiative mobilizes countries to prioritize provision of life-saving HIV prevention and treatment services to populations most at risk of HIV to drastically reduce new HIV infections and AIDS-related deaths. All In is the adolescent space within the Fast Track Initiative and provides a framework to address the HIV epidemic in the adolescent population that is a target population in most countries.

The Fast Track Cities Initiative[32]

This is an initiative that includes commitments to achieve the UNAIDS 90–90–90 targets by 2020. It encourages new, innovative service delivery programmes that address the causes of risk, vulnerability and transmission and build and accelerate an appropriate response to local needs. The UNICEF team has successfully advocated for the All In tools to be part of the toolkit for this initiative and thus encourage a focus on the adolescent epidemic as part of this initiative.

Every Woman, Every Child[33]

Every Woman, Every Child is a global movement that galvanizes international and national action by different global entities, including governments, multilaterals, the private sector and civil society to address the major health challenges facing women and children. UNICEF leadership has successfully advocated for Every Woman, Every Child to become Every Woman, Every Child, Every Adolescent and thus raise the profile of adolescents in this visible global campaign.

PEPFAR 3.0: Right Things, Right Places, Right Priorities[34]

As PEPFAR embarks on the third phase of its work, with a focus on sustainable control of the epidemic, it is emphasizing a "data-driven approach that strategically targets geographic areas and populations where we can achieve the most impact for our investments" and partnerships that include engagement with those most affected by the epidemic. This focus coincides with the methodologies and approaches inherent in the All In agenda country assessments. The All In agenda could be harnessed as a data-focused process to identify target key geographic areas and populations in relation to the adolescent HIV epidemic.

DREAMS Initiative[35]

DREAMS is a partnership between PEPFAR, the Bill & Melinda Gates Foundation, and the Nike Foundation focused on reducing new HIV infections in adolescent girls and young women in 10 sub-Saharan African countries. DREAMS is an acronym that describes the goal of the partnership to help girls develop into Determined, Resilient, Empowered AIDS-free, Mentored, and Safe (DREAMS) women. In countries implementing both initiatives, the DREAMS partnership to can be leveraged to accelerate the HIV response in adolescent girls.

Global Fund

In Cameroon and Zimbabwe, the assessments informed Global Fund applications and were able to generate essential content for resource mobilization. In Jamaica, data from the preliminary assessment prompted the GFATM to allow the MOH to allocate resources under current grant to address the adolescent HIV epidemic.

UNICEF global work around age of consent

UNICEF is currently engaged in effort to document the age of consent for HIV testing in countries to inform global dialogue on age of consent and its implications on programming. As age of consent was raised as policy barrier in multiple countries that participated in the rapid assessments, UNICEF's global age of consent work can inform for advocacy efforts within countries to address this policy bottleneck.

UNICEF work with PEPFAR on the links between sexual violence and HIV in Violence Against Children Surveys (VACS)

UNICEF is engaged in efforts with PEPFAR to look at the link between sexual violence and HIV risk within VACS, including over-sampling of girls, more questions on the association between HIV and violence and HIV testing within the VACS. Sexual violence was a featured component of the All In rapid assessments. Collection of further data on sexual violence and its link to HIV can inform countries further on the extent of these issues for advocacy and response.

Regional initiatives

Eastern and Southern African (ESA) Ministerial commitment[36]

This is a landmark commitment affirmed by health and education ministers in 20 countries in Eastern and Southern Africa to support sexuality education and sexual and reproductive health services for adolescents and young people. This commitment facilitates accelerated scale-up of HIV prevention through sexuality education and other health services. This process lead by UNAIDS with the support of UNESCO, UNFPA, UNICEF, WHO and a number of bilateral and civil society partners, including young people's organizations.

ANNEX 2: ADOLESCENT AND HIV COUNTRY RAPID ASSESSMENT KEY INFORMANT INTERVIEW QUESTIONS

1. Background

What are some of the key contextual issues in relation to the rapid assessment in (Country)?

- What were 3 motivating factors for (Country/Organization) to participate in the rapid-assessment? Who are the champions that led the process?
- To what extent was/is addressing the HIV epidemic in adolescents a priority in (Country)?

2. Methods

Can you share with me your experience with the rapid assessment methods and discuss in particular some of the following, including involvement of adolescents, collaboration between stakeholders, key success factors and challenges/issues?

- Are there any specific aspects of the process that you would change and how?
- To what extent was the rapid assessment tool applicable to country context?
- Data collection and analysis process: how did the country responded to contradictory/conflicting data and data gaps?

3. Results

What were some of the key themes and issues that came out of the assessment that stood out for you?

- What were some of the key challenges that emerged from the assessment that stood out for you?
- Did any of the key findings that came out of the assessment come as a surprise to you and/or the stakeholder group?

4. Strategic opportunities and recommendations

What are some specific ways that the country assessment can be leveraged strategically to generate/perpetuate momentum around acceleration of efforts to address the adolescent HIV epidemic?

- What do you think were some of the most critical recommendations to come out of the assessment?
- How is the assessment being carried forward by different ministries/ sectors in (Country)?
- Are there any key thematic areas/topics that should be addressed or critical issues that passed unnoticed during rapid assessment?

5. Conclusion

- How does/can the assessment in (Country) relate to or contribute to global efforts to address the HIV epidemic in adolescence?
- What are some of the lasting impacts catalyzed by the assessment in terms of the process (i.e. partnerships forged in country) and the reaction to the assessment results (i.e. decisions made to prioritize certain programming)?

ANNEX 3: LESSONS LEARNED FROM THE SWAZILAND PILOT

Early engagement and frequent communication with stakeholders leading up to the in-country validation

In Swaziland key stakeholder orientation on ALL IN including orientation of the key data providers and mobilization was done during the week of the national validation meeting. The AADM tools and data requirements (indicator list) should be shared as early as possible so that country teams can initiate the data gathering process early.[37] Early engagement of UN and other partners is crucial for coordination and assuring country ownership.[38]

Guidance and support from Headquarters

The pilot experience demonstrated the importance of having a detailed breakdown of and continuous support for the country process to guide further steps and a list of specific outcomes for each phase.

Ownership and involvement at the highest levels

Ownership at the highest levels of government facilitates advocacy for All In at all levels and encourages the continuous engagement of all partners in all phases. Engaging policy-makers early in the process facilitates government ownership and the subsequent addressing of issues related to establishment or implementation of policy.

Initial scoping and landscaping

An initial scoping of programme effort and environment is important to guide understanding of how the All Initiative fits within the current country context and how it can be adapted to add the greatest value.[39]

Closer collaboration with partners that have strategic information

Identification and communication between partners supporting work relevant to ALL IN is critical and with potential to offer synergy to the assessments is critical. In Swaziland, the assessments were initiated around the time that PEPFAR was planning its own assessments offering the country team a useful opportunity to build questions into each process to ensure complementarity.

Involvement of donors in the process

The Global Fund's participation in the Swaziland rapid assessment was instrumental in bringing the donor on board to fund All In-related work in Swaziland.

Thinking through adolescent engagement in the process

Through the Swaziland rapid assessment, it became apparent that improved methods for engagement of a diverse population of adolescents and youth are necessary as well as a parallel process for their full preparation and quality engagement in the broader stakeholder validation process.

Capacity building of other countries

The Swaziland rapid assessment included the participation of technical staff from Malawi and UNICEF and UNAIDS regional offices as a learning exercise. This was recognized as a practice to carry forward in other assessments to help accelerate the establishment of capacity for in-country support across the region.

More flexibility built into the AADM tool

The rapid assessment methodology and AADM tool are extremely helpful for consolidating what is often scattered data but the tool should be flexible. The Swaziland All In rapid assessment highlighted the need to add additional age groups or programme interventions to better suit country information needs.[40]

Webinar

The Government shared the process, key findings and results of the Swaziland rapid assessment through a global webinar. This was identified as an excellent practice to facilitate sharing of experiences and learning among countries and stakeholders.

ANNEX 4: ALL IN ASSESSMENT PARTICIPATING ORGANIZATIONS

Cameroon	Jamaica	Swaziland	Zimbabwe
Global organizations			
• UNICEF • UNESCO • UNFPA • ONUSIDA • WHO	• UNAIDS • UNICEF • UNWOMEN • UNFPA • UNESCO • UNICEF- HAITI • UNICEF-LACRO • UNICEF- NYHQ • UNICEF-BRAZIL • UNAIDS Caribbean Reg. Support Team	• UNICEF • UNAIDS • WHO • UNFPA • PEPFAR • Global Fund • EGPAF	• UNICEF-New York • UNAIDS-Lesotho • UNICEF-Lesotho • UNICEF-Malawi • UNICEF-ESARO
National organizations			
• Ministère de la Jeunesse et de l'Education civique (MINJEC) • Ministère de la Santé Publique (MINSANTE) • COMITE NATIONAL DE LUTTE CONTRE LE SIDA (CNLS) • Ministère des Enseignements Secondaires (MINESEC) • Ministère de l'Enseignement Supérieur • Ministère de la Femme et de la Famille • Ministère des Affaires Sociales	**Government** • Ministry of Education • Ministry of Health • Ministry of Youth and Culture • Ministry of Labour – Social Protection Programme • Planning Institute of Jamaica • National Family Planning Board • The Office of the Children's Advocate • The Office of the Children's Registry • Child Development Agency • Social development Commission • Statistical Institute of Jamaica • Department of Correctional Services • Centre of Investigation of Sexual Offenses & Child Abuse (CISOCA) **NGOs** • Jamaica AIDS Support for Life • Jamaica Youth Advocacy Network • National Council on Drug Abuse • Jamaica Council for Persons Disabilities • Jamaica Network of Seropositives **Other** • University of the West Indies • United Theological College • Talk up Yout' (Media) • National Secondary Students Council	**Government** • Ministry of Health (various departments represented including ASRH, HIV, HMIS,SID –HMIS,M&E and research,) • Ministry of Education • Ministry of Justice • Deputy Prime Minister's office • Central Statistics Office • Min. of Youth Culture and Sports • National Emergency Response and Coordination of HIV and AIDS (NERCHA) program **International NGOs** • ICAP • CHAI • Save the children • World Vision	**Government** • MoHCC • NAC • Ministry of Justice • MoHCC – AIDS & TB Unit • MoPSE • Ministry of Women's Affairs Gender & Community Development • Ministry of Youth Indigenization & Economic Empowerment **Development Partners** • AFRICAID • ASRH • CHAI • ILO • OPHID • UNAIDS • UNDP • UNESCO • UNFPA • USAID • WHO **NGOs** • EGPAF • Family Support Trust • JF Kapneck Trust • Plan International • Save the Children • Scripture Union • The UNION • World Education Inc. • ZNFPC • ZNNP+ • M-Consulting Group
Local organizations			
Civil Society Organisations • CAMNAFAW • Affirmation Action • Horizon Femme • Réseau des Jeunes du Cameroun • Presse Jeune • Délice • KIDAIDS	**Regional Health Authorities** **NGOs** • Children First • Eve for Life • Kingston and St. Andrew Parish Youth Council • Rise Life Management International • Ashe Ensemble • The Colour Pink	**NGOs/FBOs working with adolescents:** • FLAS, Baylor children foundation of Swaziland, PSI	**Youth Organizations** • Young People's Network on SRH & HIV & AIDS (Different regions) • Say What **Other** • PMDs (different districts) • Nkayi District Hospital • Hospital Murombe • Harare Hospital Family Support Clinic • Mpilo Central Hospital • United Bulawayo Hospital • Masvingo Musiso Mission Hospital **Municipal** • Manicaland Mutare • Gwanda District • City of Bulawayo

ANNEX 5: ENABLING ENVIRONMENT ASSESSMENT RESULTS FROM FIVE COUNTRIES (SCORES SHOWN ARE OUT OF 10)

Type of Stakeholder	Country	Programme environment dimensions							
		National Situation Analysis	National Policies or Strategies or Plan of Action	Coordination Mechanisms	Consultative Processes	Legislation	Adolescent and Youth Participation	Resource allocation and mobilization	Monitoring and evaluation
Government	Botswana	4	7	10	6	7	3	8	5
	Cameroon	7	10	10	9	5	9	10	0
	Jamaica	2	3	4	6	4	2	2	4
	Zimbabwe	10	5	6	10	8	10	5	8
International Development Partners	Botswana	5	6	9	7	3	2	7	3
	Cameroon	4	9	9	0	3	1	3	0
	Jamaica	0	4	4	4	2	2	2	2
	Zimbabwe	3	6	9	8	8	9	4	1
Civil Society/ NGOs	Botswana	4	7	9	1	7	6	8	1
	Cameroon	3	6	8	4	5	0	6	0
	Jamaica	2	2	4	1	2	2	2	4
	Zimbabwe	4	5	6	6	1	6	3	1
Adolescents/ Youth	Botswana	4	4	8	0	6	2	4	0
	Cameroon	1	7	8	0	0	2	4	0
	Jamaica	2	4	2	4	N/A	2	N/A	N/A
	Zimbabwe	8	6	8	8	6	6	3	5
Overall average country scores	Botswana	4.3	6	9	3.6	5.8	3.3	7	3
	Cameroon	3.8	8	8.8	3.3	3.3	3	5.8	0
	Jamaica	1.5	3.3	3.5	3.8	2.7	2	2	3.3
	Zimbabwe	6.3	5.5	7.3	8	5.8	7.8	3.8	3.8

ANNEX 6: SUGGESTED FURTHER READING

6.1 Combination HIV Prevention

Combination HIV prevention

No single HIV prevention strategy is sufficient to halt the HIV epidemic.[41] Yet there are a growing number of interventions that have been proven to partially protect against HIV transmission and acquisition.[42]

Kurth, A., et al., 'Combination HIV prevention: significance, challenges, and opportunities,' *Current HIV/AIDS Reports*, vol. 8.1, 2011, pp. 62-72.

HIV testing and counseling

HIV testing and counseling is the essential entry point to HIV treatment and care.[43]

Mavedzenge, S., Luecke, E., and Ross, D., 'Effective approaches for programming to reduce adolescent vulnerability to HIV infection, HIV risk, and HIV-related morbidity and mortality: a systematic review of systematic reviews,' *JAIDS Journal of Acquired Immune Deficiency Syndromes*, vol. 66, 2014, pp. S154-S169.

Condom use

When used consistently and correctly, condoms are highly effective in preventing the sexual transmission of HIV. ,

Holmes K et al., 'Effectiveness of condoms in preventing sexually transmitted infections,' *Bulletin of the World Health Organization*, vol. 82, no. 6, 2004.

Weller S et al., 'Condom effectiveness in reducing heterosexual HIV transmission,' Cochrane Database System Review, vol. 1, no. CD003255, 2002.[44,45]

Voluntary medical male circumcision (VMMC)

Evidence has shown that voluntary medical male circumcision (VMMC) can reduce sexual transmission of HIV from women to men by 60% among men that have the procedure.[46] VMMC is a one time, cost-effective intervention that confers men life-long partial protection against HIV as well as other sexually transmitted infections, reducing the number of people in need of HIV care and treatment.[47,48] It is important to emphasize continued condom use and other prevention methods as VMMC only provides partial protection.[49]

Njeuhmeli, E, et al., 'Voluntary medical male circumcision: modeling the impact and cost of expanding male circumcision for HIV prevention in eastern and southern Africa,' *PLoS Medicine*, vol. 8, no. 11, 2011, pp. 1567.

Sgaier, S., Reed, J., Thomas, A., Njeuhmeli, E., 'Achieving the HIV prevention impact of voluntary medical male circumcision: lessons and challenges for managing programs,' *PLoS Medicine*, vol. 11, no. 5, 2014, p. e1001641.

World Health Organisation, Voluntary medical male circumcision for HIV prevention fact sheet, WHO, Geneva, 2012.

Harmonized social cash transfers

The details of harmonized social cash transfers (HSCT) vary by country, but coincide with provision of unconditional cash payments in accordance with household size to labor-constrained, food-poor, vulnerable households.[50] HSCT can impact risk behaviors and structural factors contributing to HIV risk in adolescent girls in low-income settings and have been found to have significant influence on lowering transactional and age disparate sex among adolescent girls in vulnerable households receiving them.[51,52]

Baird, S., Garfein, R. S., McIntosh, C. T., & Özler, B., 'Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial,' *The Lancet*, vol. 379, no. 9823, 2012, pp. 1320-1329.

Cluver, L., Boyes, M., Orkin, M., Pantelic, M., Molwena, T., & Sherr, L., 'Child-focused state cash transfers and adolescent risk of HIV infection in South Africa: a propensity-score-matched case-control study,' *The Lancet Global Health*, vol. 1, no.6, 2013, pp. e362-e370.

Pre-exposure prophylaxis (PrEP)

Although there are no specific studies on the use of pre-exposure prophylaxis (PrEP) in adolescents, there is international scientific consensus that PrEP can significantly reduce transmission and acquisition of HIV regardless of the population or setting.[53,54]

World Health Organization, Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV, WHO, Geneva, 2015.

Harm reduction for adolescents that Inject drugs

In global research many people with injecting drug behaviors report that they began injecting drugs in adolescence.[55] Governments, civil society and organizations of people who use drugs are implementing diverse programmes globally for and with young people who inject drugs. While few of these programmes have been independently evaluated, there are examples of promising practices and lessons learned on how to address challenges in serving young people who inject drugs.[56]

World Health Organization, HIV and young people who inject drugs: a technical briefing, WHO, Geneva, 2015.

Post exposure prophylaxis (PEP)

Scientific evidence from animal transmission models, perinatal clinical trials, studies of health-care workers receiving prophylaxis after occupational exposures, and from observational studies indicates that PEP might sometimes reduce the risk for HIV infection after non-occupational exposures.[57]

Smith, D., et al., 'Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States: recommendations from the US Department of Health and Human Services,' *MMWR Recomm Rep*, vol. 54, no. RR-2, 2005, pp. 1-20.

6.2 Cross-sectoral programs

Adolescent sexual and reproductive health (SRH)

STIs

Evidence from different global contexts as well as modeling studies demonstrate that other sexually transmitted infections (STIs) facilitate HIV transmission. Treatment of STIs should be promoted as one component of HIV control programmes, particularly where there is a high burden of STIs.[58]

Hayes, R., Watson-Jones, D., Celum, C., van de Wijgert, J., and Wasserheit, J, 'Treatment of sexually transmitted infections for HIV prevention: end of the road or new beginning?,' *AIDS*, vol. 24, no. 4, 2010.

Adolescent pregnancy

Adolescent pregnancy is associated with many health risks for the mother including anaemia, malaria, HIV and other sexually transmitted infections, postpartum haemorrhage and mental disorders, such as depression.[59]

World Health Organization, 'Adolescent Pregnancy,'http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en, accessed 8 December 2015.

Family planning

Sexual and reproductive health services including contraceptive services offer a strategic entry point for efficient targeting of HIV prevention, testing, care and treatment services to groups at high risk of exposure to HIV.[60]

Hainsworth, G., Engel, D., Simon,C., Rahimtoola, M., and Ghiron, L., 'Scale-up of adolescent contraceptive services: lessons from a 5-country comparative analysis,' *JAIDS Journal of Acquired Immune Deficiency Syndromes*, vol. 66, 2014, pp. S200-S208.

Maternal health

Maternal health is an integral component of global commitments including the Sustainable Development Goals. Maternal mortality is among the leading causes of death in adolescent girls therefore access to skilled attendants at birth and immediately after birth is critical.[61,43]

Campbell, O., Graham, W. and Lancet Maternal Survival Series steering group, 'Strategies for reducing maternal mortality: getting on with what works,' *The lancet*, vol. 368, no. 9543, 2006, pp. 1284-1299.

Anemia

Anemia is common in adolescents and is an indicator or poor health and nutrition. It can lead to negative pregnancy and cognitive outcomes.[62,63]

Banhidy, F., Acs, N., Puho, E. and Czeizel, A., 'Iron deficiency anemia: pregnancy outcomes with or without iron supplementation,' *Nutrition 27*, no. 1, 2011, pp. 65-72.

World Health Organization and United Nations Children's Fund, Joint statement by the World Health Organization and the United Nations Children's Fund Towards an integrated approach for effective anaemia control, WHO and UNICEF, Geneva, 2004.

Adolescent mental health

Mental health can influence sexual-risk taking behavior and thus HIV risk.[64]

Shrier, L., Harris,S., Sternberg, M. and Beardslee, W., 'Associations of depression, self-esteem, and substance use with sexual risk among adolescents,' *Preventive medicine* 33, no. 3 (2001): 179-189.

Adolescent alcohol use

During adolescence, individuals may first experience or experiment with alcohol and other intoxicating illicit substances as part of exploring boundaries. Alcohol use is associated with increased risk-taking and risk of incident HIV infection.[65]

Baliunas, D., Rehm, J. Irving, H. and Shuper, P., 'Alcohol consumption and risk of incident human immunodeficiency virus infection: a meta-analysis,' *International Journal of Public Health*, vol. 55, no. 3, 2010, pp. 159-166.

6.3 Child protection, gender-based violence, social protection, education and life skills

Child marriage

Child marriage has a detrimental impact on adolescent health, including adolescent pregnancy and child bearing, gender-based violence and increased risk of HIV and other STIs.[66]

Nour, N., 'Child marriage: a silent health and human

rights issue,' Reviews in Obstetrics and Gynecology, vol. 2, no. 1, 2009, p.51.

United Nations Children's Fund, *A Statistical Snapshot of Violence against Adolescent Girls*, UNICEF, New York, 2014.

Gender-based violence

The links between gender-based violence and HIV risk and infection and other negative health outcomes are well-documented.[67,68,69,70,71]

Dunkle, K., Jewkes, R., Brown, H., Gray, G., McIntryre, J. and Harlow, S., 'Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa,' *The Lance*t, vol. 363, no. 9419, 2004, pp.1415-1421.

Ghanotakis, E., Peacock, D., and Wilcher, R., 'The importance of addressing gender inequality in efforts to end vertical transmission of HIV,' J*ournal of the International AIDS Society*, vol. 15, suppl 2, 2012.

Jewkes, R., Dunkle, K., Nduna, M and Shai, N., 'Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study,' *The Lancet* 376, no. 9734, 2010, pp. 41-48.

Watts, C., and Seeley, J, 'Addressing gender inequality and intimate partner violence as critical barriers to an effective HIV response in sub-Saharan Africa,' *Journal of the International AIDS Society*, vol. 17, no. 1, 2014.

World Health Organization, Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence,' WHO, Geneva, 2013.

United Nations Children's Fund, *A Statistical Snapshot of Violence against Adolescent Girls*, UNICEF, New York, 2014.

School and adolescent health

More years of school are associated with better adolescent health outcomes.[72] School-based interventions can positively affect common risk and protective factors for a range of health behaviours, even for marginalized groups of adolescents.[73] This has been demonstrated through health and economic interventions that increase school attendance, such as cash transfers targeted at adolescent girls.[74,75] A recent study in Botswana found that additional years of secondary schooling had a protective effect against HIV, especially for women.[76]

De Neve, J., Fink, F., Subramanian, S., Moyo, S. and Bor, J., 'Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment,' *The Lancet Global Health*, vol. 3, no. 8, 2015, pp.e470-e477.

World Health Organization, Health for the World's Adolescents: A Second Chance in the Second Decade, WHO, Geneva, 2014.

Hale, D., Fitzgerald-Yau, N. and Viner, R., 'A systematic review of effective interventions for reducing multiple health risk behaviors in adolescence,' *American Journal of Public Health*, vol. 104, no. 5, 2014, p. e19-e41.

De Neve, J., Fink, G., Subramanian, S., Moyo, S., & Bor, J., 'Length of secondary schooling and risk of HIV infection in Botswana: evidence from a natural experiment.' *The Lancet Global Health*, vol. 3, no.8, 2015, pp. e470-e477.

Baird SJ et al., 'Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomized trial.' *The Lancet*, vol. 379, 2012, pp. 1320–1329.

Poverty Action Lab, 'Preventing HIV and teen pregnancy in Kenya: the roles of teacher training and education,' <http://www.povertyactionlab.org/evaluation/preventing-hiv-and-teen-pregnancy-kenya-roles-teacher-training-and-education-subsidies>, accessed 8 December 2015.

Life skills-based education

Life skills-based education, a curriculum targeting young people, aims to foster critical thinking and problem solving skills, build personal worth and agency, and teach constructive and effective interaction with others.[77]

United Nations Children's Fund, 'Life Skills,' <http://www.unicef.org/lifeskills/index_statistics.html>, accessed 8 December 2015.

Comprehensive sexuality education

Comprehensive Sexuality Education (CSE) has demonstrated impact in terms of improving knowledge and self-esteem, changing attitudes, gender and social norms, and building self-efficacy. This is particularly critical during adolescence, as young people make the transition into adulthood. Integrating content on gender and rights, and delivering CSE together with efforts to expand access to high-quality, youth-friendly sexual and reproductive health (SRH) services that offer a full range of services and commodities, makes sexuality education even more effective.

Haberland, N., 'The Case for Addressing Gender and Power in Sexuality and HIV Education: A Comprehensive Review of Evaluation Studies,' International Perspectives on Sexual and Reproductive Health, vol. 41, no. 1, 2015, pp. 31-42.

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3. United Nations Children's Fund, Progress for Children: A report card for adolescents, number 10, UNICEF, New York, 2012.
4. Idele, Priscilla, Amaya Gillespie, Tyler Porth, Chiho Suzuki, Mary Mahy, Susan Kasedde, and Chewe Luo, 'Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps,' *JAIDS Journal of Acquired Immune Deficiency Syndromes*, vol. 66, 2014, pp. S144-S153.
5. United Nations Children's Fund, Analysis of UNAIDS 2014 HIV and AIDS estimates, July 2015.
6. World Health Organization, Health for the world's adolescents: a second chance in the second decade: summary, WHO, Geneva, 2014.
7. Idele, Priscilla, Amaya Gillespie, Tyler Porth, Chiho Suzuki, Mary Mahy, Susan Kasedde, and Chewe Luo, 'Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps,' J*AIDS Journal of Acquired Immune Deficiency Syndromes*, vol. 66, 2014, pp. S144-S153.
8. Clark, Shelley, 'Early marriage and HIV risks in sub-Saharan Africa,' *Studies in family planning*, vol. 35, no. 3, 2004, pp. 149-160.
9. United Nations Children's Fund, A Statistical Snapshot of Violence against Adolescent Girls, UNICEF, New York, 2014.
10. McClure, Craig, Caitlin Chandler, and Susan Bissell, 'Responses to HIV in sexually exploited children or adolescents who sell sex,' *The Lancet*, vol. 385, no. 9963, 2015, pp. 97-99.
11. Idele, Priscilla, Amaya Gillespie, Tyler Porth, Chiho Suzuki, Mary Mahy, Susan Kasedde, and Chewe Luo, 'Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps,' *JAIDS Journal of Acquired Immune Deficiency Syndromes*, vol. 66, 2014, pp. S144-S153.
12. Idele, Priscilla, Amaya Gillespie, Tyler Porth, Chiho Suzuki, Mary Mahy, Susan Kasedde, and Chewe Luo, 'Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps,' *JAIDS Journal of Acquired Immune Deficiency Syndromes*, vol. 66, 2014, pp. S144-S153.
13. Idele, Priscilla, Amaya Gillespie, Tyler Porth, Chiho Suzuki, Mary Mahy, Susan Kasedde, and Chewe Luo, 'Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps,' *JAIDS Journal of Acquired Immune Deficiency Syndromes*, vol. 66, 2014, pp. S144-S153.
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