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MAPPING HIV SERVICES AND POLICIES FOR ADOLESCENTS

A SURVEY OF 10 COUNTRIES IN SUB-SAHARAN AFRICA

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

DECEMBER 2013

This publication was made possible through the support of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development under contract number GHH-I-00-07-00059-00, AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector I, Task Order 1.

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AIDS Support and Technical Assistance Resources Project
AIDS Support and Technical Assistance Resources, Sector I, Task Order 1 (AIDSTAR-One) is funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID) under contract no. GHH-I-00–07–00059–00, funded January 31, 2008. AIDSTAR-One is implemented by John Snow, Inc., in collaboration with BroadReach Healthcare, EnCompass LLC, International Center for Research on Women, MAP International, mothers2mothers, Social & Scientific Systems, Inc., University of Alabama at Birmingham, the White Ribbon Alliance for Safe Motherhood, and World Education. The project provides technical assistance services to the Office of HIV/AIDS and USG country teams in knowledge management, technical leadership, program sustainability, strategic planning, and program implementation support.

Recommended Citation
Pitorak, Heather, Heather Bergmann, Andrew Fullem, and Malia H. Duffy. 2013. *Mapping HIV Services and Policies for Adolescents: A Survey of 10 Countries in Sub-Saharan Africa.* Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Acknowledgments
AIDSTAR-One would like to thank the Health Division of USAID's Africa Bureau's Office of Sustainable Development and UNICEF for their support and guidance throughout the activity. In particular, the authors would like to acknowledge: Jennifer Albertini (USAID), Thurma Goldman (OGAC), Chiho Suzuki (UNICEF), Priscilla Idele (UNICEF), Susan Kasedde (UNICEF), Braeden Rogers (UNICEF), Dick Chamla (UNICEF), Chewe Luo (UNICEF), and Luong Nguyen (UNICEF). The authors also acknowledge all of the key informants from the United States Government and UNICEF country offices for taking their time and sharing a wealth of knowledge regarding HIV policies and services for adolescents, in addition to all of the survey respondents who kindly participated in the online survey.

AIDSTAR-One
John Snow, Inc.
1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
E-mail: info@aidstar-one.com
Internet: aidstar-one.com

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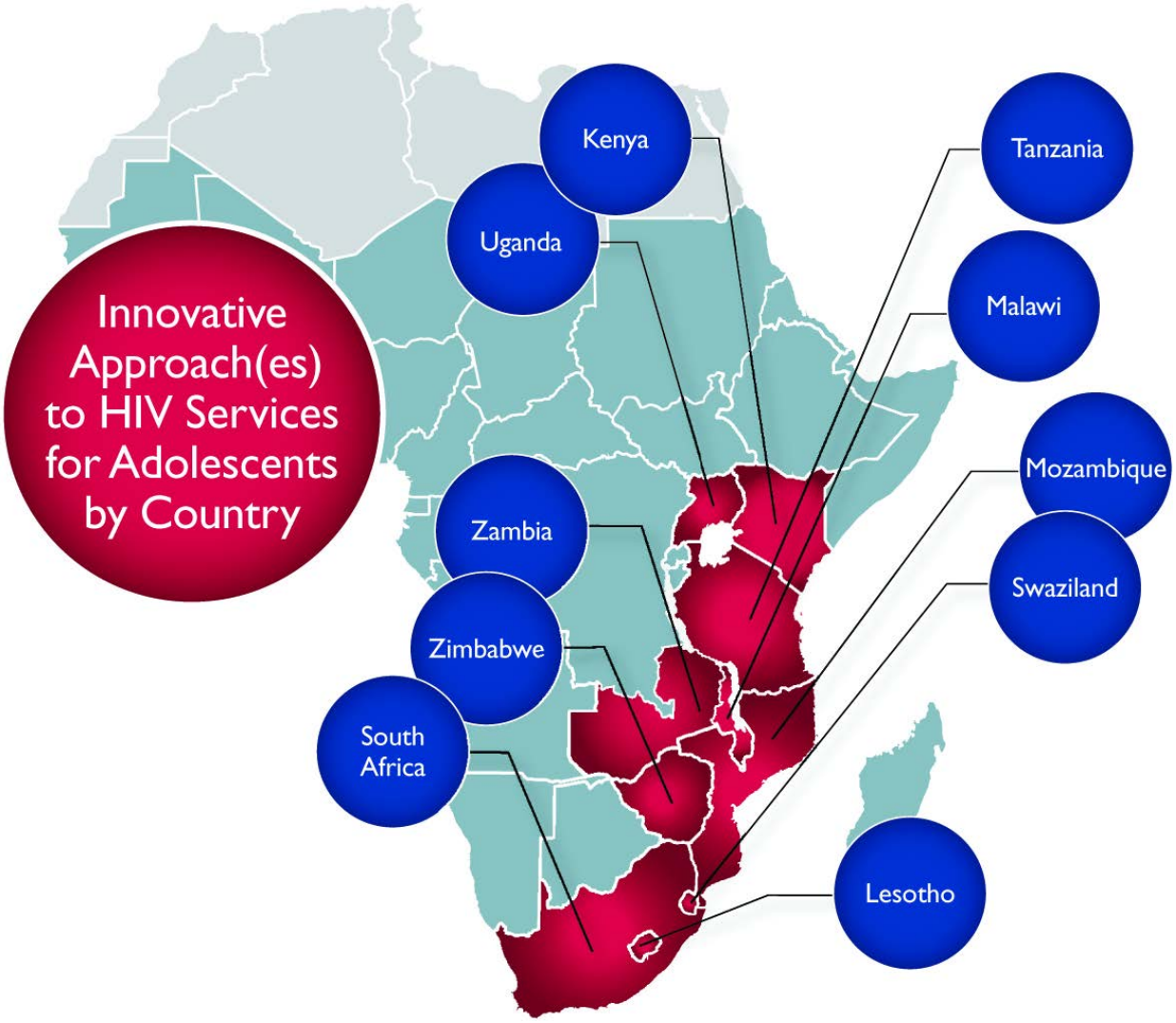
ACRONYMS

ALHIV	adolescents living with HIV
ART	antiretroviral therapy
ARV	antiretroviral
BCC	behavior change communications
CBO	community-based organization
CDC	U.S. Centers for Disease Control and Prevention
DOE	Department of Education
DOH	Department of Health
FBO	faith-based organization
FP	family planning
GBV	gender-based violence
HTC	HIV testing and counseling
IEC	information, education and communication
LGBT	lesbian, gay, bisexual, and transgender
M&E	monitoring and evaluation
MOE	Ministry of Education
MOH	Ministry of Health
MSM	men who have sex with men
NAC	National AIDS Council
NASCOP	National AIDS and STI Control Program
NGO	non-governmental organization
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHDP	positive health, dignity, and prevention
PITC	provider-initiated testing and counseling
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PWID	people who inject drugs
SRH	sexual and reproductive health

STI	sexually transmitted infection
SW	sex worker
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VACS	Violence Against Children Survey
VMMC	voluntary medical male circumcision
WHO	World Health Organization

EXECUTIVE SUMMARY



Adolescence is a period of life marked by dramatic biological, psychological, and emotional changes and is influenced by social determinants that impact health as individuals transition from childhood to adulthood (Kasedde et al. 2013; Viner et al. 2012). By the end of 2011, there were approximately 2.1 million adolescents living with HIV (ALHIV) worldwide. Of all ALHIV, 85 to 86 percent live in sub-Saharan Africa, with 60 percent residing in Eastern and Southern Africa (Kasedde et al. 2013). National population-based surveys show a steep rise in new infections in adolescents, with girls disproportionally affected (Gouws et al. 2008). Recent data show that antiretroviral therapy (ART) and viral suppression are allowing many children in sub-Saharan Africa infected perinatally to enter adolescence and adulthood (Ferrand et al. 2007). Most adolescents acquire HIV through behavioral

routes, however, particularly through sex (Cowan et al. 2009). Therefore, adolescents require structural, behavioral, and biomedical interventions to address the varying needs of perinatally and behaviorally infected adolescents and to prevent transmission to others (Cowan and Pettifor 2009).

As the number of ALHIV continues to increase, the need to improve services, policies, and programs intensifies. Yet, despite these alarming numbers, adolescents face challenges in accessing HIV testing and treatment. There is limited attention to the special health needs of adolescents in health strategies, policies, or programs, which is further complicated by conflicting adolescent age definitions (Sawyer et al. 2012). This results in indicators and health data that are insufficient for program planning and evaluation of health programs for adolescents (Patton et al. 2012). The Joint United Nations Programme on HIV and AIDS (UNAIDS) released the "Getting to Zero" guidance in 2010 that acknowledged limited HIV prevention efforts for adolescents and introduced a new goal to reduce HIV incidence, including among young people, by half by 2015 (UNAIDS 2010).

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID), in collaboration with the United Nations Children's Fund (UNICEF), supported AIDSTAR-One in conducting a mapping activity to identify HIV policies and services for adolescents in 10 sub-Saharan African countries: Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. The resulting technical report is a resource for program planners and policymakers working to improve services and policies for HIV prevention, care, and treatment among adolescents and ALHIV in sub-Saharan Africa. The report highlights service gaps, innovative approaches, areas requiring programmatic prioritization, and potential areas for integration. AIDSTAR-One used the World Health Organization's (WHO) definition of an adolescent as a young person aged 10-19.

AIDSTAR-One conducted 40 in-depth key informant interviews with PEPFAR and UNICEF country offices, and 29 online surveys with implementing and government partners who are involved in HIV services for adolescents.

Overall country findings include:

- There is strong acknowledgment across all countries of the importance of creating adolescent-specific HIV policies and youth-friendly services.
- Most countries are in the early stages of comprehensively targeting adolescents with HIV and health services. Current adolescent activities are primarily small-scale and largely uncoordinated with other services.
- The majority of HIV prevention activities for adolescents are school-based, yet many adolescents do not attend school. Key informants suggested improving or revising the current curricula; for instance, working with health facilities or non-governmental organizations (NGOs) to bring HIV prevention services into schools, along with integrating sexual and reproductive health services. Some school-based curricula were described as inconsistent or not fully implemented due to teachers' large subject load. Linkages between prevention programs in schools and other interventions are weak.
- Youth clubs or youth corners are routes for adolescents to access health services, yet these services are often described as dysfunctional or are implemented on a small scale with limited impact.
- Voluntary medical male circumcision (VMMC) has scaled up and uptake among male adolescents has been high. Challenges remain in linking them to other services.

- ALHIV typically access services in pediatric or adult care, with little focus on the transition between these two service areas, despite data that show high loss to follow-up of ALHIV in adult care. This transition period is recognized as an important step to support ALHIV.
- The age range definition of an "adolescent" is inconsistent among countries, and even within countries.
- For data collection and reporting, adolescents are often grouped into children or adults; some countries have, or are taking, steps to address data collection issues for adolescents.
- Few staff are specifically trained to provide health care services to adolescents.

Detailed country findings for each of the 10 countries start on page 17. Stemming from the key findings are policy and practice recommendations, which are summarized here. The full set of recommendations can be found on page 69.

POLICY RECOMMENDATIONS

- *Address adolescents and ALHIV in health strategies and guidelines.* Findings indicate that few national strategies and guidelines specifically address HIV programs and policies for adolescents or ALHIV. In order to build a platform that provides quality HIV prevention services for adolescents and care and treatment services for ALHIV, an essential first step is to address key issues and provide guidance within the broader health system.
- *Address age of consent.* The age of consent for HIV testing and counseling (HTC) and access to care and treatment, including VMMC, varies greatly by country or in some cases, is not defined or remains unclear. These barriers inhibit providers from offering services and limit adolescents' access. Defining and clarifying the age of consent for HTC and access to care and treatment services is critical to improve services for adolescents and ALHIV.
- *Define adolescence.* Without clear and consistent definitions of the adolescent population, data cannot be collected and disaggregated in a way that clarifies whether the needs of this population are being met. Uniform reporting will allow for disaggregation of data to capture adolescent-specific data, to identify needs, and inform program planning at all levels for ALHIV.
- *Streamline and collaborate at all levels.* Adolescent HIV services within a country should be complementary and comprehensive across donor and implementing agencies to reduce duplication and streamline strategies to address services for ALHIV.
- *Incorporate transition into care and treatment guidelines.* Transition support for adolescents, their families, and their health care providers lags behind the recognition that the transition from pediatric to adult care is a challenge.

PRACTICE RECOMMENDATIONS

- *Involve adolescents.* To adequately respond to adolescents' needs, they must be involved in all stages of programming, from identifying what their desired services are and setting targets and goals, to designing and testing adolescent-friendly materials and delivery systems, helping deliver those services to their peers, and monitoring and evaluating progress.
- *Address adolescents in programming for key populations.* To reach the goal of an AIDS-free generation, it will be critical to implement effective HIV prevention, care, and treatment services for key adolescent populations, such as sex workers, men who have sex with men (MSM), or people

who inject drugs (PWID). Adolescent members of these key populations face double challenges of stigma and age that prevent access to services. Additional efforts are needed to address their increased vulnerability to HIV and to ensure their human rights.

- *Clearly define the target population in programming.* The needs of young people change significantly as they age through early adolescence to early adulthood. An intervention appropriate for a 12-year-old may not be applicable to an 18-year-old, and what may be appropriate for girls at a certain age may not be appropriate for boys of the same age.
- *Use data to inform program design and progress.* Current data systems pose challenges to disaggregating data on 10- to 19-year-olds. However, some smaller studies exist and as monitoring systems evolve to enable further disaggregation, programs should be able to use available data to better target programming to meet adolescents' needs.
- *Provide comprehensive, combination HIV prevention services.* Although HIV education in schools is widespread, the quality is inconsistent and messages may not be evidence based or take into account the local context of the epidemic. Adolescents not in school often do not have access to accurate information and prevention services. In order to reduce new infections, these gaps must be addressed, along with condom provision and promotion among sexually active adolescents. Proven effective structural interventions, such as cash-transfer programs and activities to help adolescent girls remain in school, should be brought to scale.
- *Scale up VMMC.* In countries where VMMC is supported, adolescent boys should have access to VMMC counseling and education tailored to their needs. Many VMMC programs are reaching young men, and these programs should ensure adolescent males are effectively linked with other HIV and health services.
- *Ensure access to PMTCT and other evidence-based interventions for adolescents.* PMTCT programs should be tailored to meet the needs of adolescent mothers to ensure they are tested for HIV and that those who test positive receive appropriate care and treatment and are retained in PMTCT services. Antenatal care platforms are where many young, horizontally infected women learn of their HIV status and play a critical role in linking these young women to services for their own health. PMTCT and other evidence-based interventions could be a key platform to reach this population and ensure they receive or are effectively linked with other HIV and health services.
- *Involve families and communities and address social norms.* Adolescents spend most of their time in their communities and with their families, outside of the clinic or health care facility. HIV prevention, care, and treatment activities would be strengthened by the increased involvement of parents, guardians, and caregivers.
- *Strengthen promising multi-sector and cross-cutting collaborations.* Some partnerships, like those between the health and education sector, are more obvious than others. There are opportunities for additional collaborations to address adolescents' needs, such as reaching adolescents with HIV prevention activities at sporting events or partnering with the technology industry to use social media for health programs.

INTRODUCTION

During adolescence, individuals undergo biological and psychological changes that are impacted by social influences that can affect health (Kasedde et al. 2013; Viner et al. 2012). According to Viner et al. (2012), structural factors are the greatest determinants of adolescent health. During this period, social and gender roles are often developed. Adolescents may experience increasing familial and work responsibilities, resulting in altered social and interpersonal relationships. Support from families, peers, and communities can help adolescents transition in a healthy manner into adulthood (Kasedde et al. 2013).

Until recently, it was assumed few children infected vertically (perinatally) with HIV would live beyond their fifth birthday. However, more young HIV survivors are presenting for care, receiving antiretroviral therapy (ART), and achieving viral suppression. As a result, increasing numbers of these children in sub-Saharan Africa are entering adolescence and adulthood (Ferrand et al. 2007). Most adolescents, however, acquire HIV through sex and other behavioral routes (Cowan and Pettifor 2009). Therefore, many adolescents require HIV prevention and treatment services, in addition to other health care services. In order to prevent further HIV transmission among adolescents, multilevel structural, behavioral, and biomedical approaches are needed (Cowan and Pettifor 2009).

Approximately 2.1 million adolescents were living with HIV worldwide by the end of 2011, including those infected perinatally and behaviorally. The vast majority (85 to 86 percent) of adolescents living with HIV (ALHIV) are in sub-Saharan Africa, with over half of all ALHIV (60 percent) living in Eastern and Southern Africa (Kasedde et al. 2013). New HIV infections are dramatically increasing, particularly among girls, who comprise approximately 60 percent of all ALHIV, primarily in sub-Saharan Africa, where epidemics are mostly generalized (Kasedde et al. 2013). A study of nine countries in sub-Saharan Africa showed that HIV prevalence is three times higher in girls (aged 15-19) when compared to adolescent boys (Gouws et al. 2008).

Despite the increasing numbers of ALHIV, many adolescents face barriers in accessing HIV testing, treatment, and other services. It is estimated that only a small proportion of adolescents in low- and middle-income countries who are survivors of perinatal HIV infection have access to treatment. This is primarily through small, specialized services in urban settings. Investment in targeted HIV prevention for young people (ages 10-24) remains generally limited (Kasedde et al. 2013). As the number ALHIV continues to increase, targeted services, policies, and programs need to improve to adequately respond to the multifaceted needs of this growing population.

The overall lack of attention to the special health needs of adolescents is further complicated by conflicting adolescent age definitions (Sawyer et al. 2012). This results in indicators and health data that are inadequate for program development and for monitoring and evaluation (M&E) of adolescent HIV programs (Patton et al. 2012). To reach an AIDS-free generation of adolescents, it will be critical to strengthen political efforts, commitment, and capacity to scale up HIV programs and improve existing integrated services for adolescents, and to improve M&E and reporting systems on services and health outcomes (Kasedde et al. 2013). In 2010, the Joint United Nations Programme on HIV and AIDS (UNAIDS) released the "Getting to Zero" guidance, which

recognizes the limited HIV prevention efforts for adolescents and introduces a new goal to reduce HIV incidence, including among young people, by half by 2015 (UNAIDS 2010).

As part of the response to the high HIV prevalence rates and unmet needs of adolescents, PEPFAR and USAID's Africa Bureau—in collaboration with UNICEF and supported by AIDSTAR-One—conducted a mapping activity to identify HIV policies and services for adolescents in 10 sub-Saharan African countries: Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. Through the mapping exercise, AIDSTAR-One offers wider technical suggestions to PEPFAR, USAID, UNICEF and host country governments by highlighting service gaps, areas of programmatic prioritization, and potential areas for integration that can serve as a resource for program development.

METHODOLOGY

Applying a mixed-methods approach, AIDSTAR-One staff conducted telephone interviews with key PEPFAR country office staff and UNICEF country office staff and online surveys with implementing partners and government officials. The interview protocol and survey instrument used information that arose from the development of an AIDSTAR-One technical brief on "Transitioning of Care and Other Services for Adolescents Living with HIV in Sub-Saharan Africa" and a field-driven learning meeting on February 7-10, 2012, as well as from a UNICEF questionnaire on good practices related to services for ALHIV. The Office of the U.S. Global AIDS Coordinator, USAID's Africa Bureau, and UNICEF also provided direct input into the tools. The interview protocol and online survey had three distinct sections of questions: adolescent activities to support progress towards an AIDS-free generation, particularly within a country's national strategy; adolescent activities with donor support; and cross-cutting initiatives or potential areas for integration. For the purposes of this activity, AIDSTAR-One used the World Health Organization's (WHO) definition of an adolescent as a young person aged 10-19.

MAPPING OBJECTIVES

AIDSTAR-One's adolescent HIV services mapping activity aimed to:

1. Recommend prioritization of evidence-based adolescent activities that most enhance and support the United States Government (USG) priorities and global priorities for an AIDS-free generation.
2. Recommend prioritization of adolescent activities within the USG and global HIV portfolio.
3. Recommend prioritization of cross-occurring areas and potential areas for integration of adolescent activities within the HIV and other health portfolios.

SAMPLING AND DATA COLLECTION

PEPFAR and UNICEF headquarters staff provided contact information and introductions for key informants at UNICEF and PEPFAR offices in participating countries. Interview participants were then identified by the PEPFAR country office coordinator or the UNICEF health or HIV team lead. The number of interviewees participating in each telephone interview ranged from one participant to group interviews with up to five participants. In the group interview format, individual interviewees answered questions specific to his/her technical expertise or discussed the question with other interviewees before responding, in some cases. Following each interview with country teams, AIDSTAR-One requested that the interviewees provide contact information of other relevant stakeholders—a snowball sampling—who were suitable to complete an online survey on similar topics. AIDSTAR-One sent the online survey to those suggested by PEPFAR and UNICEF country staff. The implementing partners who participated in the online survey primarily represented in-country NGOs, in addition to government agencies (e.g., ministries of health). See Annexes One and Two for the interview protocol and online survey.

After facilitating the interviews and online survey, the authors analyzed interview notes and summarized them for each country, along with recommendations for improving or creating adolescent HIV services and programs. They included gaps and potential areas for strengthening adolescent-related policies or services. Because many countries were in nascent stages of developing or implementing adolescent strategies, challenges or gaps were often discussed during the interviews. During review and analysis, commonly discussed gaps were identified and areas for improvement determined.

The authors analyzed survey responses for additional information regarding HIV service provision to supplement interview data and to identify innovative approaches that other country programs or governments may want to consider. They used the following criteria to select innovative approaches: 1) the program/services targeted adolescents (at least within a larger target), 2) addressed HIV prevention, care, and/or treatment, in addition to potentially integrating services, and 3) employed a new or pioneering program or activity, compared with traditional models. Due to the inherent lack of data among adolescent programs, innovative approaches do not necessarily represent strategies proven to be effective.

LIMITATIONS

The findings provide an understanding of the context of each country's HIV services and policies specific to adolescents, but some limitations exist. As the nature of interviews yield subjective feedback, the findings may subjectively rate effectiveness of specific services or policies. In terms of USG participants, all PEPFAR implementing department and agencies were invited to participate, however, the majority were from one agency. This limits not only the breadth of implementing partners and activities discussed during interviews, but also those suggested to participate in the online survey as part of the snowball approach.

The services and policies included may not be an exhaustive list of all relevant services or policies in each country, as they are limited to information provided from the interviews and online surveys. They do not include interviews with representatives from governments responsible for implementing national programs. The authors recognize that other HIV-related activities targeting adolescents likely exist, and future activities and research should aim to identify an exhaustive list of relevant activities implemented through a wide range of governments, donors, and implementing partners.

Further, because the interviews were conducted via telephone or Skype, with occasional poor connections, the interviewers may have inadvertently recorded misinformation or misunderstood the interviewees. The interviewers tried to probe to gain comprehensive feedback for each question; however, due to limited time to conduct each interview, and the comprehensiveness of the interview guide, there were occasional challenges. To mitigate these potential biases, AIDSTAR-One provided a draft of each country section of the report to the interviewees to verify, edit, and provide feedback on the findings.

The sample size of the interviews and online surveys was not large enough to suggest the findings are representative of all stakeholders in each country, however, the range of stakeholders from USG, UNICEF, and various implementing partners provided comprehensive feedback and various perspectives. Despite the limitations, AIDSTAR-One has provided a foundation to understanding the availability of HIV services and policies in 10 countries in sub-Saharan Africa.

COUNTRY FINDINGS: HIV SERVICES FOR ADOLESCENTS

Forty UNICEF and USG informants from 10 countries participated in the interviews and 29 implementing partners and Ministry of Health (MOH) officials from 8 countries participated in the online survey. Of 31 respondents who initiated the online survey, 21 completed the survey (67.7 percent). Interview and survey participants are presented in Tables 1 and 2.

Although the importance of incorporating adolescent-specific HIV strategies and adolescent-friendly HIV services is generally acknowledged, most countries are in early stages of strategy or policy development for doing so. The age group definitions of adolescents are inconsistent, even within countries. Some countries acknowledge the WHO definition of an adolescent—a young person between the ages of 10-19—but may not practically implement it. More commonly, adolescents are referenced as within a "youth" or "young people" category. Data are commonly collected as children, 0-15, and adults, over age 15. This impedes effective data collection and disaggregation into an adolescent category.

Further, the "age of consent" for an adolescent to seek HIV testing varies. Table 3 displays the age variations by county. Some countries have implemented HIV activities specifically for adolescents, although these are mostly on a small scale and largely uncoordinated with other services. Most HIV prevention activities for adolescents are located in schools. However, many of the school-based curricula are not comprehensive and linkages from the school setting to accessible, quality, and youth-friendly HIV services is challenging. Youth clubs or youth corners were highlighted as points of health access for adolescents, although many were described as dysfunctional or small-scale.

Voluntary medical male circumcision (VMMC) has scaled up in several countries in this survey. Although efforts did not originally target male adolescents, according to those surveyed, this population has accessed the services more than other age groups. Challenges remain, however, in linking them to other services. Adolescents (both HIV-positive and HIV-negative) are still typically seen in either pediatric or adult HIV services. The transition in care between pediatric and adult services remains a challenge in most settings, although there is acknowledgment that it is important to improve care for adolescents. Further complicating access issues are the limited human resources who are specifically trained to provide adolescent services.

Findings compiled from the interviews and surveys are presented in the following sections, by country. In each section, findings are summarized by the component of the HIV services continuum of care—prevention, HIV testing and counseling (HTC), and care and treatment—with an analysis on the stage of development, existing gaps in implementation, and information on health systems strengthening and multi-sector collaborations. Innovative approaches are also identified throughout the report. Each country section also contains links to resources available. In describing reportedly available policies and programs, the authors defer to each country's definition of youth or adolescents. Because the findings presented are based on key informant interviews and survey results, the strategies, services, and programs detailed for each country are limited to the information they provided.

Table 1. Key Informant Interviews by Country

Country	PEPFAR and/or UNICEF Participation	Number of Key Informants
Kenya	PEPFAR, UNICEF	4
Lesotho	PEPFAR, UNICEF	4
Malawi	UNICEF	2
Mozambique	PEFPAR, UNICEF	5
South Africa	PEPFAR, UNICEF	5
Swaziland	PEPFAR, UNICEF	5
Tanzania	PEPFAR, UNICEF	6
Uganda	UNICEF	2
Zambia	PEPFAR, UNICEF	4
Zimbabwe	PEPFAR, UNICEF	3
	Total Number of Key Informants:	40

Table 2. Implementing Partner Survey Respondent Organizations

Country	Implementing Partner(s)	Number of Participating Organizations
Kenya	Government, NGO	3
Lesotho	NGO	3
Malawi	n/a	0
Mozambique	NGO, UN agency	3
South Africa	NGO	4
Swaziland	Government, NGO	4
Tanzania	Government, NGO, UN agency	6
Uganda	n/a	0
Zambia	NGO	1
Zimbabwe	NGO	5
	Total Number of Participating Organizations:	29

Table 3. Adolescent Age Definitions and Data Disaggregation by Country

COUNTRY	ADOLESCENT AGE RANGE DEFINITION	AGE OF CONSENT FOR HIV TESTING	DATA DISAGGREGATION
Kenya	10-24*	13	<15; and >15[+]
Lesotho	10-25*	12	10-14; 15-19**
Malawi	13-18*	13	18 months-14 years; 15-24**
Mozambique	10-19*	16	<15; and >15[+]
South Africa	10-19*	12	Not specified
Swaziland	10-24[a]	12	Not specified; adolescent data not collected at national level
Tanzania	10-19*	18	<15; and >15
Uganda	15-19*	18	Not specified
Zambia	15-19*	16	10-14; 15-19[b]
Zimbabwe	12-19*	16	0-14; 15-19; >19

*definition may vary (e.g., may be extended in practice to include older youth);

[+]most common reporting; **HTC data; [a] youth age range definition; [b] not necessarily uniform

KENYA

ADOLESCENT DEFINITION

In Kenya, interview findings suggested that an adolescent is defined according to the WHO definition, ages 10-19. However, in daily management at the point of service delivery, youth up to age 20 or 21 may access services for "adolescents," especially if there are issues of transition from pediatric to adult care. An adolescent may in fact continue to consult pediatric services into their early twenties. Most reporting tools do not capture the adolescent age group accurately (i.e., disaggregating by 0-15 and >15 or 0-18 and >18), thus it is a challenge to quantify the actual number of adolescents in Kenya who need or who access HIV services. The population of "youth" or "young people" in Kenya being targeted by HIV programs may even include those up to the age of 35.

The sheer number of youth in Kenya makes coverage a challenge, with nearly two-thirds (61.2 percent) of Kenya's population between the ages of 0-24 years old (ages 0-14 comprise 42.4 percent, and ages 15-24 comprise 18.8 percent) (Central Intelligence Agency Factbook 2013). In 2011, there were an estimated 220,000 children living with HIV, and an HIV prevalence of 2.6 percent among young people (ages 15-24), with a higher rate in young women than young men (UNICEF 2003).

Adolescent Age Range	Ages 10-24*
Age of Testing Consent	Age 13
Data Disaggregation**	<15 and >15+

*age range definition may vary

**common health services reporting tools

HEALTH SYSTEMS STRENGTHENING

The MOH Department of Reproductive Health developed a policy, the *Adolescent Reproductive Health and Development Policy and Action Plan (2005-2015)*, that addresses adolescent sexual and reproductive health (SRH), and includes some discussion of HIV, youth-friendly services, and provisions for health care provider training to build capacity for delivering adolescent-friendly services. Guidelines for the clinical management of ALHIV are in development, but have not yet been implemented. Piloting of the guidelines is planned for late 2013. These guidelines are specific to the adolescent package of care and other HIV services. Previous policy guidelines exist for adolescent health, drawing from other policy areas, but, according to interview findings, they have not been implemented successfully on a wide scale. The National AIDS Strategic Plan will be revised when the results of a recent AIDS indicator survey are available, though it is not yet clear if there will be a specific component for adolescents.

"Continuous community mobilization and education for the health care providers is needed to strengthen provision of services for ALHIV." NGO, Kenya (survey respondent)

HIV PREVENTION

The national HIV prevention program includes a component for 15- to 24-year-olds and HIV education is part of the national curriculum in primary and secondary schools. The National AIDS and STI Control Program (NASCOP) and the MOH have adopted an evidence-based life skills intervention developed in the United States, *Healthy Choices for a Better Future*. It is for implementation with both in- and out-of-school adolescents and addresses STI, HIV, and pregnancy prevention. The program promotes abstinence, delaying sexual debut, safe sex, life skills, and information about HIV and STIs. The primary target group is adolescents aged 10-15 in schools, and the interventions are delivered in either a one-on-one or small group setting. Out-of-school youth targets are married adolescents and sexually active 13-17 year olds; the focus for them is on sexual and reproductive health (SRH) and being faithful. HTC is encouraged and referrals provided.

Another HIV prevention activity for adolescents engages parents and caregivers. This recognizes that adolescents want to get information on HIV and SRH from these important adults in their lives, but can instead receive sometimes incorrect information from their peers. The intervention engages parents and caregivers and provides them with information and skills to talk to their adolescents about these issues. The MOH and Ministry of Education (MOE) collaborate to develop life skills-based programs implemented by service providers.

The Kenyan MOH has released guidelines on interventions for key populations, but adolescents are not explicitly included in them. Young sex workers (SWs), men who have sex with men (MSM), and people who inject drugs (PWID) can access services in the same facilities as adults in these key populations. People in prisons are also a target population for the National AIDS and STI Control Program's work with key populations. Reaching younger adolescent key populations (under the age of 18) is difficult due to dual discrimination—age and stigmatized behaviors.

HIV TESTING AND COUNSELING

HIV testing services are available to anyone over the age of 13 in Kenya without parental consent. HTC is offered at facilities, specific HTC sites, and through home-based testing programs. There are no adolescent-specific HTC services, and HTC data is disaggregated by two age groups, <15 and 15+ years. The MOH and MOE work together to ensure that HTC is promoted in prevention programs, but as HTC is not available in schools, adolescents are referred to testing sites.

Mass media, including radio campaigns, also target adolescents. Especially around World AIDS Day, there are many testing events that especially target adolescents and youth. An example of specific activities encouraging testing among adolescents is the presence of "testing tents" at football games. It is not yet clear if adolescent testing rates have increased from these efforts.

Adolescents are also identified for testing through positive health, dignity, and prevention (PHDP) programs. If a family member has been identified as HIV-positive through a PHDP program, this provides an entry point to encourage other family members to also be tested and enrolled into care.

Interview findings indicated that, according to HTC disclosure guidelines, disclosure for perinatally-infected children ideally happens before adolescence, around the age of 8 or 9, by a parent, guardian, or caretaker. Health care facility staff may support the caretaker in the process if needed. Support groups have been established for adolescents who know their status; however these are not widely implemented.

CARE AND TREATMENT

Care and treatment for ALHIV has long been enveloped within adult services without distinction for age. Adolescent-specific services, including transition support, may be available in some small-scale programs, but are not implemented in a systematic manner. In some cases, programs are already targeting adolescents.

The MOH is currently discussing development of guidelines for HIV management of adolescents, including a specific package of care and treatment services. All implementing partners will treat adolescents as a unique age group of individuals with specific care and treatment needs instead of as adults. The initial rollout will be in 50 facilities across the country. The services package will include care and treatment, adherence, retention, mental health, reproductive health, psychosocial support, transition, and disclosure services. The youth-friendly service package includes an "adolescent day," an activity to encourage young people to access services as a package, including ART appointments for adolescents offered separately from adult appointment days. School holidays will used to allow the students to attend the clinic.

NASCOP is working to adapt general PHDP materials for adolescents. The materials currently include both community and clinical components. These tools will allow service providers to offer at least three services to ALHIV, including adherence counseling.

The mothers2mothers program, in collaboration with the MOH, implements support groups for HIV-positive mothers in Kenya. They don't have a specific adolescent program, but they offer peer mentoring and counseling for young mothers, many of whom are adolescents.

MULTI-SECTOR COLLABORATIONS

An adolescent technical working group (TWG) within the MOH oversees adolescent HIV services, including prevention and treatment. The composition of the TWG is over 80 percent PEPFAR partners, and also includes WHO and UN agencies. The WHO supports adolescent policy and advocacy issues, especially around defining the minimum package of care. The TWG develops guidelines and policies and coordinates activities at the regional level through stakeholder meetings with various government agencies. Within the MOH, the departments of SRH and child health participate, as does the MOE.

Programs addressing gender-based violence (GBV) include provision of information on HIV, but the linkages between services are poor. A multi-sector GBV steering committee is coordinating the response to GBV in Kenya. One site is piloting a "one-stop shop" for victims of sexual violence, including HIV services, but adolescents are not a specific target for GBV efforts.

Within the community health strategy, there is advocacy to engage older adolescents and youth as community health workers. Although some of the health workers may be older than the "adolescent" age range because the younger cohort would be in school, youth community health workers spearhead community-level activities for adolescents and youth and give a voice to their peers.

CURRENT GAPS AND AREAS FOR STRENGTHENING

- Adapt data collection procedures so adolescent-specific data are available.
- Improve availability of adolescent-friendly HTC and strengthen linkages between schools and testing centers.
- Consider the integration of primary care and SRH services for ALHIV and HIV-negative adolescents, as the HIV-negative adolescents are at risk for HIV and both groups have overlapping health needs, including improved support for adolescents in schools.
- Increase disclosure education and support for parents of perinatally-infected adolescents.
- Create and strengthen linkages between GVB and HIV services, and prioritize adolescents.

RESOURCES

Adolescent Reproductive Health and Development Policy: Plan of Action 2005-2015.
http://www.policyproject.com/pubs/policyplan/KEN_ARH_POA%202005-15.pdf

Kenya National AIDS Strategic Plan, 2009-10-2012/2013, Delivering on Universal Access to Services
http://hivaidsclearinghouse.unesco.org/search/resources/5752_KenyaPlan2009.pdf

National Testing Guidelines for HIV Testing and Counseling in Kenya (2010)
http://nascop.or.ke/library/HTC/National%20Guidelines%20for%20HTC%20in%20Kenya%202010.pdf

LESOTHO

ADOLESCENT DEFINITION

Stakeholders in Lesotho use the WHO definition of adolescent, but programming is also targeting "youth," a more ambiguous group without firm age limits that often refers to young people between the ages of 10 and 25. This complicates understanding the scope and reach of current programs. Determining how well most HIV services meet adolescents' needs is difficult, as data are collected by pediatric (under 15 years) and adult (15 years and older) categories. HTC registers include more precise age ranges (10-14 and 15-19), yet interview findings suggest that this routine data are not used to improve service delivery.

Nationally, there are ten "adolescent health corners," which aim to provide enhanced and expanded youth-friendly services, including HIV services. But generally they are not functioning well and are poorly coordinated with mainstream facilities. Lack of coordination between primary care and HIV services at the national level creates challenges for linking adolescents to necessary services. As a result, adolescents are often lost between these services.

Adolescent Age Range	Ages 10-25*
Age of Testing Consent	Age 12
Data Disaggregation **	10-14; 15-19

*age range definition may vary

**HTC data

HEALTH SYSTEMS STRENGTHENING

Lesotho's *National Strategic Plan on HIV and AIDS* 2011/12-2015/16 guides the national and multi-sectoral AIDS response through focus on high-impact interventions, and mentions an adolescent and youth strategy. Youth are considered a key group within the strategy for HIV services, including behavior change communication (BCC), HTC, and condom promotion in and out of school programs. The MOH created the *Strategic Plan for Elimination of Mother to Child Transmission of HIV and for Pediatric HIV Care and Treatment* (2011/2012-2015/2016). The TWG overseeing implementation of the strategic plan initiated discussions with the MOH to specifically include adolescents. This strategic plan incorporates expanding access to youth-friendly services, improving psychosocial support for ALHIV, and advocating for equal access to quality HIV services (MOHSW 2011).

HIV PREVENTION

According to key informant interviews, comprehensive HIV knowledge is low among youth. The government directly provides prevention services through the MOH, including HIV testing and counseling and VMMC. The Ministry of Education is currently reviewing an in-school curriculum to incorporate sexual health education. Many HIV prevention campaigns do not specifically target adolescents, but reach them through activities targeting the general population. Prevention activities prioritize people aged 15-35, so older adolescents are a part of this target group.

Several implementing partners also play key roles in HIV prevention in collaboration with government activities. Population Services International (PSI) implements BCC interventions, condom social marketing, HTC outreach, and mobile and fixed HIV testing for the general population, including adolescents. Although there is a dearth of information, education, and communication (IEC) materials specifically targeting adolescents, PSI and the Johns Hopkins Center for Communication Programs are producing improved IEC materials for youth focusing on condom use, HTC, and positive living. Existing curriculum-based HIV prevention for adolescents in schools includes messaging on abstinence, being faithful, referrals for condoms, and voluntary counseling and testing services, although this content is delivered inconsistently. These activities are primarily conducted through the curriculum life skills program, but may not be implemented fully due to teachers' heavy subject load. Culture and religious beliefs present a challenge to messaging and communication due to the taboo of discussing SRH and HIV prevention with adolescents, particularly in schools.

Together with MOH activities, PEPFAR partners are working to strengthen HIV prevention messages and services in programs designed for OVC, however, these programs are not specifically geared to adolescents. Although not focused only on HIV prevention, economic strengthening activities target youth who have dropped out of school and provide vocational training. In addition, PEPFAR partners also implement prevention for out-of-school youth through income-generating activities that incorporate messages surrounding sexuality, HIV, and where to access HIV services. UNICEF, the European Union, and the Ministry of Social Development support "cash grant programs" to impoverished households with vulnerable children. Recipients include adolescents of

child-headed households, as part of a larger social protection program for children. The program was being evaluated to assess impact on access to health services at the time the interviews were conducted.

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) is the lead provider of PMTCT services in Lesotho. Although adolescent girls aren't specifically targeted, pregnant adolescent girls are reached through routine service provision. JHPIEGO, affiliated with the Johns Hopkins University, is scaling up VMMC services among the general population. To date, approximately 80 percent of young clients have sought VMMC without deliberate demand creation, signaling the high levels of interest in this service among young men. Linking VMMC recipients to other health services remains a challenge.

National prevention services are not focusing on key populations. The United Nations Population Fund provides some services to vulnerable populations, for example, sex workers and "herd boys," boys who traditionally were expected to herd and often lack education at all (Lesotho Herd Boys Association [Monno Kha Khomo] 2010). Programming for key populations remains somewhat controversial, and key informants suggested that it may be a better use of resources to first focus on strengthening HIV prevention services for adolescents overall before focusing on adolescent key populations.

HIV TESTING AND COUNSELING

Adolescents can access HTC in facilities and community sites. In Lesotho, children and adults who are age 12 or older can give informed consent for HIV testing. For children younger than 12, a parent or guardian consents to testing for the child (MOH 2007). According to interview findings, HTC services are generally weak in targeting and reaching adolescents. National HTC guidelines are currently being reviewed to encourage targeted HTC for adolescents. HTC for young pregnant women has been successful as a result of PMTCT services and outreach, but reaching more adolescent girls outside of PMTCT clinics is a priority. Reaching adolescent boys for HTC is particularly challenging, but with the scale-up of VMMC services, there will be increased opportunities.

The MOH oversees HTC services, PSI provides mobile testing, and EGPAF supports the ministry at the clinic level. Yet, the greatest barriers to overcome are to increase the number of adolescents accessing HTC and linking them to appropriate care, as well as to train health care providers on communicating with and caring for this age group.

CARE AND TREATMENT

Through the MOH, and with support from implementing partners, HIV treatment services for adolescents are primarily integrated into adult treatment services, without an adolescent-specific focus. Key informants noted there is discussion of scaling up "adolescent corners" — youth-friendly services, similar to Baylor International Pediatric AIDS Initiative model—but these are not currently available on a national scale. Key informants reported that there are 10 adolescent corners, yet only a few may be functional.

"Adolescents rarely attend health facilities; however, the services available at adolescent corners have been greatly improved in last two years."
–NGO, Lesotho (survey respondent).

Baylor provides pediatric care with a focus on adolescent services, including psychosocial and disclosure support, yet their work is not at a scale sufficient to meet the needs of all ALHIV in Lesotho. Responding to identified need, in collaboration with UNICEF, Baylor has begun training, mentoring, and supporting other facilities throughout the country to improve adolescent-friendly services on a larger scale. Interviewees reported that adolescent corners in referral hospitals under Baylor support are showing promise.

In two districts of Lesotho in 2012, the MOH, UNICEF, and EPGAF piloted "adolescent health week," which was designed as an avenue to reach adolescents outside of school hours. During these activities, health care providers offered integrated health care, e.g. HTC, blood pressure screening, and diabetes care to adolescents and their families. Lessons learned from the pilot included that adolescents were accessing the services because of the services hours and holistic approach to "healthy living" (not only focused on HIV). The lessons learned are being adopted into a targeted "adolescent health day," which is one activity within a larger, established event, "child health weeks" that are implemented biannually in each district.

The U.S. Peace Corps is revising a project framework to target youth aged 10-24 to improve the continuum of HIV care and linkages to services. This new program is an opportunity for other stakeholders to collaborate to strengthen HIV care services for adolescents.

MULTI-SECTOR COLLABORATIONS

The MOH aims to work closely with the MOE and the Ministry of Social Development to implement HIV services, yet in reality, finding platforms to collaborate has challenges. Areas of collaboration include the rapid scale-up of VMMC services. VMMC can be an opportunity to provide or link young men to a package of health and follow-up HIV services, including peer counseling and discussion, as many young men are already seeking VMMC without activities to generate demand. Broader HIV prevention issues—such as gender norms and such structural issues as providing condoms in schools—could be incorporated into the classroom environments, yet these remain challenges in a deeply religious society. Both family planning (FP) and SRH are focus areas in Lesotho, and therefore entry points into the health system.

"Identification of those needing services remains the largest barrier, particularly those who are infected during adolescence (sexual contact). Improving access and uptake of STI and SRH services by adolescents will facilitate prevention and early recognition of HIV infection in adolescents." NGO, Lesotho (survey respondent).

CURRENT GAPS AND AREAS FOR STRENGTHENING

- Adapt data collection procedures so adolescent-specific data are available.
- Recognize the unique needs and motivations of adolescents and design services around them, scale up effective initiatives, and improve outreach to increase HTC, particularly among adolescent males.
- Continue improving and scaling up high-quality adolescent health corners.
- Increase and strengthen HIV prevention activities, as HIV knowledge among adolescents is low.
- Create cross-cutting activities with adolescent HIV care, FP, SRH, and other health services and coordinate services at the national level.

RESOURCES

Strategic Plan for Elimination of Mother to Child Transmission of HIV and for Paediatric HIV Care and Treatment.
http://www.emtct-iatt.org/wp-content/uploads/2012/11/Lesotho_National-EMTCT-Plan_2011.pdf

HIV and AIDS Strategic Plan 2010-2012 for the Herd Boys Community in Lesotho
http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_150846.pdf

MALAWI

ADOLESCENT DEFINITION

Although stakeholders refer to the WHO definition of "adolescent" in Malawi, programming has been directed towards a broader "youth" group. Only recently has the focus begun specifically shifting towards adolescents. The National Youth Council oversees organizations that implement adolescent-focused HIV activities. The ministries of Health, Education, and Youth are the key stakeholders responsible for implementing the strategy.

The current strategy focuses on primary prevention with limited attention to care, treatment, and post-test support services for adolescents. However, some stakeholders and donors, such as PEPFAR, the Global Fund, Christian Health Association, and various ministries (MOH, MOE, and Ministry of Youth) are collaborating to scale up services for adolescents. "Youth" comprise a large portion of the population accessing HTC, but with the wide age brackets on the current HTC

register—ages 0-17 months, 18 months-14 years, 15-24 years, and 25 and over—identifying and using specific adolescent data remains a challenge.

Adolescent Age Range	Ages 13-18*
Age of Testing Consent	Age 13
Data Disaggregation**	18 months-14 years; 15-24

*youth age range defined: 10-29 in the recently launched Youth Policy

**HTC data

HEALTH SYSTEMS STRENGTHENING

The National HIV Prevention Strategy (2009-2013) addresses prevention among young people, including strategies to reduce the number of concurrent partners and transgenerational sex (National AIDS Commission, Malawi 2009). However, there is growing recognition that adolescents have special needs apart from this larger group. The *Five-Year Plan to Scale Up HIV Testing and Counseling Services in Malawi (2006-2010)* includes a section detailing how youth-friendly services (ages 12-24) will be expanded, such as by integrating them into stand-alone or more comprehensive HTC facilities; integrating testing services into youth reproductive health services; and encouraging NGOs to create youth-friendly HTC services (Malawi Ministry of Health 2006). In 2007, the MOH developed *Guidelines for Paediatric HIV Testing and Counseling,* which incorporates adolescents (13-18) in a small section on educating adolescents on safe sex practices and counseling on disclosure of their status to sexual partners (Malawi Ministry of Health 2007). A rapid assessment was conducted on adolescent HTC uptake, and some partners advocated for targeted HTC services for adolescents in the 2012 HTC Campaign. The MOH is trying to make services more "youth friendly" and train health care providers on youth's needs.

HIV PREVENTION (INCLUDING KEY POPULATIONS)

Young people, though not necessarily adolescents, are prioritized for HIV prevention services. In-school youth receive basic HIV prevention information through curriculum-based life skills programs that focuses on abstinence, faithfulness, and condom use. However, these messages do not address risky behaviors and both comprehensive HIV knowledge and uptake of other HIV services remain low. The MOE is responsible for this school curriculum. However, a revised life skills curriculum for secondary schools encourages CBOs, health service providers, and other stakeholders to work with schools to provide more comprehensive education and services.

Youth clubs and related social activities that include interpersonal communication and BCC are also implemented in school settings. An additional school-based intervention is the "test for the test," a self-administered five-item questionnaire that helps adolescents assess their risk and encourages them to get tested for HIV if indicated. UNICEF is supporting districts to implement the Sister2Sister program, which targets 15- to 18-year-old girls with HIV prevention and life skills activities. Integrating mobile HTC into sporting events reaches young people through a partnership with NGOs such as GrassRoots Soccer. Cash transfer programs have shown some promise in keeping girls in school and reducing their vulnerabilities to HIV, STIs, and other poor health outcomes.

With PEPFAR funding, the MOH is implementing VMMC services. In the districts where they are offered, uptake among young men is reported to be very high. Current programs have targeted adult men above the age of 29, but an opportunity exists to reach younger men with HIV prevention

information and services, including links to HTC. PEPFAR is currently working with the government to scale up and ensure VMMC services are available and accessible.

The national HIV strategy identified priority groups for primary prevention services, including sex workers and sexual minorities. However, adolescents are not specifically mentioned, nor are interventions tailored to meet their unique needs. Legal restraints may also complicate the delivery of HIV prevention services for adolescent key populations. For example, an adolescent female who is a sex worker (and a minor) must be treated in the context of sexual abuse instead of sex work.

HIV TESTING AND COUNSELING

According to national guidelines, adolescents from the age of 13 can access HTC services without parental/guardian consent. However, some adolescents become sexually active at a younger age, and providers may, at their discretion, provide testing to those as young as 9 years old. Pregnant females (some as young as 10) accessing antenatal services are also tested without parental consent. HTC is available in both public and private facilities, but neither includes specialized centers for adolescents. Specific data for adolescents are not available, but routine data from HTC services suggest young people receive HTC via routine testing, community outreach campaigns, and national campaigns such as "HTC Week" targeting the general population.

Along with the MOH, partners such as the National AIDS Council (NAC) and UNICEF collaborate to support HTC, and offer an entry point to HIV prevention and PMTCT services. Interviewees indicated that some implementing partners advocated for specific services targeting adolescents for the 2012 HTC campaign. UNICEF recently conducted a rapid assessment at HTC facilities in five districts, which indicated that uptake is very high among older adolescents aged 15-19. Reportedly 95 percent of adolescents accessing HTC are in this age range. But access is very low among younger adolescents aged 10-14, possibly due to their greater challenges in traveling distances to reach the facilities and their low risk perception. An average of 20 percent of HTC clients at these facilities were between 10 and 19 years of age, but use was variable and less than 10 percent in some districts participated in the assessment.

Key informants suggested that some small-scale and uncoordinated interventions are targeting "youth," using schools as an entry point for HIV testing. They are linking youth to other services for HIV prevention or, if diagnosed HIV-positive, to psychosocial support and treatment. The key informants suggested how HTC as an entry point to HIV prevention should be scaled up. They could provide a package of post-test services for those who test negative, such as condoms, VMMC referral, peer support, and FP referral.

The rapid assessment also examined referral systems and found that the majority (almost 90 percent) of adolescent HTC clients who tested HIV-positive were referred for ART, but less than one percent of those who tested HIV-negative were referred for any services, including post-test risk reduction counseling. This is a missed opportunity for adolescents who were already accessing the health system.

Adolescents who are accessing HTC services may be accompanied by a parent and may have been ill for some time. Disclosure often happens at the time of testing. Disclosure to partners is being encouraged through programs placing an emphasis on couples testing.

CARE AND TREATMENT

According to the national HIV treatment guidelines, young adolescents under the age of 14 access care and treatment services in pediatric clinics and adolescents over the age of 14 receive services through the adult clinics. ART services are widely available in different types of facilities, public and private, including the Christian Health Association of Malawi, hospitals, and health centers.

Baylor initiated their Teen Club model in 2006, and in 2010, began scaling up services in a phased approach to other district hospitals and health centers to support ALHIV. UNICEF is supporting Baylor to expand Teen Club to 10 sites in 2013, and plans an additional 10 sites in 2014. The clubs provide ALHIV with support, including psychosocial and adherence support, and follow-up for appointments. They also engage parents and guardians and are working with teachers to decrease stigma and discrimination. At Teen Club Day, the adolescents can discuss any issues they may be facing with their parents/guardians and receive comprehensive services, including family planning and condom distribution (for those that are sexually active), and treatment of illnesses. The model, supported by the Global Fund, is being replicated by other stakeholders, and every district currently has at least one club. Reaching adolescents in remote areas with these comprehensive care services remains a challenge and in facilities without a Teen Club, accessing the range of services in one place is difficult.

The rapid assessment of HTC in five districts also identified such major issues for ALHIV as poor access to ART and support services. Other documented challenges to care and treatment include current, adolescent-friendly messaging and language barriers (i.e., information not available in local languages) as well as stigma on the part of the health care workers, who often treat adolescents negatively if they seek condoms or SRH information. This is compounded by staffing shortages and the fact that health care workers do not think they need to invest the time to provide such services to adolescents. Interviewees discussed that a youth-friendly approach is recognized as necessary to increase the reach and uptake of services among adolescents.

MULTI-SECTOR COLLABORATIONS

The Ministry of Gender and Child Protection operates One-Stop Centers to provide sexually abused or exploited children and youth (and adults) with health services, using HTC as an entry point for referrals for other needs. There are four One-Stop centers in Malawi: in Lilongwe, Mzuzu, Zomba, and Blantyre (Malawi Ministry of Health 2012). The majority of current multi-sector collaborations occur between MOH (and implementing partners) and the MOE on school-based interventions, which include integrating HIV curriculums into schools for HIV prevention. However, more comprehensive prevention is needed. In some cases, current HIV services are also integrated with maternal and child health and FP programs.

YONECO, a local NGO, is providing a toll-free child helpline for children and young people who need information and support on issues that affect them, including issues of SRH and HIV. It has the support of the Ministry of Gender and Child Development, through UNICEF funding, and the toll-free line is provided by a local private telecommunications company. Data from the NGO shows that the majority of users of the helpline are seeking information and assistance on SRH and HIV issues.

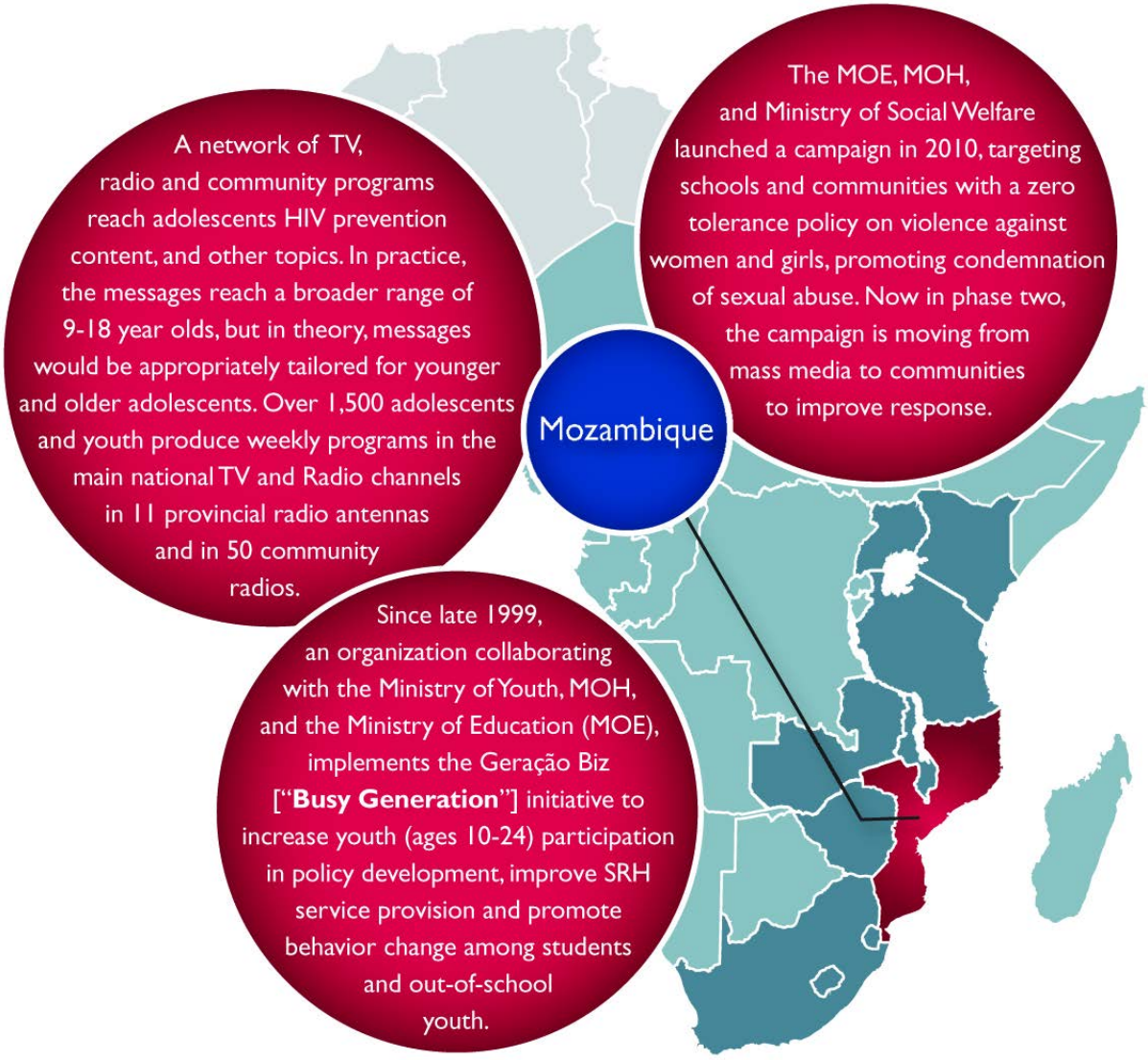
CURRENT GAP AND AREAS FOR STRENGTHENING

- Adapt data collection procedures so adolescent-specific data are available.
- Plan and implement activities for out-of-school adolescents, as reaching them is a challenge. Activities should include HIV prevention services.
- Obtain information on routine adolescent testing across all HTC facilities in Malawi, as there are currently difficulties due to the age disaggregation in reporting.
- Plan post-test HTC activities; most adolescents who test negative for HIV are not referred for risk-reduction counseling, condoms, family planning counseling, or other follow-up services. This is a large missed opportunity.
- Scale up HTC services specifically for adolescents. HTC should be targeted to bolster its position as an entry point to prevention and care. Adolescents who test positive could be referred to ART and post-test services in the community, including psychosocial support, such as the Baylor Teen Clubs. Providing integrated services, including primary care services, will be useful for ALHIV.
- Collaborate to address some of the challenges to providing adolescents with comprehensive HIV services, such as the lack of adolescent-appropriate information, education and communication (IEC) materials and resource shortages, for example, of test kits and condoms. This will be especially important as HTC is increasingly used as a platform for HIV prevention, and this strategy should also be a component of the roll out of VMMC.
- Identify opportunities for integration and collaboration to maximize resources and bring together family planning, FP, and STI services with HIV to address adolescents' needs in these areas together.

RESOURCES

The 5 Year Plan to Scale Up HIV Testing and Counselling Services in Malawi 2006-2010
http://www.hivunitmohmw.org/Main/HIVTesting

MOZAMBIQUE



ADOLESCENT DEFINITION

The official definition of "adolescent" in Mozambique is the WHO definition of ages 10-19, but in practice the age ranges may vary. Many interventions target adolescents, young people, or both groups. Some programs separate younger adolescents, such as the MOE's One Club life skills program, which targets 10- to 14-year-olds. In general, services are separated for those younger than 15, and those 15 or older. Data are collected according to these age groups, making it difficult to specify services and disaggregate data for adolescents.

UNFPA is the lead UN agency in adolescent programming in Mozambique, with UNICEF also being actively involved. Through implementing partners, USAID is also a stakeholder. The Elizabeth Glaser Pediatric AIDS Foundation has implemented adolescent-specific services, and Pathfinder has taken a more youth-friendly approach. Since there is overall recognition that

adolescents require specific services, policy discussions regarding adolescent health services are at a critical stage in Mozambique.

Adolescent Age Range	Ages 10-19*
Age of Testing Consent	Age 16
Data Disaggregation**	<15; >15+

*age range definition may vary

**general health service reporting

Note: For ARV treatment program, <15 are under the pediatric ART services, and >15 are within the adult ART services.

HEALTH SYSTEMS STRENGTHENING

The National AIDS Council (NAC) developed the *National Strategic HIV and AIDS Response Plan, 2010-2014*. Adolescents are addressed throughout the document and are considered a priority group, yet there is not a specific strategy or section for them. Adolescents will be targeted in the new *HIV/AIDS Acceleration Plan 2013-2015*, which aims to increase the number of HIV-positive persons on ART, including pregnant women, and increase number of men circumcised (PEPFAR 2013). The NAC is responsible for overall coordination and monitoring of the HIV response in Mozambique, but their leadership in developing an adolescent strategy needs strengthening. Under the coordination of NAC, various involved stakeholders—including ministries, civil society, and the private sector—developed individual operational plans under the *National Strategic HIV and AIDS Response Plan*, in which strategies to address adolescent needs are included. The MOH plays a significant role and addresses adolescents more specifically in their policies than other stakeholders.

Most HIV services for adolescents are not differentiated between pediatric (younger than age 15) or adult care. However, a youth-friendly services approach is being adopted throughout the system. How to operationalize youth-friendly services has not yet been well understood, however, and without a clear plan and adequate follow-up, application of resources may not be effective. Further, the different components (e.g., prevention, care, and treatment) of the plan are not well coordinated.

The NAC supports national HIV activities and adolescents are a key group for prevention, PMTCT, pediatric treatment, and psychosocial support. Adolescent girls are included in the prevention of early marriage and reduction of transgenerational sex, in addition to violence prevention. Several partners, including USAID and UNICEF, provide technical assistance in the development of national HIV response. Adolescent training is incorporated into broader health care trainings, but remains minimal.

Discussions acknowledging that adolescents require specialized care, treatment, and psychosocial support are underway. USAID, UNICEF, WHO, Pathfinder International, the MOH, and other partners are planning to pilot a package of services for adolescents and, based upon pilot findings, adjust services to most appropriately meet adolescent needs. Movement towards combination HIV prevention provides an opportunity to better integrate adolescents into the different components, as well as within HTC and treatment, in a more deliberate way.

HIV PREVENTION

The MOE operates the One Club initiative, a life skills program providing HIV prevention education to youth in schools, which is currently under review to assess if any revisions are needed. UNICEF currently supports a network of radio and community programming to reach young people with variable content, of which HIV prevention is a dominant topic. The messages may

target a broader range of ages (9-18) in some areas, but in theory, messages are tailored for ages 9-11, 12-15, and 15-18 (or sometimes up to 21).

UNICEF supports the Communication for Development program, working with national partners to deliver HIV information, including prevention, life skills, hygiene and sanitation, nutrition, and other health messages. Messaging is tailored to target groups and uses multimedia, mobile units, and community radios in rural areas to reach youth. As one of the lead adolescent services donors, UNFPA has supported stand-alone adolescent HIV prevention services, such as life skills, gender programs, and condom promotion, which are being increasingly integrated into other services. Both UN agencies have supported life skills and peer education in schools. Several partners, including USAID, Johns Hopkins, and UNICEF, provide technical assistance and support NAC in developing and launching national HIV prevention campaigns. One example is the PEPFAR-funded multiple concurrent partners campaign "Andar Fora é Maningue Arriscado," which has been promoted since 2011. With current investment in combination prevention, there has been a shift away from behavioral interventions, yet a balance should be made to include considerations for adolescent services.

HIV prevention programs do not currently target adolescent key populations in Mozambique. Anecdotal evidence suggests sex work may be on the rise in Mozambique, with young women representing a significant proportion of the sex workers. Mobile populations are also particularly vulnerable to HIV and young men may be moving to work in mines or other industries. More data are needed on adolescents in Mozambique to improve targeted HIV prevention services.

HIV TESTING AND COUNSELING

Most HTC services for adolescents are available through the mainstream testing and counseling services. Adolescents who are 16 or older can consent to HTC without a parent or guardian (McCauley 2004), however, key informants were uncertain of the official age of consent for an adolescent. There is not a specific HTC strategy for adolescents, but adolescents and youth will be addressed in the National Accelerated HIV Prevention Strategy, according to interview findings. However, there are a few stand-alone health centers for youth that include HTC services. PEPFAR is the largest supporter of HTC services in Mozambique. HTC is also offered at the community level through mobile services for the general population, including adolescents, and some specialized NGO clinics for adolescents. To improve support for adolescents around disclosure, UNICEF is working to strengthen psychosocial support overall by developing new programs, such as peer support, training adolescents as peer HTC counselors or educators, and improved training materials, to build health care providers' capacity to address adolescent health needs.

"Adolescents directly provide services at our sites (e.g., through peer education, as HTC counselors)." NGO, Mozambique (survey respondent).

CARE AND TREATMENT

There is general recognition that ALHIV need more specialized care, treatment, and support services. Currently treatment services are divided into two groups, under 15 and 15 and older. Adolescents can access treatment at sites providing ART for pediatric or adults, but health care providers are not necessarily prepared to address adolescent-specific needs, and their skills for

communicating with adolescents may be lacking. Most care and treatment activities in Mozambique are supported by PEPFAR, as are PMTCT services.

Transition from pediatric to adult care is an issue. Implementing partners have discussed small-scale initiatives, including youth clubs and peer support groups for both ALHIV and parents. A pilot to improve transition, coordinated by USAID and UNICEF with the MOH, focuses on training materials for health care providers and is currently underway. An important focus will be on SRH and family planning, to provide adolescents and youth living with HIV with options for having children should they so desire.

"Our method consists of organizing music workshops and shows to encourage Mozambicans to sing their own solutions, young local leaders to emerge from their community, and become great artists and HIV/AIDS activists." – NGO, Mozambique (survey respondent)

MULTI-SECTOR COLLABORATIONS

With UNFPA, under the National Youth Policy, the Ministry of Youth works with the MOH and the MOE to implement the Geração Biz ("Busy Generation") initiative. It aims to increase youth participation in policy development, improvement of SRH service provision, and promotion of behavior change among students and out-of-school youth. "Geração Bis" targets youth ages 10 to 24 years old and was launched in late 1999 with youth-friendly health services (YFHS) and education and youth components. UNICEF was instrumental in the inception of YFHS and supported these services countrywide until 2007. UNFPA is the leading agency for youth issues following the division of labor among UN agencies within the UNDAF framework. MOH is now repositioning the adolescent program to prioritize and harmonize interventions toward adolescent health development. YFHS account for more than 300 sites; only 118 sites are stand-alone services covering 57 percent of districts. The MOE, MOH, and Ministry of Social Welfare, with support from UNICEF, launched a campaign in 2010, targeting schools and communities with a zero tolerance policy regarding violence against women and girls. Now in the second phase, the campaign is moving from mass media to communities to improve the response. However, linkages to other services, including HIV services, remain weak.

"The program [Geração Biz] addresses adolescent reproductive health, including HIV and AIDS, by increasing youth knowledge and skills regarding risky behavior and protective measures and by increasing access to youth friendly services." NGO, Mozambique (survey respondent)

CURRENT GAPS AND AREAS FOR STRENGTHENING

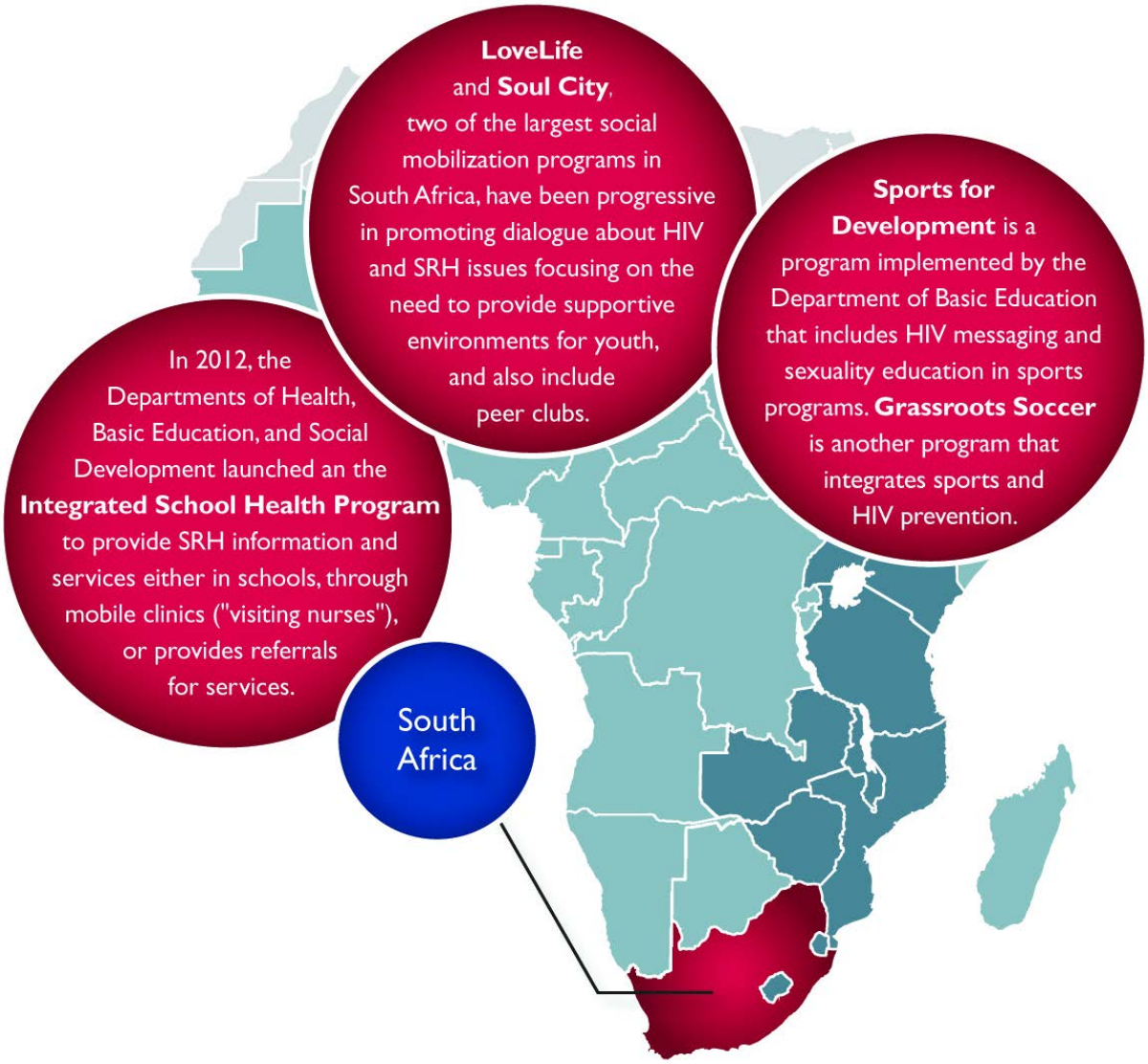
- Adapt data collection procedures so adolescent-specific data are available.
- Clearly and systematically define and implement HIV resources for adolescents in a coordinated effort by all stakeholders.
- Create HIV prevention resources for adolescents, which in Mozambique are lacking despite media campaigns. In order to meet the need, a clear coordinating body needs to design and implement a well-coordinated strategy.
- Ensure that adolescents access HTC services, which remains an area for improvement.

- Increase training on adolescent care and treatment for health care providers to improve transition from pediatric to adult care, and scale up effective youth clubs and peer support groups.
- Create a comprehensive framework to coordinate the various ministries, including those managing refugee services and employment. This is needed to better integrate HIV services for adolescents overall throughout these various systems.

RESOURCES

National Strategic HIV and AIDS Response Plan, 2010 – 2014.
http://www.cncs.org.mz

SOUTH AFRICA



ADOLESCENT DEFINITION

HIV programs in South Africa use the WHO definition of "adolescent" as 10-19 years old, but the term is often applied differently in practice and in older policies and documents. Two large-scale HIV prevention campaigns, such as LoveLife and Soul City, specifically target young people, but gaps in HIV services specific to adolescents still exist. Other target groups for health programming include "youth" (ages 15-24) and "young people" (ages 10-24), but this latter definition can extend up to age 35. A rapid assessment examining pediatric HIV services conducted by UNICEF in 2012 identified several weaknesses in programs for adolescents (see below). Other surveys have researched issues regarding adolescents, including the National Household Survey (which included an HIV dimension) and the Youth Risk Behavior Survey (specifically focused on sexual violence and high risk activities), but the disaggregation of this data by age is inconsistent, as is disaggregation of standard HIV programming indicators.

Adolescent Age Range	Ages 10-19*
Age of Testing Consent	Age 12
Data Disaggregation	Not specified

*age range definition may vary; youth definition includes ages 15-24 and "young people" ages 10-24 (and can extend to 35)

HEALTH SYSTEMS STRENGTHENING

The National Strategic Plan for HIV and AIDS (2012-2016) launched in 2011 includes prevention, treatment, care, and support components targeting adolescents, who are considered a priority in the national AIDS response. Universal access to HTC and treatment are targets within the plan. The strategy reflects a multi-sectoral approach to adolescent health, involving the departments of Health, Basic Education, and Social Development, in order to better respond to the vulnerability of adolescents. Each department has created its own adolescent health strategies or policies. Development of the plan used data from the UNAIDS and World Bank's Know Your Epidemic and Response evaluation. It is too early in the implementation of the plan to determine its success, and opportunities remain to increase provider capacity. Vestiges of the previous strategy remain in current programs.

USAID/South Africa has a new health systems strengthening unit that is working with the government and building government capacity to develop adolescent policies and programs. There are no activities specific to adolescents yet, but there is a focus on education projects and public-private partnerships for young people, especially in rural areas. New funding encourages innovation in strengthening adolescent services.

HIV PREVENTION

Primary HIV prevention for adolescents is a priority of the *National Strategic Plan on HIV, STIs, and TB*. Various stakeholders are involved in programming, with young people considered a key population in South Africa. Within the strategic plan, strategies to improve HIV prevention efforts among youth include accessible SRH services, targeted BCC initiatives, and increasing HIV testing. An interagency prevention TWG works to ensure there are no overlaps in programs and resources are maximized. Communications campaigns are implemented at national, provincial, and local levels with HIV prevention messaging. LoveLife and Soul City, two of the largest HIV prevention and social mobilization programs in South Africa, also include peer clubs. These two initiatives have been progressive in promoting dialogue about HIV and SRH issues with a focus on providing supportive environments for youth.

At the municipal level, community-based programs and NGOs manage HIV prevention in schools and at youth centers and include sexuality education. Faith-based organizations (FBOs) and churches provide life skills education throughout the country. Implemented by the Department of Basic Education, with technical and financial support from UNICEF, Sports for Development is a program that includes HIV and AIDS messaging and sexuality education in sports programs. Grassroots Soccer is similar program that integrates sports and HIV prevention.

The departments of Health, Basic Education, and Social Development launched the joint initiative Integrated School Health Program in 2012. The program provides SRH and primary home care services, either directly in schools or via mobile clinics by visiting nurses (including counseling for SRH or TB screening) or by referrals for services elsewhere. Reaching adolescents in a school environment where they are already getting information and services helps address challenges of access. The Integrated School Health Program provides comprehensive health education, including

on HTC, stigma, abuse, and nutrition. The government launched a large VMMC campaign in 2012 targeting adolescent boys. This campaign is a part of the new HIV strategy, in which the Integrated School Health Program provides information.

However, there are still gaps in all these programs: in the referral process, follow-up on referrals (i.e., whether the adolescents seek these services), and the quality of services at referral sites. Increasing health care providers' comfort and capacity for addressing adolescent SRH remains a challenge. Prevention and SRH for ALHIV has been largely left out of current efforts, but with increasing numbers of ALHIV in South Africa, more attention is warranted. HIV prevention activities for adolescents have been affected by changes in funding priorities. According to interviewees, HIV prevention activities for youth were a greater priority in earlier funding cycles, but recent funding changes have shifted to activities targeted to a wider population.

HIV prevention for adolescent key populations has not kept pace with the increased efforts for adolescents in general. Efforts are underway to advocate for HIV policies for sexual minorities and LGBT. USAID is working to improve services for sex workers and MSM, including training health care workers to be sensitive to MSM needs. MSM programs in South Africa have been reaching older members of the population, so work is scaling up to reach young MSM.

HIV TESTING AND COUNSELING

Adolescents over the age of 12 can access HTC services without parental/guardian consent. The Integrated School Health Program includes HTC on a referral basis. Testing is sometimes offered at the schools, but requires parental/guardian consent. Testing in schools raised concerns from some NGOs about confidentiality and adequate linkage to care and support for those who test positive. A UNICEF rapid assessment conducted in 2012 indicated there are no facility-based services specifically for adolescents, although HTC for the general population is widespread. There are issues concerning the quality and confidentiality of pre- and post-test counseling. Additional marketing materials and targeted HTC campaigns may increase testing among adolescents, as might adolescent-specific testing services. The government is working towards this end and may apply lessons learned from smaller-scale NGO campaigns that have targeted adolescents for testing.

There are a few pediatric sites that offer HTC. These have become centers of excellence in providing counseling to young people being tested for HIV, as adolescents who are perinatally-infected slow progressors are being identified. Little is known about the overall quality of pre- and post-test counseling and how appropriate it is for adolescents. Ensuring that an adolescent receives appropriate counseling is particularly challenging in rural areas.

LoveLife operates a call center for young people to provide disclosure support. However, not all youth being tested for HIV have information about this service. Other NGOs are working to increase the use of call centers to increase coverage across all the provinces.

CARE AND TREATMENT

South Africa has a large number of children growing up with HIV and transitioning to adulthood. Most ALHIV transition to the adult clinic around the age of 15. ALHIV currently access care and treatment in either the pediatric or adult clinic, as there are no adolescent-specific services. The 2012 UNICEF rapid assessment identified transition from pediatric to adult care as a challenge, with

inconsistencies in the treatment of adolescents, the referral system, and clinical care. A Child and Adolescent Committee within the Southern African HIV Clinicians Society (2011) is revising treatment guidelines to include considerations for adult, adolescent, and pediatric treatment, as well as PMTCT. A clear transition plan from pediatric to adult care will be a component.

The assessment also identified gaps in care services in addition to ART, such as SRH counseling, psychosocial support, and adherence support. Health care staff did not have the capacity or materials to deal with adolescent-specific issues. PHDP services in general are lacking in South Africa, and especially for adolescents. Parents of ALHIV may also be HIV-positive and should be included in psychosocial support services to deal with stigma and other issues.

PEPFAR funds several NGOs to provide care and support for PLHIV under the Right to Care program. These NGOs focus on psychosocial support for child-headed households, social grants to ensure the children remain in school, and life skills education. FBOs also provide care services, but their programming isn't specifically for adolescents. Some primary health facilities have designated spaces for youth where ALHIV may access primary care. However, according to interview findings, progress was described as lagging in reaching the target of 20 percent of all health facilities being youth-friendly in South Africa.

MULTI-SECTOR COLLABORATIONS

Within the national HIV strategy, different stakeholders have individual policies and guidelines to address adolescent health. The South African AIDS Council coordinates all the partners. The DOE has an internal AIDS strategy and a new draft policy, and the departments of Health and Social Development are developing their action plans. The DOE and DOH work together to assess peer education programs. The DOE and NGOs apply lessons learned from previous activities to explore what services may be standardized and offered universally in all schools.

The Department of Justice provides care and support for victims of violence and referrals for other services, and the Greater Rape Intervention Project supports the survivors of sexual assault and affected family members though legal and health services, including HIV services. Implementing partners are scaling up programs to raise awareness of gender-based violence (GBV), motivating and mobilizing communities. Brothers For Life, implemented by Johns Hopkins University, is an example of a sensitization campaign addressing GBV with links to HIV. A Family Planning and Contraceptive Policy that incorporates adolescents, especially for girls, is being rolled out.

Other South African government departments involved in HIV programming include the Department of Public Service (oversees workplace programs), the Department of Correctional Services, the Department of Defense, and the provinces and local governments. PEPFAR, UNFPA, UNICEF and other UN agencies, the German International Development (GIZ), and the British Department for International Development (DFID) are among the stakeholders providing technical support and funding for HIV services for adolescents. The Global Fund is another collaborator with a focus on treatment. The South Africa Social Security Agency authorizes social grants that aim to reduce the vulnerability of adolescents.

USAID is working with the Department of Basic Education and the Department of Social Development to strengthen prevention programming for vulnerable children (OVCs). UNFPA is working with the Department of Social Development to create more holistic services for adolescents with a focus on psychosocial care and support. The South African government is implementing an integrated program for young people in schools that provides education and comprehensive care

with an emphasis on SRH issues. Opportunities exist for collaboration among the health, education, and social support sectors.

Opportunities also exist for collaborations with the technology sector. Through the MoviHealth initiative, individuals can send a text message (SMS) with a phone number and information request and receive a response with a link to services. Using this and other new technologies, including social media outlets, may increase the reach of health services and information to adolescents.

CURRENT GAPS AND AREAS FOR STRENGTHENING

- Adapt data collection procedures so adolescent-specific data are available.
- Improve adolescent SRH within the context of education and rights in order to address SRH and secondary prevention for ALHIV.
- Work towards sustainability of youth HIV prevention programs.
- Coordinate donor funding with the new South African government initiatives and ensure the institutionalization of coordination for sustainability of new HIV services for adolescents.
- Coordinate partners to avoid competition and maximize resources.

RESOURCES

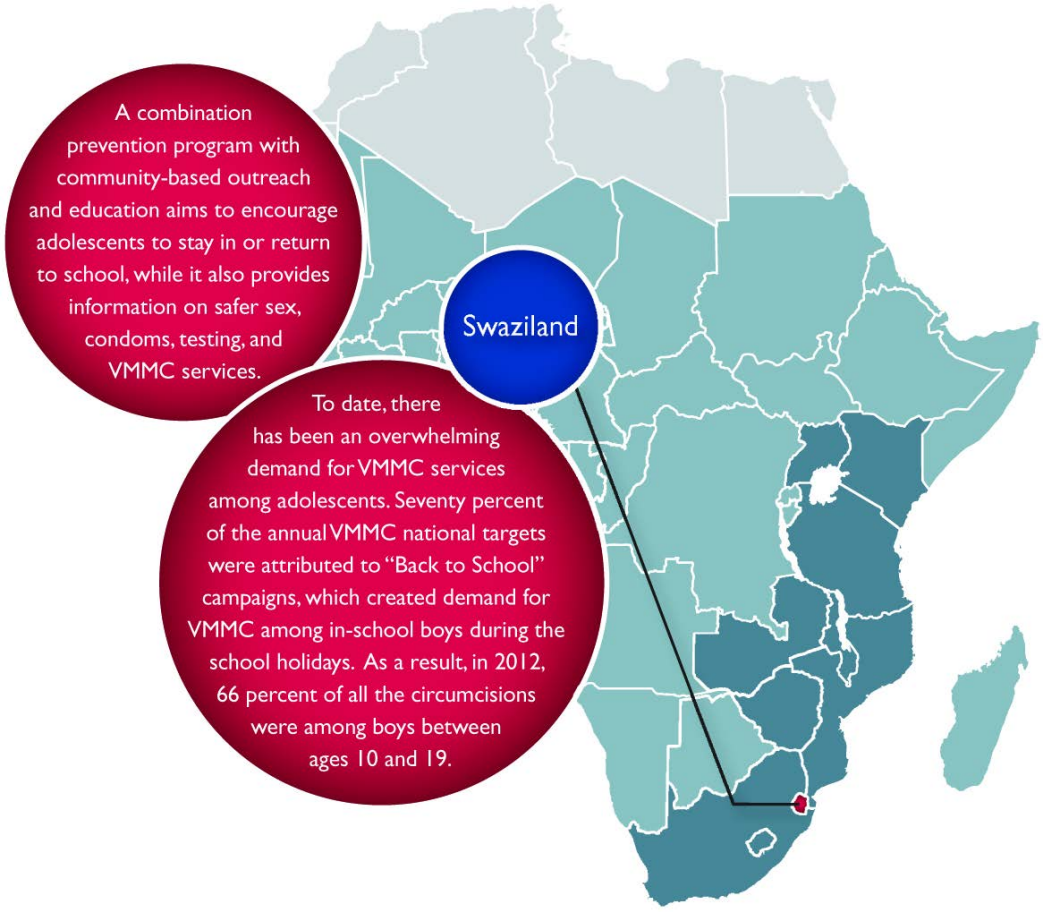
National Strategic Plan on HIV, STIs, and TB (2012-2016)
http://www.laylacassim.co.za/pdf/National%20Strategic%20Plan%20on%20HIV,%20STIs%20and%20TB.pdf

Integrated School Health Program: School Health Nurse Resource Manual
http://www.education.gov.za/LinkClick.aspx?fileticket=kN%2FI2VVGCG4%3D&tabid=667

Policy Guidelines for Youth & Adolescent Health
http://www.doh.gov.za/docs/policy/2001/part1.pdf

Department of Education, Draft Integrated Strategy on HIV and AIDS, 2012-2016
http://www.education.gov.za/LinkClick.aspx?fileticket=u6KgP4PKpOw%3D&..

SWAZILAND



ADOLESCENT DEFINITION

In Swaziland, there is some confusion between the terms "adolescent" and "youth, but most HIV stakeholders consider the WHO definition to be the standard. According to an interviewee, "youth" is generally defined as ages 10-24. However, most programming targets ages 15-19 or 15-24, with young adolescents (ages 10-14) left out of most efforts. Data on adolescents are not routinely collected at a national level, leading to difficulties in analysis of adolescent programming. HIV efforts targeting adolescents have been fragmented to date, but there is a growing recognition of the need to address their prevention, care, and treatment needs, especially of adolescent girls.

Adolescent Age Range	Ages 10-24*
Age of Testing Consent	Age 12+
Data Disaggregation	Not specified**

*youth age range definition

+The Child Protection & Welfare Act, recently enacted, changed the age of consent to 12, however, it has not been implemented. Previous age of consent was 18.

**adolescent data not collected at the national level

HEALTH SYSTEMS STRENGTHENING

Adolescents are addressed in some components of the national HIV strategy, but they do not have a specific section. The National Action Plan for Children, although not specific to HIV, limitedly incorporates adolescents. Although strategies for adolescents are minimal, some organizations specifically target youth. The National Youth Council and Family Life Association of Swaziland are two examples of organizations that advocate and provide services for youth, including HIV. The National Youth Council is a youth-led organization that aims to increase and improve youth-friendly services. Family Life Association of Swaziland works primarily in Manzini and Mbabane, but has mobile outreach in some rural locations to reach young people on SRH issues.

There is some potential to strengthen services for adolescents. PMTCT services provide an example of how the government has prioritized a type of programming and improved interventions, making them more accessible and effective. The Ministry of Health recently developed the *Elimination of New HIV Infections Among Children by 2015 and Keeping Mothers Alive: National Strategic Framework for Accelerated Action (2011-2015)*, in which targeting adolescents and teenage pregnant women is considered a priority action to address current gaps in service and coverage (Swaziland MOH 2011). PEPFAR supported the Swaziland HIV Incidence and Measurement Survey in 2011, which highlighted the vulnerability of adolescents, particularly women ages 18-19, with an HIV incidence rate of nearly 4 percent, compared to less than 1 percent for young men the same ages. The findings from the survey have been useful for stakeholders and the Swazi Government. As a result, girls and young women have been identified as a key population in the draft National Strategic Framework extension covering 2014-2018, as well as for programming for adolescents as a whole.

"Creating adolescent SRH support groups in each facility, be it a NGO or a government facility, would strengthen provision of services for ALHIV." Government representative, Swaziland (survey respondent)

HIV PREVENTION

HIV prevention activities in Swaziland reach adolescents through a variety of NGOs implementing school-based activities, including life skills and health clubs, girls' empowerment, and gender norms. Because many different NGOs implement these activities, coverage is inconsistent and small-scale. There is no curriculum approved for use in all schools and existing IEC and education materials are not specific to adolescents, although some are being adapted for this purpose. UNICEF supported the production of an HIV Prevention Toolkit that targets young people aged 10-24 and includes interventions and messages for specific age groups (10-14, 15-19, 20-24). However, the toolkit has not been fully adopted and used in Swaziland. Key informants did not verbalize the barriers to its implementation.

The PEPFAR-funded program implemented by PSI supports a combination prevention program with community-based outreach and education to encourage adolescents to stay in school or go back. It also provides information on safe sex, condoms, testing, and VMMC. The high uptake among young men of VMMC provides an opportunity to also reach them with other HIV prevention services.

In 2012, the Ministry of Health and the VMMC TWG lowered the eligibility age from 15 to 10 for VMMC, due to the large population of youth in Swaziland. By changing the eligibility age, the younger age group is targeted for HIV prevention, which has helped influence positive social, cultural, and gender norms surrounding health care-seeking behavior. To date, there has been an

overwhelming demand for VMMC services among adolescents. "Back to School" campaigns to create demand for VMMC among in-school boys held during the school holidays accounted for 70 percent of the annual VMMC national targets. In 2012, 66 percent of all the circumcisions were among boys between ages 10 and 19.

Sex workers are a key population receiving HIV services in Swaziland. Interventions include education on HIV prevention and safer sex and condom distribution, but these do not specifically target adolescent sex workers.

HIV TESTING AND COUNSELING

Until recently, an individual had to be 18 years of age or older to receive HIV testing and treatment without parental or guardian consent. The minimum age for accessing SRH services is 16 (UNFPA 2008). The recently enacted Child Protection and Welfare Act lowers the age of HTC consent to 12 years of age, and indicates that health care providers cannot deny or refuse medical care and reproductive health information or services to a child. Although the act has not yet been implemented, PEPFAR is providing education to communities about the act and plans to support an action strategy.

Provider-initiated testing and counseling (PITC) in facilities aims to increase the number of children and adolescents tested. Community outreach also provides mobile testing to all age groups, and PSI in particular is targeting adolescent boys by aligning testing services with agricultural activities that they participate in. The Family Life Association offers youth-friendly services, primarily in Manzini and Mbabane, among the few places in Swaziland where an adolescent might access youth-friendly HTC, in addition to primary health care services. The government has also trained some staff in public clinics on the provision of youth-friendly services and age-appropriate HIV messaging.

As a part of their clinical services, Baylor provides disclosure and psychosocial support for the adolescents who attend their facilities and Teen Clubs. There is no national policy regarding HIV status disclosure to or by children.

CARE AND TREATMENT

Adolescents are targeted for care and treatment services throughout the country through general clinic services. Current efforts include decentralization of services to increase access while focusing on quality and supervision. Family Life Association of Swaziland (an IPPF affiliate) implements youth-friendly services and captures youth by providing primary care and SRH services and education at mobile and static clinics, including at recreational facilities. Baylor's Teen Clubs and some government facilities provide support to ALHIV. These support groups include information on adherence, retention, and PHDP. However, these interventions are uncoordinated and sporadic throughout the country.

With PEPFAR funding, World Education implements the Bantwana School Integrated Program (BSIP), which was launched in the Lubombo region in 2008. The program supports families and communities to lessen the impact of HIV on OVCs, with particular focus on adolescents. Using a school platform, the BSIP offers comprehensive care and support services for OVC adolescents and aims to improve capacity of schools and communities to support and advocate for them. The program is currently in 18 schools, and strives to add 16 new secondary schools in the same district,

enabling it to reach more than 10,000 adolescents, families, and community leaders with linkages to nutrition, psychosocial services, education, economic support, and child protection services.

Retention in treatment is estimated to be 83 percent after one year at the national level, but disaggregation of this information is not available by age. Stakeholders recognize that having adolescent-specific data would allow for increased efforts around retention if warranted.

MULTI-SECTOR COLLABORATIONS

The UN is a key player, with UNICEF and UNFPA being the lead agencies, and together they are in discussions to focus on the neglected 10- to 14-year-old age group. The Peace Corps program in Swaziland has a youth focus and is collaborating with Grassroots Soccer, a sports program that incorporates HIV prevention messaging. With PEPFAR funding, the U.S. Ambassador's Small Grants Program provides funding to community-based organizations supporting HIV services for children. One such grant goes to Compassionate Swaziland, which is one of the few local organizations working with children living with HIV, providing life skills and facilitating support groups. Outcome data were not available on these programs at the time of the interviews. The Clinton HIV/AIDS Initiative is increasingly working with adolescents as well, by collaborating with the Ministry's SRH unit to implement psychosocial support interventions. Findings from the Violence against Children Survey have led to an increased national focus on GBV and attempts to integrate gender issues into HIV services.

With PEPFAR funding and collaboration with the Ministry of Education, Pact implements the Super Buddies Club as part of the "Adolescent and Youth Peer Education for HIV Prevention" project. The club provides education to youth on life skills, HIV, children's rights, psychosocial support, and gender issues, including GBV, through platforms such as peer-to-peer discussion and media programs. In 2006, the organization opened 20 clubs in four regions targeting out-of-school youth and, due to demand, in 2011, introduced peer education groups at over 40 primary and high schools. Trained "youth mentors" participated in the program and further trained "peer educators." From August 2013 to September 2014, the program plans to scale up in 40 primary and high schools in four regions, and use a youth radio show to focus on GBV prevention and HIV issues.

CURRENT GAPS AND AREAS FOR STRENGTHENING

- Adapt data collection procedures so adolescent-specific data are available.
- Strengthen adolescent HIV programming overall and increase advocacy efforts to make adolescents a priority population.
- Coordinate across donor agencies the focus on adolescents and strengthen advocacy efforts to encourage the government to recognize the special needs of adolescents and to support programs for them.
- Coordinate adolescent programming efforts between the MOH and implementing partners to enhance existing programs and scale up to geographic areas where, as of yet, no services for adolescents exist.
- Expand SRH efforts to include HIV prevention services, such as integrating PMTCT, STI, and VMMC referrals into routine SRH services. The education system and network of churches are other potential collaborators in adolescent programming.

RESOURCES

Elimination of New HIV Infections Among Children by 2015 and Keeping Mothers Alive: National Strategic Framework for Accelerated Action (2011-2015)
http://www.zero-hiv.org/wp-content/uploads/2013/03/Swaziland_EMTCT-National-Strategic-Framework_20131.pdf

Family Life Association of Swaziland
http://www.flas.org.sz/index.php?option=com_frontpage&Itemid=1

TANZANIA

ADOLESCENT DEFINITION

PEPFAR/Tanzania uses the WHO definition of adolescent as a young person aged 10-19, yet within the National Health Sector Strategic Plan, youth are defined as ages 9-24. Thus, in Tanzania, the term may refer to a youth up to age 24, especially when referring to young women. Programs and documents may also refer to "young people" aged 10-24 or "youth" aged 16-24. The Tanzanian National Commission on AIDS conducted a study on adolescent services and found an enormous gap in HIV services overall, including a lack of support for the transition from pediatric to adult care, counseling, disclosure, packaging of services, and human resources to provide adolescent services. Data disaggregation to monitor and evaluate HIV services for adolescents is a challenge, with many services documenting two age groups (<15 years and 15+ years), both of which include adolescents. Furthermore, current monitoring of HIV treatment is not disaggregated for adolescents, leading to limitations in treatment data for this population.

Adolescent Age Range	Ages 10-19*
Age of Testing Consent	Age 18
Data Disaggregation**	<15; >15+

*age range may include up to age 24

**HIV services reporting

HEALTH SYSTEMS STRENGTHENING

The National Health Sector Strategic Plan prioritizes HIV prevention among young people aged 9-24. The next Health Sector Strategic Plan, currently in progress at the time of the interviews, will prioritize adolescents and will cover the next five years of HIV programming in Tanzania. A new National Multi-sectoral Strategic Framework for HIV/AIDS is also in development and will capture adolescent issues, including the definition of adolescence.

UNICEF developed a programming framework for adolescents, specifically adolescent girls, at the request of the Tanzania Commission for AIDS and in collaboration with key stakeholders from government, NGOs, other implementing partners, and young people. The framework uses information from a recent UNICEF-supported situational analysis of ALHIV and prioritizes three areas: HIV prevention, adolescent pregnancy, and issues of sexual violence. A pilot is currently underway to test the recommendations and national-level stakeholder discussions are ongoing. This consortium effort was considered successful.

HIV PREVENTION

Prevention activities for adolescents in Tanzania were previously focused on promoting abstinence and faithfulness in sexual relationships. Currently, facility-level HIV prevention integrates HTC, STI services, and treatment as prevention. Other components of HIV prevention are community-based interventions and messaging regarding transgenerational sex. A number of PEPFAR-funded youth prevention programs have ended, which interviewees described as creating a service delivery gap. The Fataki program, which focused on trangenerational sex and community messaging, has ended. UJANA worked with influential adults and community members to help youth develop skills to abstain from or delay sex, remain faithful to one partner, reduce their number of sexual partners, and use condoms. It also included a gender component.

PMTCT remains a focus area in Tanzania and other biomedical interventions are gaining visibility. There are a few services held at special times specifically for adolescents, but the majority of services occur alongside services for adults. Other related interventions for adolescents include life skills and livelihood support through OVC programs. Resources designated for HIV prevention may be diminishing in favor of diverting funding to care, treatment, and PMTCT. The Swedish International Development Cooperation Agency and various UN agencies are supporting the national strategic plans to ensure young people are prioritized in HIV prevention programming.

Multiple stakeholders collaborate to deliver HIV prevention activities in primary and secondary schools. The MOE and the Tanzania Commission for AIDS are key partners in school-based HIV prevention. HIV prevention materials have been developed specifically for use in schools. An assessment was conducted on what IEC materials exist for young people, and findings showed that the materials are uncoordinated and inconsistent. The Ministry of Information, Youth, Culture, and Sports Development aims to reach out-of-school youth (15-24).

Implementing partners are also involved in programming for OVCs. Interventions include health promotion, including HIV prevention and HTC promotion, as well as risk reduction messaging. PEPFAR recently developed guidance on HIV prevention within OVC programming and is helping to integrate adolescent issues into OVC programs.

HIV TESTING AND COUNSELING

Adolescents can access HTC in Tanzania at the same facilities or community-based outreach services as adults, and current guidelines are the same for both populations. There are also a limited number of youth friendly HTC centers. A parent or guardian must provide consent for adolescents under the age of 18 for testing. However, parent or guardian consent is not required for mature minors including pregnant and sexually active youth. PITC is available in the majority of primary care facilities in Tanzania, and links clients directly to care and treatment services in the same setting. Overall, there are challenges in reaching pediatric enrollment targets, due to human resources for health challenges in regards to the number of staff available and the number of staff specifically trained to provide youth friendly HTC. PMTCT programs promote uptake of HTC among young women and girls. A PEPFAR-funded three-year radio drama program has recently been launched to promote HTC and condom use among youth.

There are a few PEPFAR-funded programs providing HTC for youth. PEPFAR is designing strategies to increase testing among children and adolescents to improve pediatric enrollment in care and treatment. Challenges in provision of HTC targeting youth include limited specially trained counselors to provide appropriate pre- and post-test counseling. Facility hours often overlap with the school day, making it difficult for adolescent students to access services.

Although disclosure guidelines exist, there are few counselors who are trained in disclosure for children and adolescents. Similarly, materials for preparing families and communities for disclosure support for children and adolescents have not been widely disseminated. Anecdotal evidence suggests some children and adolescents may be on HIV treatment but unaware of their status.

CARE AND TREATMENT

Although a few facilities have special clinic days for adolescents, care and treatment services for adolescents are largely the same as for adults. Younger adolescents access care and treatment through pediatric services. Despite this, adolescents are specifically mentioned in the national care and treatment guidelines, including management of symptoms and opportunistic infections, treatment guidelines, and strategies for improving drug adherence. Implementing partners are working to address the gap in psychosocial counseling for adolescents, as well as support for income-generating activities. Some OVC programs include HIV-specific youth clubs to provide psychosocial support and livelihoods and skills training for adolescents.

Some programs provide a holistic model for adolescent services, with Teen Clubs that address issues of adherence, retention, loss to follow-up, psychosocial issues, and positive living. Other implementing partners have established pediatric care and treatment programs and are looking to better address the needs of adolescents, especially as their current pediatric clients are growing up.

PHDP was a component of previous care and treatment guidelines, but revisions have created separate guidelines that include an adolescent component and are being piloted in two areas in Tanzania.

MULTI-SECTOR COLLABORATIONS

Integrated youth-friendly services are offered for STI prevention and treatment and FP counseling at some facilities. There is strong collaboration between the MOH and MOE, particularly around OVC programming. GBV programs include a focus on adolescents. A Violence Against Children Survey conducted in 2009 identified a widespread issue of violence, and as a result, the UNICEF programmatic framework for adolescents will incorporate GBV and sexual violence issues into its HIV program. The Ministry of Community Development, Gender, and Children is leading the response to high rates of violence against children that was identified in the survey. Community groups aim to strengthen protection for youth against violence (not specific to ALHIV). The National Police Force is collaborating with Ministry of Home Affairs on an HIV program to prevent violence against children within a larger GBV program. USG-supported OVC programs support districts to develop one-stop-centers that provide comprehensive services for children who have experienced sexual violence. The USG also collaborates with UNICEF to support district-level child protection systems, which respond to child and gender-based violence cases. The Ministry of Information, Youth, and Sports Development is working to reach out-of-school adolescents with information on HIV. To reach more adolescents, PEPFAR is seeking to collaborate with communities and streamline activities.

"The VAC study raised awareness of the seriousness of the problem (GBV) in the country. Stakeholders have been taking measures to either mainstream GBV/VAC into their interventions or introduce new programs to tackle the matter." NGO, Tanzania (survey respondent)

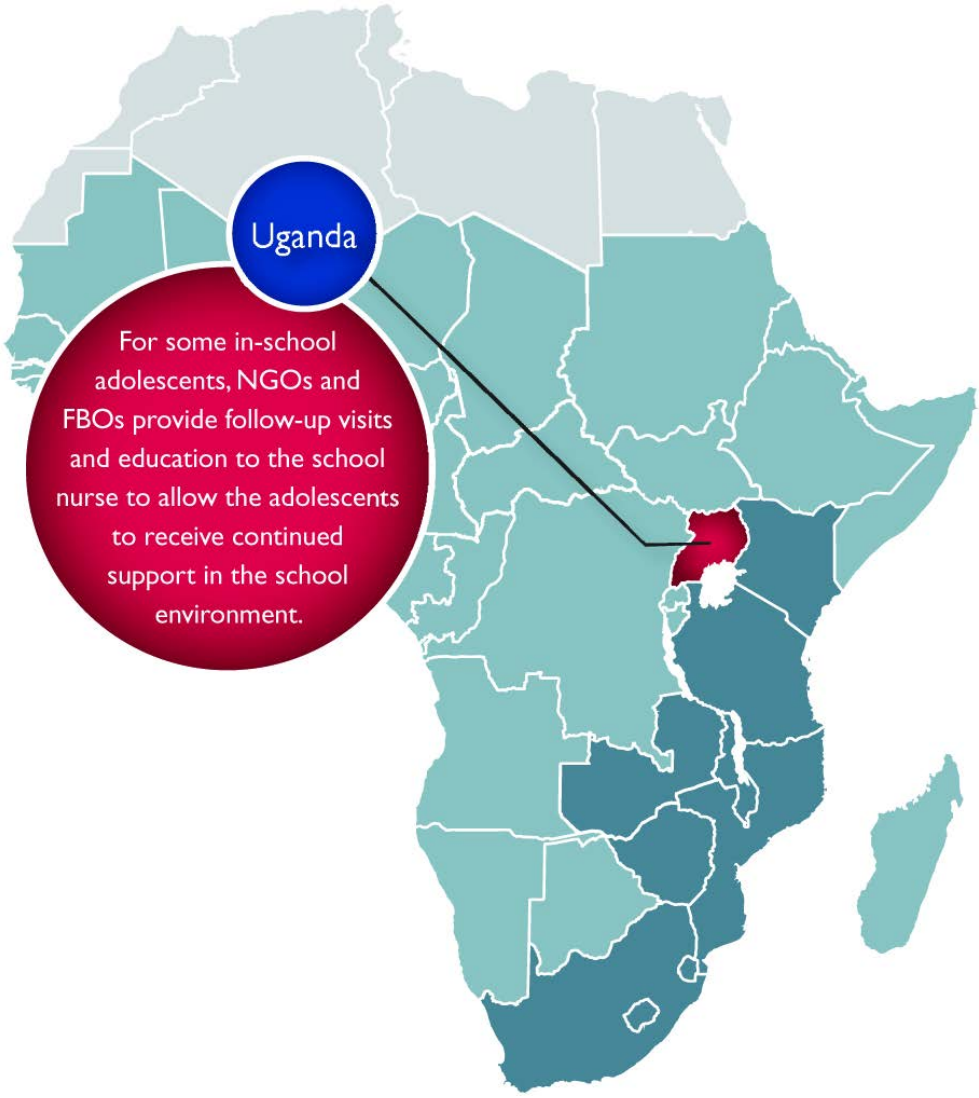
CURRENT GAPS AND AREAS FOR STRENGTHENING

- Adapt data collection procedures so adolescent-specific data are available.
- Create HIV prevention initiatives to equip adolescents with knowledge and access to services so they can make informed decisions about SRH.
- Reach out-of-school youth, as this remains a significant challenge.
- Bring to scale interventions that prepare ALHIV for transition into adulthood and adult care.
- Create an enabling environment to address socio-economic issues that put girls at HIV risk, such as early marriage and childbearing
- Create alternative testing sites, as adolescents may be reluctant to access facility-based HTC due to lack of adolescent-friendly services, and may prefer community-based or mobile testing.
- Improve HTC and ensure adequate and qualified human resources.
- Improve adolescent-specific care and treatment services at the national level.
- Strengthen community-based care and support activities for adolescents.

RESOURCES

National Guidelines for the Management of HIV and AIDS (2012)
http://www.nacp.go.tz/documents/nationalguideline42012.pdf

UGANDA



ADOLESCENT DEFINITION

In Uganda, HIV-related guidance, services, and programs for adolescents focus on youth ages 15-19. However, programs will provide services to young people slightly outside this age range as long as they demonstrate need. Adolescents are primarily considered within pediatric or adults HIV services, and therefore, limited data exists specifically for adolescents.

Adolescent Age Range	Ages 15-19*
Age of Testing Consent	Age 18
Data Disaggregation	Not specified

*Age range may vary

HEALTH SYSTEMS STRENGTHENING

Although there is no specific section for adolescents in the National HIV & AIDS Strategic Plan (2011/2012-2014/2015), adolescents are included in objectives related to improving HIV care and treatment. Improving linkages to youth-friendly HTC for adolescents is included within pediatric care (Uganda AIDS Commission 2011). The MOH Reproductive Division developed the National Adolescent Health Policy for Uganda in 2004, which incorporates some HIV targets into the SRH goals, such as increasing access to and integrating HTC in all levels of health care and increasing the number of ALHIV on HIV treatment (Uganda MOH 2004). Most adolescents access HIV services through the pediatric programs. The MOH has a focal person to coordinate pediatric and adolescent health. A few NGOs, including Baylor and the Infectious Disease Institute, are developing specific HIV programs for adolescents. UNICEF is working with the MOH to map out adolescent issues in all the districts of Uganda. The results will be used to inform an updated national plan for adolescent health, which will also address HIV.

HIV PREVENTION

Schools provide education on HIV prevention. For younger adolescents, the main messaging focuses on abstinence with some information on condom use. Older adolescents receive more information on condoms and other safe sex practices, but condoms are not distributed at schools. The MOE oversees the HIV prevention curriculum. Some schools collaborate with local churches to have preachers provide education in schools or implement HIV prevention outreach in churches. To reach out-of-school youth, many districts have youth centers and outreach programs.

UNICEF is supporting youth centers in two Ugandan regions, in Karamoja and the Western Region, with digital libraries to help adolescents with reading skills, especially targeting out-of-school youth. The project also aims to empower adolescents and encourage them to ask questions about health. Key informants were not aware of HIV prevention activities targeting key populations.

HIV TESTING AND COUNSELING

According to the MOH, the age of consent for HTC theoretically should be the age when a child can comprehend the results, ideally age 12 (Ugandan MOH 2005). Despite this, in Uganda, only those 18 years of age or older may consent to HTC, otherwise parental consent is required. Adolescents attend the same HTC centers as adults. These services may be in a particular unit in a health facility or provided through outreach conducted in churches or communities. Many perinatally-infected adolescents learn they are HIV-positive when they are tested due to deteriorating health. Positive living counseling begins at the point of testing if HIV-positive, when the individual is linked to care.

CARE AND TREATMENT

ALHIV access care and treatment in facilities depending on their age—a younger adolescent would go to the pediatric clinic but at the age of 15 or so, would be sent to the adult clinic. There is no support for the transition from pediatric to adult care.

Positive living counseling educates adolescents, like any other PLHIV, about HIV as a manageable disease. For some adolescents in schools, NGOs and churches provide follow-up visits and information to the school nurse to allow the adolescent to receive continued support in the school environment. Parents receive counseling to help their younger adolescent adhere to treatment, but

older adolescents receive the same adherence counseling as adults. Baylor, EGPAF, and the AIDS Support Organization, as well as the USAID-funded STAR (regional/district HIV programs), are among the most active large NGOs providing care and support services for adolescents in Uganda.

MULTI-SECTOR COLLABORATIONS

HIV is perceived as a multi-sector issue in Uganda, with the MOH, MOE, and other ministries working with local governments, NGOs, donor agencies, and the UN system. Nearly 90 percent of funding for HIV programming in Uganda is from PEPFAR. Each ministry has its own guidelines for HIV within its sector. Within the health sector, different programs are collaborating to support linkages between HIV programs and activities around nutrition, GBV, and tuberculosis. Preventing early marriage for young adolescent girls and reducing early pregnancy are other potential areas for collaboration.

CURRENT GAPS AND AREAS FOR STRENGTHENING

- Adapt data collection procedures so adolescent-specific data are available.
- Build a national plan for ALHIV using UNICEF results and any other data available.
- Provide adolescent-specific HTC, including pre- and post-test counseling in locations that are adolescent friendly.
- Consider various models of transition to support adolescents as they move from pediatric to adult clinical services.
- Adapt current models of counseling, care, and treatment specifically for ALHIV and prioritize training of human resources in these capacities for ALHIV.
- Build collaboration among the various ministries and NGOs to identify areas for partnership and scale-up for ALHIV services.

RESOURCES

National Adolescent Health Policy for Uganda (2004)
http://www.opendev.ug/sites/opendataug-01.drupal01.mountbatten.ug/files/national_adolescent_health_policy_for_uganda.pdf

National HIV & AIDS Strategic Plan (2011/2012-2014/2015) [Draft]
http://ms-hiv-gdc.org/wp-content/uploads/2011/09/NSP-2011-2015.pdf

ZAMBIA

ADOLESCENT DEFINITION

Policy documents in Zambia refer to adolescents as youth aged 15-19, but variation in the use of the term is common. Programming may also target "young people," which refers to 18- to 35-year-olds. In addition to the lack of clarity about the target population, additional challenges exist in M&E, resource limitations, and stigma. Disaggregation of age groups varies across service types, making analysis of services for adolescents complicated. Overburdened staff may lack the motivation or time to add an additional step to monitoring activities. With limited resources, public services may not be able to create separate clinics or spaces specifically for adolescents, especially in light of competing priorities.

Adolescent Age Range	Ages 15-19*
Age of Testing Consent	Age 16
Data Disaggregation	10-14; 15-19**

*youth age range; with often extends to ages 18-35

**not necessarily uniform across all services

HEALTH SYSTEMS STRENGTHENING

Linked to the overall national health strategic plan, the Zambian Ministry of Health has developed the Adolescent Health Strategic Plan (2011-2015) to provide guidance on areas to strengthen, including SRH, HIV prevention, quality of care, and management of chronic diseases for adolescents. The Ministry of Health established "Youth Health Corners," facility-based centers where staff are trained to provide integrated adolescent-friendly SRH and FP services. These centers are largely managed by local NGOs supported by PEPFAR through the Centers for Disease Control and Prevention (CDC) and USAID. Although the centers are scaling up in Zambian communities, there are no data yet on these services. When the data become available, it will be important to analyze to see if ALHIV are effectively accessing these adolescent-friendly SRH services. Anecdotal feedback suggests there are still insufficient adolescent-friendly services at the facility level.

Overall current HIV strategies for Zambia include a focus on adolescents in different programmatic areas, including care and support, economic strengthening, and skills building. Adolescents and young people are the most targeted segment of the population for prevention interventions and are also considered a priority for treatment.

To specifically address the needs of ALHIV, the National HIV Program has collaborated with UNICEF and PEPFAR to develop a National Training Manual on Caring for Adolescents with HIV. The manual has been validated and in 2013 will be taken to scale following an assessment to identify the gaps in existing services.

HIV PREVENTION

UNICEF and the Zambian government are reprioritizing prevention activities in an effort to sustain achievements in the country's HIV response. Behavioral HIV prevention services are provided mostly in schools through a school-based curriculum, in which the MOE incorporates life skills and behavior change interventions. The MOE also partners with NGOs to provide health promotion and health services in schools, and they particularly focus the in-school services in rural communities where adolescents are highly vulnerable.

School regulations in Zambia prevent adolescents under age 14 from receiving HIV prevention services in schools and adolescents over age 16 are often out of school and accessing HIV prevention services in the community. A community-based project implemented by fhi360 provides individual prevention communication as well as economic skills building. Recognizing the importance of the relationship with their families and communities, World Vision targets caregivers of OVCs to provide prevention services. Although information about referrals for services is a part of the education, the linkages are weak.

The MOH is also collaborating with other stakeholders to implement biomedical HIV prevention services. For these services, adolescents are divided into two age groups, 10-14 years and 15-19 years, to identify and provide the most appropriate interventions. The program aims to ensure adolescents know how to prevent HIV, know their status for effective prevention, reduce their

number of sexual partners, use condoms, and are aware of VMMC services. To date, condom use programs have demonstrated little impact. However, VMMC uptake is higher among young people than older males, and is being scaled up by the government.

UNICEF supports design and implementation of an innovative, youth-friendly platform called Zambia U-Report, which provides real-time counseling and education on HIV and STIs through a free and confidential short message service (SMS) on mobile phones. Information is also made available through mass media for those who don't have phones. The platform also obtains feedback from adolescents about services. The evaluation of Zambia U-Report is planned for 2014 (Tsague et al. 2012). According to Tsague et al. (2012), from December 2012 to June 2013, 9,395 U-reporters joined the program: 44 percent were female, 35 percent were aged 15-19, and 39 percent aged 20-24. Approximately 6,000 (64 percent) U-reporters engaged counselors through SMS, generating 23,600 texts. Most U-reporters reside in Lusaka (51 percent) and Copperbelt (30 percent) provinces. In analysis of 13,000 SMS texts, the following knowledge needs were identified: symptoms of HIV and STI (28 percent), mode of transmission (18 percent), male circumcision (12 percent), mother-to-child HIV transmission (9 percent), masturbation (8 percent), condoms (8 percent), HIV treatment and cure (8 percent), and other STIs (9 percent). During the June-July 2013 HIV testing campaign, U-reporters received tailored SMS messages, and the uptake of HTC among U-reporters in Lusaka increased by 28 percent compared to baseline.

Limited prevention activities are available for key populations in Zambia. Although sex work is illegal in the country, adolescent sex workers do have the right to health services and are receiving HTC and condoms. However, there is no organized system to provide preventative services for this population. Another key population in Zambia is incarcerated individuals, including youth, Efforts are underway to change the punitive approach for youth under the age of 18 (adolescents as young as 12 may currently be incarcerated). HIV prevention services are also being provided in prisons. Migrant populations are also considered key populations, and the FHI 360 project Corridor of Hope focuses on cross-border HIV prevention, HTC, and care and support, but without a specific focus on adolescent migrants.

HIV TESTING AND COUNSELING

The adolescent-friendly youth centers provide FP, SRH, and HTC services, but their current coverage is inadequate for the demand in Zambia. It is important to improve access to youth-friendly services at the approximately 1,500 health facilities throughout Zambia that offer HTC, including training staff to better meet the needs of adolescents. HTC is provided on an opt-out basis for individuals over the age of 16. For adolescents less than 16 years of age, parent or guardian consent is required for testing. However, routine enforcement of these policies may not be common practice.

Mobile and grassroots approaches to HTC may be able to reach more adolescents. Grassroots Soccer is a program that provides testing and counseling at soccer games. But care must be taken to reach girls as well as boys, as sporting events are usually better attended by adolescent boys. Additional opportunities for innovation may exist with cross-sector collaborations, and PEPFAR is currently exploring ways to link with public-private partnerships and capitalize on existing resources.

Disclosure: *UNICEF is currently working with one civil society group to encourage a small number of HIV-positive youth to speak publically about their status in support of other ALHIV. Clients currently receive support, as do their parents and caregivers, as a part of the counseling component of HTC. At the moment, there is no national level policy supporting disclosure of HIV status by adolescents.*

CARE AND TREATMENT

PEPFAR supports most of the pediatric HIV treatment centers in Zambia, where implementing partners are working to increase access to services, including those specifically targeting adolescents. Programs have traditionally focused on younger children without a unique approach for adolescents. Little is known about the coverage, whether standards are being followed to provide comprehensive care, and the quality of care. Analyzing available data is complicated by the use of different age disaggregation for treatment (<15 or 15+ years) and care and support (<18 and 18+ years). UNICEF and the MOH will assess HIV care for adolescents in 2013.

The new national training manual includes peer support and adherence counseling to encourage adolescents to adhere to their treatment and remain in care. It is not clear how this support translates to the reality of an adolescent's daily life, especially for those still in school. Adolescents in boarding school may have difficulty adhering to treatment based in a clinic near their home. Those in boarding and local government schools may be reluctant to disclose their status to school administration. There have been initiatives to improve workplace support for PLHIV in Zambia. A policy is currently under review for care and support at the school level.

Youth in Luapula and Eastern Provinces (Petauke and Lundazi) were reached through a health program, STEP OVC, which is managed by USAID and funded by PEPFAR. The program included linking OVC (ages 15-18) who were HIV-positive to ART clinics for pre-ART or ART services. Other youth activities through STEP OVC and the Zambia-led Prevention Initiative include psychosocial support. Activities include adherence counseling about medication for HIV-positive youth, prevention of HIV transmission using prevention adherence contracts, counseling on disclosure issues, and discussions about bereavement/grief issues. These activities reach 24, 2407 youth.

Children and youth have been identified as a weak point in PHDP activities. To provide positive living and palliative care programs with the knowledge and skills to increase their focus on children, adolescents, and youth, palliative care guidelines and health care worker trainings are in place

MULTI-SECTOR COLLABORATIONS

The health and education sectors have well established linkages in the area of HIV prevention and are increasing collaboration in HIV care and support. SRH and FP are integrated into some HIV services for adolescents. Other programs linking HIV to other sectors are underway, but do not have a specific focus on adolescents. These programs include nutrition services and food security (e.g., Feed the Future), economic strengthening, and malaria (linking to couples counseling and testing). Protection services are another area of collaboration and integration—prevention, child abuse programs, and justice programs are coordinated through central resource centers.

An initiative called "Junior Reporters" aims to empower Zambian youth to make a difference in the development of their society, build their confidence to take part in the public debate, and be a channel for advocacy for child rights issues. The backbone of the project is the magazine called *The Junior Reporter*, which is produced by youth, with support from the project team. With its circulation of 17,000 copies, it is the largest magazine in Zambia.

CURRENT GAPS AND AREAS FOR STRENGTHENING

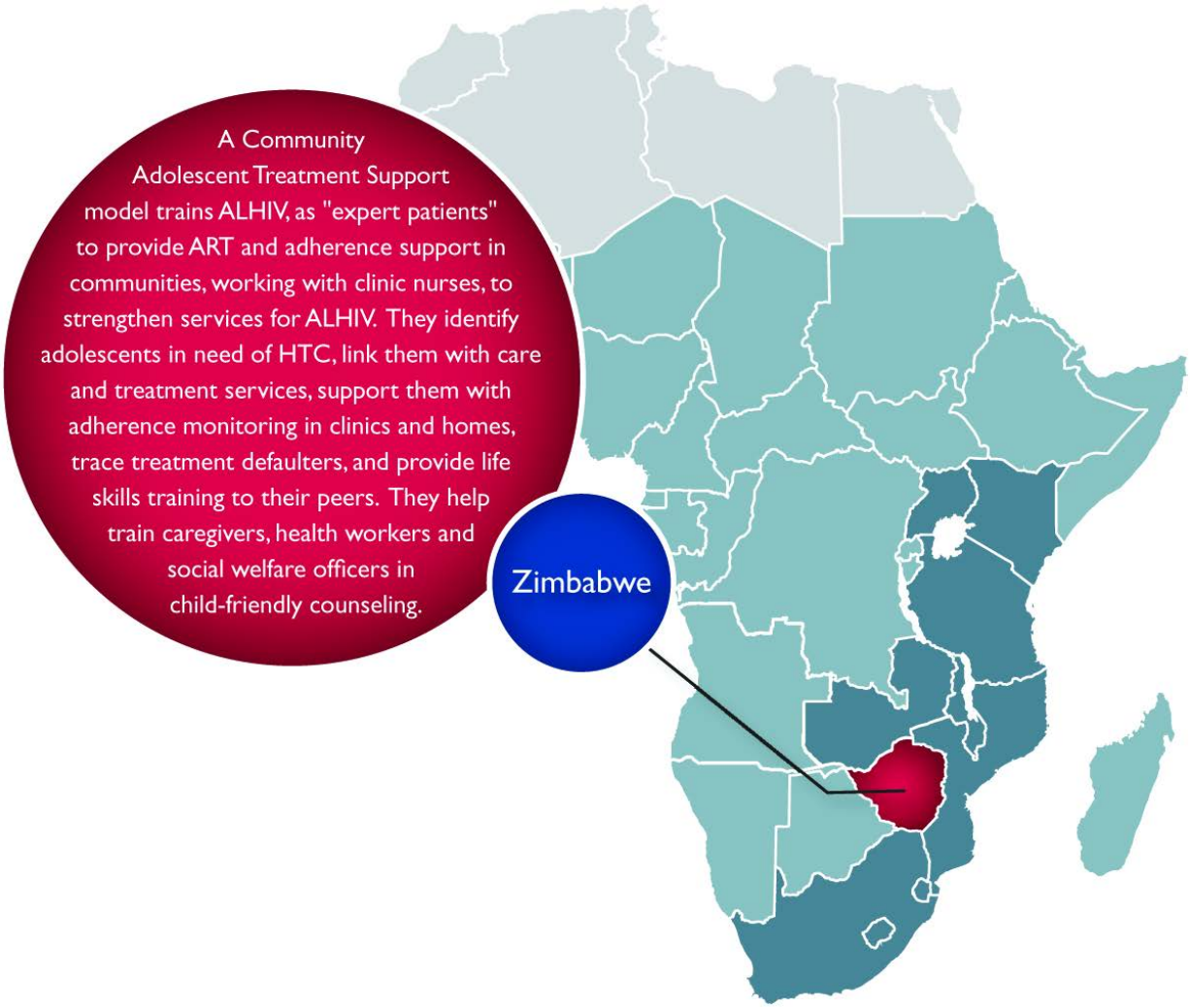
- Adapt data collection procedures so adolescent-specific data are available.
- Expand HIV prevention activities to younger adolescents and out-of-school adolescents.

- Expand adolescent-friendly centers to increase adolescent access to HTC and expand HTC efforts to include adolescent girls.
- Build on MOH and MOE collaboration to expand prevention, HTC, care and treatment services to adolescents who attend school through adapting the current curriculum. Specific out-of-school hours for adolescents to attend appointments and mobile clinics near schools should be considered.

RESOURCES

Zambia U-Report Power point presentation, unpublished slides by L. Tsague et al. 2012
http://www.unicef.org/zambia/health_nutrition_12205.html

ZIMBABWE



ADOLESCENT DEFINITION

In terms of HIV service provision, an adolescent is considered to be a young person between 12 and 19 years of age in Zimbabwe. However, within the national M&E system, although there is disaggregation by age, reports are broken down into three categories, 0-14 years, 15-19 years, and 19+ years of age. This leads to difficulties in data analysis, especially for younger and older adolescents. The new National Adolescent Sexual and Reproductive Health (ASRH) strategy defines its target population as 10- to 24-year-olds and aims to provide youth with life skills to adopt positive behaviors regarding SRH.

Adolescent Age Range	Ages 12-19*
Age of Testing Consent	Age 16
Data Disaggregation**	0-14; 15-19; >19

*Age range definition may vary in practice

**National health reporting system

HEALTH SYSTEMS STRENGTHENING

The *Zimbabwe National HIV/AIDS Strategic Plan, 2011-2015* (ZINASP II), briefly mentions improving adolescent sexual and reproductive health and provisions for OVC. It includes children 0-18 years old, identifying young people (15-29) as a priority population, who should be targeted, both inside and outside of the educational system, to receive messages about safe sex. Children under the age of 12 are considered to be a part of pediatric services, and the focus of pediatric HIV services in Zimbabwe is to strengthen PMTCT programs to support the children born within the system and to keep their mothers healthy. Older children above age 12 are likely to be seen by adult services. This division between pediatric and adult services is only seen at the higher level facilities, which may also further separate adults and adolescents depending on available resources, including staff. At lower level facilities, the same providers are seeing both sets of clients. According to interview results, a 2010 assessment documented that few health care workers were trained specifically in adolescent care. However, under the new ASRH Strategy, an increasing number of health workers are receiving training in ASRH care.

Youth-friendly services to promote family planning and STI prevention among adolescents and young people have been a part of the Zimbabwean reproductive health policy since 2003, but are not well implemented. UNFPA, supported by donors and the Ministry of Health and Child Welfare (MOHCW), are working to strengthen and revitalize the youth-friendly focus of service delivery, creating space in every health facility to address youth issues and integrate health services through the Integrated Support Program. Family planning will serve as the entry point, with GBV screening, STI care, HTC, PMTCT, and condom distribution also being key services. Implementation is planned for late 2013 and will incorporate training for providers on adolescent-friendly services. In addition, UNICEF is supporting youth-friendly corners in city health clinics in Harare and other major urban centers. Primarily staffed by peer counselors, these corners specifically address the needs of ALHIV, providing a safe place for them to receive treatment support. Approximately 40 percent of facilities in Harare have youth corners, but results suggest that even those that are functional still do not offer comprehensive services for the adolescent.

"Work with adolescents to identify training needs, plan, organize, monitor and evaluate programmes for the different client groups of adolescents in SRHR." NGO, Zimbabwe (survey respondent).

UNICEF manages the Health Transition Fund to support human resources retention, procurement, and distribution of essential health commodities, health facility financing, and the strengthening of MCH and nutrition services. Services for adolescents will also be captured in this work, but are not a specific focus. Similarly, the Global Fund supports health system strengthening overall, including health worker retention, which will indirectly benefit adolescents.

The SRH department within the MOHCW is responsible for coordinating the ASRH strategy, collaborating with the department of HIV, TB, and STIs. UN agencies and other partners participate in the national ASRH forum to ensure HIV and AIDS issues are well articulated in the strategy, training manuals, and other materials. The ASRH strategy also includes a M&E component and advocacy for indicators to be sensitive to adolescents. Electronic data systems are being piloted to improve disaggregation of the adolescent age group.

HIV PREVENTION

There are few HIV prevention activities that routinely specifically target adolescents in Zimbabwe. However, various BCC programs periodically target specific populations, including adolescents. The current intervention focuses on VMMC. Previous campaigns have promoted prevention of transgenerational sex and delay of sexual debut. Although HIV and life skills are part of the primary and secondary school curriculum, delivery is inconsistent. The Ministry of Education, Sport, Art and Culture (MOESAC) is currently reviewing a strategic plan integrating life skills and HIV/ASRH information, moving towards an evidence-driven approach to HIV education. Once the strategy is approved, the national curriculum will be revised. Already, however, teacher training is reflecting the new strategic plan, emphasizing HIV services for adolescents.

Zimbabwe has recently adopted a combination HIV prevention approach, which includes HTC, BCC, VMMC, PMTCT, condoms, and treatment of adolescents. PSI and UNFPA have been the lead implementers of BCC services, with PSI focusing on social marketing and UNFPA on community-based BCC facilitators. These efforts are complemented by other implementers, such as UNICEF, working directly with young people. PSI, supported by PEPFAR and the Gates Foundation, has led technical and social mobilization support for VMMC. PEPFAR and the UK's Department for International Development are supporting additional partners to expand national VMMC coverage. The VMMC initiative originally targeted adolescent boys and young men 13-29 years of age, but as parents are bringing most of the younger clients in, adolescent boys are now accepted if they are over 10 years old.

Periodic surveys document HIV knowledge in the community, and a recent 2010-2011 survey demonstrated relatively high knowledge of HIV among adolescents, but a lack of translation of that knowledge into practice or behavior change. Adolescent-targeted PMTCT services will be strengthened as the youth-friendly corners are implemented, but no programs currently are specifically mobilizing young pregnant women to access PMTCT services. According to the Zimbabwe Demographic and Health Survey, 2010-2011, this is a critical gap as 24 percent of women 15-19 years old have begun childbearing (Zimbabwe National Statistics Agency and ICF International 2012).

A key population for HIV prevention services in Zimbabwe is sex workers. However, there are currently limited programs for sex workers and even fewer specifically targeting adolescents engaging in sex work. Sixteen static and mobile health care sites, supported by peer educators, have been established to bring health services to sex workers. These will be expanded to 36 sites in 2013. HIV prevention programs and services for MSM is a politically sensitive issue and very little is known about MSM in Zimbabwe. According to one interviewee, sex work and MSM are illegal in Zimbabwe. HIV services for men and women in prisons are slowly being implemented with a focus on access to treatment, but do not specifically focus on the adolescent. There is acknowledgment that disabled populations also need to be reached for HIV prevention in Zimbabwe.

HIV TESTING AND COUNSELING

HTC is widely available in the public sector, and adolescents can access testing in the same facility as adults, but there is no adolescent-specific counseling. The age of consent for HTC is 16, but parental/guardian consent is waived in cases of rape and in clinically symptomatic adolescents. The National Guidelines for HTC in Children are being revised in order to make HTC more accessible to minors, particularly those without parents or legal guardians. In PITC, which is now the main HTC approach in the public sector in Zimbabwe, providers are also targeting adolescents.

Adolescents are not frequently seeking HTC at health care facilities, but providers are offering the test when they present for other health issues. However, it is not clear if referrals for care are strong for those who test positive, and even less is known about post-test counseling for adolescents who test negative, a potential missed opportunity for additional HIV prevention services.

"Population Services International's New Start Centres and various other NGOs (provide HTC for adolescents); our program does not implement HTC but works very closely with others and invites them to provide service to our beneficiaries." NGO, Zimbabwe (survey respondent)

Adolescents access HTC services more commonly through the private or NGO system. At these locations, privacy, confidentiality, and quality are perceived as better by adolescents, and they generally are willing to pay a fee (US $1 at USG support sites) for services instead of going to the free public clinics. Although they are not designed specifically for adolescents, these private clinics provide more valued anonymity for the adolescents. PSI's New Start program targets young couples and may capture adolescents as a result.

Little to no data exists regarding disclosure support or post-test counseling. Some NGOs, including PSI, Africaid, and MSF, manage post-test support services, which though not specifically targeted at adolescents, are still more accessible to them than those offered in the public sector. The Southern Africa AIDS Trust recently conducted a survey that examined post-test and post-disclosure services for ALHIV; results are pending. There is no specific disclosure policy at public sector health facilities, but primary care counselors are trained to address adolescents' and children's issues. To the extent possible, an adult caregiver would be involved in the disclosure process, but this is at the discretion of the counselor. In the cases of perinatal transmission, the preference is for a family member (with a counselor's support) to begin disclosing in an age-appropriate manner beginning around age 8.

CARE AND TREATMENT

Treatment for adolescents is primarily included under integrated management of adult and adolescent illnesses. Younger adolescents may access services via pediatric clinics, but there is little transition support other than support groups. Within the AIDS and TB unit of the MOHCW, there is a care and treatment coordinator, who oversees a team that includes a pediatric treatment coordinator, which helps align activities on a national level. The two largest central hospitals in Harare have adolescent-specific HIV clinics. These clinics are held at certain times, three days per week, and are staffed by personnel trained in adolescent HIV services. However, the vast majority of ALHIV access care and treatment services in the adult clinics, where few health care workers are trained in providing adolescent care.

PHDP activities are not specific to adolescents, but group counseling or support groups attempt to address issues such as secondary prevention. PEPFAR-supported OVC programs are scaling up a model for linking ALHIV and other children living with HIV to provide them with psychosocial and adherence support in certain provinces. The government and UNICEF have recently started to lead scale-up of the PEPFAR-supported model in other provinces. Peer support services in general are growing in urban areas and civil society is driving PHDP activities. UNICEF is also working to support ALHIV with partner disclosure and condom use, and by supporting young women growing up with HIV who are now getting married and starting families.

"One partner implements a Community Adolescent Treatment Support model, through which HIV-positive adolescents are trained and mentored to provide ART and adherence support in communities. They identify adolescents in need of ART, refer them for ART, support them through initiation, and then with adherence support, home visits, clinic visits, caregiver training and counseling, SMS support, and follow-up of ALHIV lost to follow-up or with complications to ART and suspected treatment failure. They work alongside clinic nurses, strengthening services for ALHIV." NGO, Zimbabwe (survey respondent).

MULTI-SECTOR COLLABORATIONS

The MOHCW and MOESAC have collaborated to develop curricula for students beginning at low levels and continuing through high school, with age appropriate changes in information. However, there is a lack of adolescent-friendly health services to which to link or refer students should they have additional questions or require specialized health care. These challenges may be addressed by the policy and strategic plan changes currently underway. Several ministries have approved the adolescent SRH strategy. Through the ASRH Forum, the MOHCW brings the various partners together to ensure consistency and coherence among programs. A multi-sector plan to respond to sexual violence identified in the National Baseline Survey on the Life Experiences of Adolescents has been drafted. Eighteen percent of women 15-19 years old have experienced sexual violence, primarily by a partner or boyfriend (ZDHS 2010-11), highlighting the need for a multi-sector response.

To involve young people themselves, the National AIDS Council has a National Youth Coordinator, who, in addition to coordination of young people's interventions, oversees the Young People's Network for HIV and SRH, which has member organizations throughout the country that integrate adolescents. Since 2005, UNICEF has implemented the "Young People We Care" program in which youth volunteers provide community service to vulnerable households, for example supporting orphans, children with disabilities, and the elderly. As volunteers, the program also educates them on HIV prevention, care and treatment, and skills to prepare for the future. Also, UNFPA sponsors Girls Clubs that provide girls with HIV/SRH knowledge and life skills. UNICEF and SAfAIDS are supporting radio and social media programs specifically designed for young people.

"We need a stronger continuum of care, to ensure ALHIV do not fall through the cracks between the clinic and the community and are supported in treatment, care, and prevention. We need more work with families and communities so that they can better understand the needs of ALHIV and provide appropriate support. It is in the communities where they are facing most of their challenges and it is here that we should be focusing support, including in schools." NGO, Zimbabwe (survey respondent)

CURRENT GAPS AND AREAS FOR STRENGTHENING

- Adapt data collection procedures so adolescent-specific data are available.
- Create services to support transition in care for ALHIV.
- Train more human resources about adolescent care and treatment. The majority of adolescents in Zimbabwe are not accessing services at the two larger hospitals in Harare where there are clinicians trained in care for ALHIV.
- Build multi-sector collaborations to address structural drivers of HIV in Zimbabwe.

RESOURCES

National Youth Policy Zimbabwe
http://planipolis.iiep.unesco.org/upload/Youth/Zimbabwe/Zimbabwe_National_Youth_Policy.pdf

Zimbabwe National HIV and AIDS Strategic Plan, 2011-2015
http://www.safaids.net/content/zimbabwe-national-hiv-and-aids-strategic-plan-znasp-ii-2011-2015

Others (not yet available online):
- National Adolescent Sexual and Reproductive Health Strategy 2010-2015
- National Combination HIV Prevention Approach, 2013
- National HIV/AIDS, Sexuality and Life Skills in Education Strategy (pending)
- National Voluntary Medical Male Circumcision Strategy

OPPORTUNITIES FOR INTEGRATION

Seizing opportunities to provide adolescents with efficient and effective HIV prevention, care and treatment services is critical to address the multi-faceted needs of ALHIV and to increase opportunities for comprehensive HIV services. Key informant interviews revealed a number of examples of integration that may be considered for broader expansion to other countries. Integration efforts that have been identified are summarized below.

HIV AND EDUCATION

- Provision of comprehensive HIV prevention education in schools
- Provision of HTC in schools and/or linkages from the school to quality, youth-friendly HTC and ASRH services
- Provision of condoms in schools
- Collaboration between the MOH and MOE to create training materials for health care workers on ALHIV

HIV AND PRIMARY HEALTH SERVICES

- Integration of ALHIV services within youth-appropriate primary health and preventive health services
- Integration of VMMC for HIV prevention, with youth-friendly primary health and SRH services or referrals to related services

HIV AND MATERNAL NEWBORN CHILD HEALTH SERVICES

- Integration of HTC into pre-natal services for adolescent mothers and PMTCT

HIV AND SOCIAL PROTECTION

- Integration of HIV with GBV programs, including linking adolescents who are victims of domestic violence and/or have been sexually assaulted to HTC and other health services
- Integration of HIV with post-rape care services for adolescents
- HIV prevention education and vocational training for adolescents
- HTC and vocational training for adolescents, including linkages with the labor sector

HIV AND COMMUNITY INITIATIVES

- Implementation of HTC and VMMC during youth sports programs or social events
- HIV prevention education during youth sports programs or social events

RECOMMENDATIONS

Improving HIV services for adolescents must take the local context and needs into consideration. From the information collected in the interviews and surveys, the following tables offer general policy and practice recommendations for strengthening adolescents HIV services.

POLICY RECOMMENDATIONS

Recommendation	Summary	Next Steps
Address adolescents and ALHIV in health strategies and guidelines	Findings indicate that few national strategies and guidelines specifically address HIV programs and policies for adolescents or ALHIV. In order to build a platform that provides quality HIV prevention services for adolescents and care and treatment services for ALHIV, an essential first step is to address key issues and provide guidance within the broader health system.	Continue working with national government and relevant stakeholders on developing specific guidelines and action plans that address adolescents and HIV, in addition to other health and social support needs.
Address age of consent	Age of consent for HTC and access to care and treatment varies greatly by country. In some cases, it is not addressed or remains unclear. These barriers inhibit providers from offering services and limit adolescents' access. Defining and clarifying the age of consent for HTC and access to care and treatment services in a manner that increases access for adolescents and ALHIV to these essential services is critical to identify and address the health needs of adolescents.	Determine the age of consent at the national level so it increases access to HIV testing and other services for ALHIV. Although age of consent may vary by country, ensure age of consent to HIV testing is defined, clear, and realistic for young people.
Define adolescence	Setting the age limits for adolescence across programs and within monitoring and evaluation (M&E) at all levels to achieve uniform reporting is critical. Without clear and consistent definitions of the adolescent population, data cannot be collected and disaggregated to identify needs and inform program planning at all levels for adolescents and ALHIV.	Define the period of adolescence at the national level. Create M&E indicators and reporting forms specific for this age group. Then, working with all relevant implementing partners, build this into data collection and M&E activities.
Disaggregate adolescent data	None of the countries that participated in the mapping activity were capturing adolescent-specific data, resulting in a dearth of information that is needed in order to adequately plan and monitor activities for this population.	The national level should provide guidance on data disaggregation specifically to capture and use data for planning and monitoring purposes and to improve policies and services for adolescent populations.

Streamline and collaborate at all levels	Adolescent HIV services within a country should be complementary and comprehensive across donor and implementing agencies to reduce duplication. Streamline strategies to address services for all adolescents including ALHIV.	Streamline activities with other donors, government, and implementing partners to ensure quality and reduce redundancy or mixed messages. Clearly identifying the roles and responsibilities of each stakeholder in a concerted manner will support coordinated strategies, policies, and programs.
Incorporate transition into care and treatment guidelines	Transition from pediatric to adult HIV care is widely recognized as a challenge, but transition support for adolescents, their families, and their health care providers is lagging behind this recognition.	Incorporate transition or linkage from pediatric to adult care in national HIV guidelines and strategic plans. Identify areas in the health system to strengthen so that this transition is recognized and addressed.

PRACTICE RECOMMENDATIONS

Recommendation	Summary	Next Steps
Involve adolescents	To adequately respond to adolescents' needs, they must be involved in all stages of programming, from identifying what their desired services are, setting targets and goals, designing and testing adolescent-friendly materials and delivery systems, helping deliver those services to their peers, and monitoring and evaluating progress.	Identify ALHIV who can act as spokespersons to inform the design, management, and evaluation of programs targeting the population.
Address adolescents in programming for key populations	Implementing effective HIV prevention, care and treatment services for key adolescent populations, such as sex workers, MSM, or PWID will be critical in reaching the goal of an AIDS-free generation. Key adolescent populations face double challenges of stigma and age, preventing access to care, and therefore may require additional efforts to address their increased vulnerability to HIV and ensure a human-rights based approach.	Facilitate continued research on adolescent health and related-needs to inform programs and services for them, including key populations in this age group. Programming for key populations is just beginning in much of the region, and adolescents must be specifically considered in interventions. Identify HIV-positive adolescents from key populations who can act as leaders and help to inform programming for key populations.
Clearly define the target population in programming	The needs of young people change significantly as they age through early adolescence to early adulthood. An intervention appropriate for a 12-year-old may not be as applicable to an 18-year-old. In addition, the appropriateness of interventions for boys/young men and girls/young women may differ.	Programs need to clearly define who they are working with and provide age-, development-, and gender-appropriate interventions.

Recommendation	Summary	Next Steps
Use data to inform program design and progress	Current data systems pose challenges to disaggregating data on 10- to 19-year-olds. However, some smaller studies exist and as monitoring systems evolve to enable further disaggregation, programs should use any available data to better target programming to meet adolescents' needs, including ALHIV.	Stakeholders can use available data from broader categories (e.g., youth) to advocate for the resources needed to implement adolescent-specific programming. Clearly defined targets and data management systems will help provide better quality reporting.
Provide comprehensive, combination HIV prevention services	Although HIV education in schools is widespread, the quality is inconsistent and messages may not be evidence-based or adapted to the local context of the epidemic. Additionally, many adolescents do not attend school and do not have access to accurate information and prevention services. These gaps must be addressed along with provision and promotion of condoms to sexually active adolescents. Implementing evidence-based structural, biomedical, and behavioral interventions for adolescents are needed with effective referral and linkages.	Implement combination, evidence-based interventions for adolescents for HIV prevention and PHPD appropriate to the local context of the epidemic. HIV prevention must also take place in the community to reach adolescents who are not in school. As data emerge on effective structural interventions, such as cash-transfer programs and activities to help adolescent girls remain in school, these programs should also be scaled up.
Scale up VMMC	Many VMMC programs are reaching young men without demand generation activities, and therefore, could be a key platform to reach this population and ensure they receive or are effectively linked with other HIV and health services.	In countries where voluntary medical male circumcision (VMMC) is supported, adolescent boys should have access and VMMC counseling and education should be tailored to their needs. Many VMMC programs are reaching young men and should ensure they are effectively linked with other HIV and health services.
Ensure access to PMTCT program for adolescents	Adolescent girls make up a significant proportion of women becoming pregnant each year and HIV-positive pregnant adolescents are more likely to fall out of PMTCT services. Antenatal-care services are the site where many young, infected women learn of their HIV status and play a critical role in linking these young women to services for their own health.	PMTCT programs should be tailored to the needs of adolescent mothers to ensure they are tested for HIV and those who test positive receive appropriate care and treatment. Effective strategies for youth-friendly PMTCT and other HIV prevention programs to effectively reach and ensure adolescent girl are retained in care must be identified and employed. Additional interventions are needed for adolescent girls who are not accessing PMTCT.

Involve families and communities and address social norms	Adolescents spend most of their time in their communities and with their families, outside of the clinic or health care facility. HIV prevention and care and treatment activities would be strengthened by the increased involvement of parents, guardians, and caregivers.	Implement programs that provide information and encouragement to families and communities to support adolescents in engaging in behaviors to stay healthy, reduce their risk of HIV, and adhere to treatment if HIV-positive.
Strengthen promising multi-sector and cross-cutting collaborations	Some partnerships, like those between the health and education sector, are more obvious than others, but there are opportunities for additional collaborations to address adolescents' needs. Continue building multi-sectoral and cross-cutting collaborations to provide adolescents with comprehensive health care and HIV prevention, care and treatment services.	HIV program planners should seek to collaborate with the labor sector to increase employment opportunities for youth completing schooling; with nutrition services for ALHIV; protection services to incorporate GBV issues, child abuse and rape services and prevention; athletic and sporting events and programs; religious and spiritual organizations; and with the technology industry to increase use of growing social media, SMS text messaging, and other platforms.

CONCLUSION

Working with adolescents can be a challenge, beginning with the programming lexicon. Adolescents, youth, and young people are often used interchangeably as definitions, but may have different meanings with relevance to programming. The participating countries were at different stages of designing and implementing HIV services for adolescents, however, there was overall recognition that creating adolescent-specific HIV strategies and youth-friendly services will be a critical component of each country's HIV response.

Some innovative approaches for implementing HIV programs for adolescents were identified. Opportunities exist for south-to-south collaborations and technical exchange as countries with more advanced and comprehensive adolescent services can support their neighbors. Strengthening HIV services for adolescents in a collaborative and transparent manner will provide a platform for strengthening adolescent health services overall and will help attain the goal of an AIDS-free generation for adolescents.

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ANNEX I

USG AND UNICEF KEY INFORMANT INTERVIEW GUIDE

AIDSTAR-ONE ADOLESCENT SERVICE MAPPING INTERVIEW QUESTIONS

INTRODUCTION

Until recently it was assumed few children infected vertically would live beyond their fifth birthday, however recent data shows ART and viral suppression is allowing many of these children in sub-Saharan Africa to enter adolescence. Additionally, the number of adolescents who are infected via behavioral routes (such as sexual transmission or injecting drug use) remains high, and needs to be addressed. In 2010, an estimated 960,000 young people aged 15 – 24 were newly infected with HIV and three out of every four infected are from sub-Saharan Africa. Although no firm estimate is available yet for the proportion aged 15 – 19 years, national population-based surveys show a steep rise in new infections in adolescents, particularly among girls. Nine countries in sub-Saharan Africa show that HIV prevalence is three times higher in adolescent girls aged 15 – 19 when compared to adolescent boys. As the number of adolescents living with HIV (ALHIV) continues to grow, the need to improve services, policies, and programs intensifies.

Supported by PEPFAR and USAID's Africa Bureau and in collaboration with UNICEF, as part of the response to the unmet needs of this emerging population, AIDSTAR-One is conducting a survey of HIV services for adolescents in five countries: Kenya, Malawi, Mozambique, Zambia, and Zimbabwe. The questions from this survey have been developed based on the information that arose from the development of a technical brief and a recent meeting focused on the needs of ALHIV, as well as from a UNICEF questionnaire on good practices related to services for ALHIV.

This interview should take approximately 30 – 45 minutes of your time. We thank you in advance for your responses, as they will help inform USAID Africa Bureau and PEPFAR's work in the area of HIV services for adolescents. Should you have any questions, please feel free to contact Malia Duffy (mduffy@jsi.com) with the AIDSTAR-One Project or Jenny Albertini at USAID (jalbertini@usaid.gov).

SECTION 1: BACKGROUND INFORMATION

1. Please confirm your name, title, and agency/organization.
2. We are interested in HIV services for adolescents. We are using the WHO definition of "adolescent" as a young person between the ages of 10 and 19. Is this how you define adolescence in your context?
   - Probe: If you use a different definition of "adolescent," what is it?
   - Probe: Do all agencies and organizations in your context use the same definition? How is "adolescent" defined and by whom?
   - Probe: Please tell me about any difficulties caused by the various definitions.

SECTION 2: ADOLESCENT ACTIVITIES TO SUPPORT PROGRESS TOWARDS AN AIDS-FREE GENERATION

1. Tell me about health system strengthening (HSS) activities in your context:
   - Probe: Within the national HSS initiative, is there a strategy specifically for adolescents?
   - Probe: How long has it been in place?
   - Probe: Please describe the main points of the strategy.
   - Probe: Who has primary responsibility for overseeing implementation of the strategy (e.g., MOH, Ministry of Youth)?
   - Probe: Who are the primary partners responsible for implementing HSS activities?
   - Probe: Has the strategy, as it pertains to adolescents, been implemented successfully? (If yes) why do you consider it to be a success? Why or why not? What are some of the challenges to implementation?
   - Probe: Which strategies, related to adolescents, have been most successful and why do you consider them to be successful? What would it require to replicate this strategy? What would it take to integrate this strategy into other programs for adolescents?
   - Probe: Are there strategies related to other chronic diseases, like diabetes, that have an adolescent-specific component? Which strategies have been most successful and why do you consider them to be successful? What would it require to replicate this strategy? What would it take to integrate this strategy into other programs for adolescents?
   - Probe: What are the current gaps in adolescent-focused HSS activities? Please elaborate. What are strategies to address the gaps?
   - Probe: How are data about HSS activities collected from implementing partners? Are there any specific ways in which HSS (pertaining to adolescents) are monitored? For example, disaggregation of data by age/sex; successful referral to appropriate services, such as counseling and testing
   - Probe: Is there any research underway regarding HSS and adolescents? Please describe.

2. Tell me about the national HIV strategy in your context:
   - Probe: Within the national HIV strategy, is there a strategy specifically for adolescents?
   - Probe: How long has it been in place?
   - Probe: Please describe the main points of the strategy.
   - Probe: Who has primary responsibility for overseeing implementation of the strategy (e.g., MOH, Ministry of Youth)?
   - Probe: Who are the primary partners responsible for implementing the strategy?
   - Probe: Has the strategy, as it pertains to adolescents, been implemented successfully? (If yes) why do you consider it to be a success? Why or why not? What are some of the challenges to implementation?
   - Probe: Which strategies, related to adolescents, have been most successful and why do you consider them to be successful? What would it require to replicate this strategy? What would it take to integrate this strategy into other programs for adolescents?
   - Probe: What are the current gaps in the national HIV strategy pertaining to adolescents? Please elaborate. What are strategies to address the gaps?

3. Tell me about HIV prevention activities for adolescents in the general population in your context.
   - Probe: Within the national HIV prevention program, is there a strategy specifically for adolescents?
   - Probe: How long has it been in place?
   - Probe: Please describe the main points of the strategy.
   - Probe: Who has primary responsibility for overseeing implementation of the strategy (e.g., MOH, Ministry of Youth)?
   - Probe: Who are the primary partners responsible for implementing services in support of the strategy?
   - Probe: Has the strategy been implemented successfully? (If yes) why do you consider it to be a success? Why or why not? What are some of the challenges to implementation?
   - Probe: Which prevention strategies have been most successful and why do you consider them to be successful? What would it require to replicate this strategy? What would it take to integrate this strategy into other programs for adolescents?
   - Probe: What are the current gaps in adolescent focused prevention activities? Please elaborate. What are strategies to address the gaps? Probe: Are there any specific guidance or training materials that deal explicitly with HIV prevention among adolescents?
   - Probe: Are there nationally mandated/vetted specific IEC materials that have been developed for adolescents that focus on prevention?

- Probe: How are data about HIV prevention activities collected from implementing partners? Are there any specific ways in which HIV prevention services are monitored? For example, disaggregation of data by age/sex; successful referral to appropriate services such as counseling and testing
- Probe: Is there any research on prevention needs or new models of service delivery?

4. Tell me about HIV prevention activities for adolescents who are parts of key populations (most-at-risk populations) in your context.
   - Probe: Within the national HIV prevention program, is there a strategy specifically for adolescents who are parts of key populations (most-at-risk populations, MARPs)?
   - Probe: How long has it been in place?
   - Probe: Please describe the main points of the strategy. Which key populations (MARPs) are included?
   - Probe: Who has primary responsibility for overseeing implementation of the strategy (e.g., MOH, Ministry of Youth)?
   - Probe: Who are the primary partners responsible for implementing services in support of the strategy?
   - Probe: Has the strategy been implemented successfully? (If yes) why do you consider it to be a success? Why or why not? What are some of the challenges to implementation?
   - Probe: Which prevention strategies have been most successful and why do you consider them to be successful? What would it require to replicate this strategy? What would it take to integrate this strategy into other programs for adolescents?
   - Probe: What are the current gaps in adolescent-focused prevention activities for key populations? Please elaborate. What are strategies to address the gaps? Probe: Are there any specific guidance or training materials that deal explicitly with HIV prevention among most-at-risk adolescents?
   - Probe: Are there nationally mandated/vetted specific IEC materials that have been developed for key population adolescents that focus on prevention?
   - Probe: How is data about HIV prevention activities collected from implementing partners? Are there any specific ways in which HIV prevention services are monitored? For example, disaggregation of data by age/sex; successful referral to appropriate services such as counseling and testing and harm reduction
   - Probe: Is there any research on prevention needs or new models of service delivery?

5. Tell me about HIV counseling and testing activities for adolescents in your context.
   - Probe: Within the national HIV testing and counseling (HTC) program, is there a strategy specifically to strengthen testing services for adolescents?
   - Probe: How long has it been in place?

- Probe: Please describe the main points of the strategy.
- Probe: Who has primary responsibility for overseeing implementation of the strategy (e.g., MOH, Ministry of Youth)
- Probe: Who are the primary partners responsible for implementing services in support of the strategy?
- Probe: Has the strategy been implemented successfully? (If yes) why do you consider it to be a success? Why or why not? What are some of the challenges to implementation?
- Probe: Which HIV counseling and testing activities have been most successful and why do you consider them to be successful? What would it require to replicate this strategy? What would it take to integrate this strategy into other programs for adolescents?
- Probe: Where are testing services available for adolescents? (e.g., mobile clinics, STI clinics, FP clinics)
- Probe: What are the current gaps in adolescent focused testing activities? Please elaborate. What are strategies to address the gaps?
- Probe: Are there any nationally mandated guidance or training materials that deal explicitly with HIV prevention among adolescents and what to do about ensuring that those who are negative stay negative and those that are positive receive the treatment/care services that they need?
- Probe: How is data about HIV testing activities collected from implementing partners? Are there any specific ways in which HIV prevention services are monitored? For example, disaggregation of data by age/sex; successful referral to appropriate services for those found to be HIV negative and HIV positive.
- Probe: Is there any research on test needs or new models of service delivery?

6. Tell me about disclosure activities for adolescents in your context.
   - Probe: Is there a national policy for disclosure of HIV status to adolescents by health care workers, parents/guardians, or others? What about disclosure by the adolescent to others, such as his/her sexual partners?
   - Probe: Please describe the main points of the policy.
   - Probe: Who has primary responsibility for overseeing implementation of the strategy (e.g., MOH, Ministry of Youth)?
   - Probe: Who are the primary partners responsible for implementing services in support of the strategy?
   - Probe: Has the policy been implemented successfully? Why or why not? What are some of the challenges to implementation?
   - Probe: Are there any specific national guidance or training materials that have been developed to support disclosure to adolescents? And for adolescents in disclosing their HIV status to others?

- Probe: Are there any examples of programs using innovative approaches to increase disclosure to/by adolescents? How can these be replicated and/or integrated into other programs for adolescents?
- Probe: What are the current gaps in adolescent disclosure activities? Elaborate. What are strategies to address the gaps?
- Probe: Is there any research on disclosure needs or new models of service delivery?

7. Tell me about care and treatment activities for ALHIV in your context.
   - Probe: Within the national HIV care and treatment program, is there a strategy to specifically increase access for adolescents?
   - Probe: Please describe the main points of the strategy.
   - Probe: Who has primary responsibility for overseeing implementation of the strategy (e.g., MOH, Ministry of Youth)?
   - Probe: Who are the primary partners responsible for implementing services in support of the strategy?
   - Probe: Has the strategy been implemented successfully? (If yes) why do you consider it to be a success? Why or why not? What are some of the challenges to implementation?
   - Probe: Which care and treatment strategies have been most successful and why do you consider them to be successful? What would it require to replicate this strategy? What would it take to integrate this strategy into other programs for adolescents?
   - Probe: Are there any specific national guidance or training materials directed to meeting the specific needs of ALHIV to access services and overcome barriers?
   - Probe: Are there any specific national guidance or training materials that deal with consent and confidentiality for ALHIV?
   - Probe: Are there examples of successful programs that are helping address barriers to accessing services by adolescents?
   - Probe: What are the current gaps in access for adolescents to care and treatment services for adolescents? Please elaborate. What are strategies to address the gaps?
   - Probe: How are data related to adolescent in care and treatment collected? Are there any specific ways in which HIV care and treatment services are monitored? For example, disaggregation of data by age/sex; successful referral to appropriate services such as psychosocial support, mental health services, etc.
   - Probe: Is there any research on care and support needs or new models of service delivery?

8. Tell me about adherence and retention activities for ALHIV in your context.
   - Probe: Is there a strategy specifically to retain adolescents in HIV care and treatment?
   - Probe: Please describe the main points of the strategy.

- Probe: Who has primary responsibility for overseeing implementation of the strategy (e.g., MOH, Ministry of Youth)?
- Probe: Who are the primary partners responsible for implementing services in support of the strategy?
- Probe: Has the strategy been implemented successfully? (If yes) why do you consider it to be a success? Why or why not? What are some of the challenges to implementation?
- Probe: Are there any programs that have been successful in ensuring ALHIV who do not need ART are in care and maintain regular contact with health services?
- Probe: What are the current gaps in access for adolescents to care and treatment services for adolescents? Please elaborate. What are strategies to address the gaps?
- Probe: Are there any nationally mandated training or other programs for providers, parents/caregivers, and ALHIV to increase the adolescent's adherence to ART?
- Probe: Are there any examples of innovative approaches to monitoring adherence among ALHIV on ART? What is known about adolescent treatment failure?
- Probe: Is there any research on adherence support needs or new models of service delivery?

9. Tell me about positive health, dignity and prevention (PHDP) activities for ALHIV in your context.
   - Probe: Are there any specific national guidance or training materials or programs that have been developed to improve prevention for/with ALHIV? Who are they for (service providers, parents/caregivers, ALHIV)? What behaviors are they targeting (condom use, avoidance of high-risk behaviors, nutrition, etc.)?
   - Probe: Are there specific national approved IEC materials that have been developed for ALHIV that focus on prevention?
   - Probe: Are there any effective secondary prevention programs for ALHIV?
   - Probe: What are the current gaps in access for adolescents to care and treatment services for adolescents? Elaborate. What are strategies to address the gaps?
   - Probe: How are data about PHDP collected? Are there any specific ways in which PHDP services are monitored and reported? If yes, what are the indicators reported? Is the data disaggregated by gender, and age?
   - Probe: Is there any research on prevention needs or new models of service delivery?

10. How are HIV services specifically targeting adolescents in your context?
    - Probe: Are adolescent services offered at separate facilities? What services? At which facilities? Do you think that this has an impact on retention of adolescents in care?
    - Probe: Are adolescent services being offered on special days or during specific hours? What services? At which facilities? Do you think that this has an impact on retention of adolescents in care?

- What successful examples have you noted that integrate adolescents with HIV into routine health services?
- Probe: What are the current gaps in access at integrating services? Please elaborate. What are strategies to address the gaps?
- Probe: Are providers being trained to offer "adolescent-friendly" services? What level of provider? Where do they provide services? In-service? Pre-service? Supportive supervision?

11. Tell me about primary care services for ALHIV in your context.
    - Probe: Are there national training materials or programs for healthcare providers to improve ALHIV access to the range of healthcare services they need (including family planning, nutrition, mental health, protection, GBV prevention and treatment, etc.)?
    - Probe: Do you have examples of programs that are ensuring ALHIV access to the range of healthcare services they need (including family planning, nutrition, mental health, protection, GBV prevention and treatment, etc.)?
    - Probe: What are the current gaps in access for adolescents to primary care services for adolescents? Elaborate. What are strategies to address the gaps?
    - Probe: Tell me about livelihood programs or other economic strengthening programs for ALHIV.
    - Probe: How is ALHIV access to primary care monitored? Are there mechanisms for communication between primary care services and HIV services? If yes, how does this work?
    - Probe: Are there good examples of referrals within the healthcare system for ALHIV? Why are they considered good and are they replicable?

12. Where can adolescents access HIV services specifically for them?
    - Probe: What level of facility has adolescent-specific services? (Level IV or national/referral hospitals, Level III, Level II/I, etc.)
    - Probe: Why are adolescent services not available at lower levels? Or, if adolescent-specific services are available at lower levels, how have facilities accomplished offering adolescent services at different levels given smaller staff size, more limited resources, etc.?
    - Probe: Please tell me about community-based HIV services for adolescents.
    - Probe: How could HIV services for adolescents be offered at a greater number and variety of sites? What resources would you need? What training would be needed and for whom?
    - Probe: Do you have any additional thoughts or examples of programs to strengthen the provision of services for ALHIV through facilities, communities and families?

13. How are HIV services for adolescents documented and evaluated?
    - Probe: How are data for adolescents disaggregated in reports (at the program/facility level, at the national level, etc.)? What ages are reported? Is gender also reported?

- Probe: Who evaluates HIV services for adolescents at the national level?
- Probe: Are services adjusted based on program progress and evaluation? If yes, how?

SECTION 3: ADOLESCENT ACTIVITIES IMPLEMENTED WITH DONOR SUPPORT

1. Most support from the U.S. Government comes through the President's Emergency Plan for AIDS Relief (PEPFAR). Tell me about what HIV activities PEPFAR is implementing or ways PEPFAR is supporting adolescents in your country.
   - Probe: What USG agencies are involved? (CDC, USAID, State, NIH, etc.)
   - Probe: Are particular agencies more active in certain types of programs or specific geographic areas? Please describe.
   - Probe: What types of activities are U.S. Government agencies supporting? (PMTCT, ART, VMMC, condom distribution, etc.)
   - Probe: Where are there still gaps remaining in services for adolescents that could be supported by PEPFAR?
   - Probe: In your experience, which PEPFAR efforts for adolescents have been most successful thus far and why?

2. Tell me about what HIV activities other external donors are implementing or ways they are supporting adolescents in your country.
   - Probe: What multilateral agencies are involved? (UNICEF, UNAIDS, GFATM, etc.)
   - Probe: What private donors are involved? (universities, Gates, Clinton, etc.)
   - Probe: What other foreign governments are involved? (DFID, EU, etc.)
   - Probe: Are particular agencies more active in certain types of programs or specific geographic areas? Please describe.
   - Probe: What types of activities are external donors supporting? (PMTCT, ART, VMMC, condom distribution, etc.)
   - Probe: Where are there still gaps remaining in services for adolescents that could be supported by external donors? Which donors?
   - Probe: In your experience, which efforts for adolescents have been most successful thus far and why?

3. How could donor agencies improve support for HIV services for adolescents?
   - Probe: What resources could USG agencies provide (aside from funding)?
   - Probe: What resources could other donors provide (aside from funding)?
   - Probe: How could the U.S. Government provide technical support or assistance?

- Probe: How could other donors provide technical support or assistance? Which donors?
- Probe: Have you advocated for this support? When and how? What was the response?

4. What HIV activities are not currently priorities but should be for adolescents?
   - Probe using examples (PMTCT, ART, VMMC, condom distribution, etc.)

SECTION 4: CROSS-CUTTING AREAS AND POTENTIAL FOR INTEGRATION

1. Tell me about how HIV services for adolescents are collaborating with other health initiatives.
   - Probe using examples (MNCH, FP/SRH, malaria, mental health)
   - Probe: Who is responsible for these cross-cutting activities? How are they managed?
   - Probe: What resources or support (technical assistance) were required to initiate these programs?

2. Tell me about how HIV services for adolescents are collaborating with other (non-health) sectors.
   - Probe using examples (education, economic support)
   - Probe: Who is responsible for these cross-cutting activities? How are they managed?
   - Probe: What resources or support (technical assistance) were required to initiate these programs?

3. Tell me about protection services for ALHIV in your country.
   - Probe: Has a Violence Against Children Survey (VACS) been implemented in your country? How has it impacted HIV programming for adolescents?
   - Probe: How are HIV programs incorporating GBV prevention and treatment?

4. Tell me about how HIV services for adolescents could collaborate with other health initiatives in the future.
   - Probe using examples (MNCH, FP/SRH, malaria, mental health)
   - Probe: Who would be responsible for seeing this integration happens?
   - Probe: What resources or support (technical assistance) would be needed?
   - Probe: When would it be feasible to accomplish this collaboration?

5. Tell me about how HIV services for adolescents could collaborate with other (non-health) sectors in the future.
   - Probe using examples (education, economic support)
   - Probe: Who would be responsible for seeing this integration happens?
   - Probe: What resources or support (technical assistance) would be needed?

Probe: When would it be feasible to accomplish this collaboration?

Thank You

Thank you very much for participating in this follow-up interview! If you have any questions, please let me know or feel free to contact Malia Duffy (mduffy@jsi.com) or Heather Bergmann with the AIDSTAR-One Project (hbergmann@jsi.com), or Jenny Albertini at USAID (jalbertini@usaid.gov).

ANNEX 2

IMPLEMENTING PARTNER SURVEY

AIDSTAR-ONE ADOLESCENT SERVICE MAPPING SURVEY QUESTIONS

INTRODUCTION

Until recently it was assumed few children infected vertically would live beyond their fifth birthday, however recent data shows ART and viral suppression is allowing many of these children in sub-Saharan Africa to enter adolescence. Additionally, the number of adolescents who are infected via behavioral routes (such as sexual transmission or injecting drug use) remains high, and needs to be addressed. In 2010, an estimated 960,000 young people aged 15 – 24 were newly infected with HIV and three out of every four infected are from sub-Saharan Africa. Although no firm estimate is available yet for the proportion aged 15 – 19 years, national population-based surveys show a steep rise in new infections in adolescents, particularly among girls. Nine countries in sub-Saharan Africa show that HIV prevalence is three times higher in adolescent girls aged 15 – 19 when compared to adolescent boys. As the number of adolescents living with HIV (ALHIV) continues to grow, the need to improve services, policies, and programs intensifies.

Supported by PEPFAR and USAID's Africa Bureau and in collaboration with UNICEF, as part of the response to the unmet needs of this emerging population, AIDSTAR-One is conducting a survey of HIV services for adolescents in five countries: Kenya, Malawi, Mozambique, Zambia, and Zimbabwe. The questions from this survey have been developed based on the information that arose from the development of a technical brief (and a recent meeting focused on the needs of ALHIV.

This survey should take 30-45 minutes of your time. We thank you in advance for your responses, as they will help inform USAID Africa Bureau and PEPFAR's work in the area of HIV services for adolescents. Should you have any questions, please feel free to contact Malia Duffy (mduffy@jsi.com) with the AIDSTAR-One Project, or Jenny Albertini at USAID (jalbertini@usaid.gov).

SECTION 1: BACKGROUND INFORMATION

1. Please enter the following information:
   - Name: _____
   - Title: _____
   - Agency/organization: _____
   - Country: _____
   - Please briefly describe your role in HIV programming for adolescents: _____

2. For the purposes of this survey, adolescents are defined as young people between the ages of 10 and 19. Is this how your agency/organization defines adolescents?
   - Yes
   - No
     - If no, please indicate the age range for "adolescents" that your agency/organization uses: _____

3. Please indicate the adolescents for whom you provide services (select all that apply):
   - Adolescent girls (HIV-negative or unknown status)
   - Adolescent boys (HIV-negative or unknown status)
   - Adolescents living with HIV
   - Adolescents who have been identified as OVC
   - Self-identified LGBTQ adolescents
   - Other adolescents with same sex behavior who don't identify as LGBTQ
   - Adolescents who have been trafficked or forced into sex work
   - Adolescents with disabilities
   - Adolescents who inject drugs
   - Adolescents who use other, non-injecting substances (e.g., alcohol, inhalants)
   - Married/cohabitating adolescents
   - Pregnant adolescent girls
   - Other category not mentioned above
     - Please describe: _____

4. Please indicate the number of years your agency/organization has provided HIV-related services to adolescents: _____

5. How do you engage adolescents in program planning, management, and evaluation?
   - Adolescents participate on an advisory committee to help set priorities
   - Adolescents provide feedback on services as a part of routine program evaluation
   - Adolescents directly provide services at our sites (e.g., through peer education, as HTC counselors)
   - Adolescents are currently not a part of our program planning, management, and evaluation processes
   - Other method not mentioned above:
     - Please describe: _____

SECTION 2: ADOLESCENT ACTIVITIES TO SUPPORT PROGRESS TOWARDS AN AIDS-FREE GENERATION

6. Is there a strategy for health system strengthening for your country?
   - Yes
     - If yes, is there a specific section addressing health needs of adolescents?
   - No

7. Is there a national HIV Strategy for your country?
   - Yes
     - If yes, is there a specific section pertaining to the needs of adolescents?
   - No
     - If no, are there guidelines/policies for other chronic diseases in your country?
   - If yes, what are they? _____

8. Is there currently a strategy (either stand alone or related to the national strategy) related to **HIV prevention for adolescents** in your country?
   - Yes (check only one)
     - If yes as a national strategy: When was it enacted? _____
     - If yes as a stand -alone strategy: Where is this enacted and is it successful? _____
   - No
   - If no: Is there a national strategy for another chronic disease (e.g., diabetes) that has a specific component for adolescents?

9. The following are ways my program is addressing **HIV prevention for adolescents** (all adolescents, not ALHIV): (select all that apply)
   - Individual HIV prevention counseling and education
   - Group HIV prevention education in schools
   - Group HIV prevention education in communities
   - VMMC for adolescent boys
   - PMTCT for pregnant adolescent girls
   - Male condom distribution specifically targeting adolescents
   - Female condom distribution specifically targeting adolescents
   - HIV Prevention Information Education and Communication (IEC) materials specifically for adolescents
   - Mass media campaigns targeting adolescents
   - Events in schools to increase HIV awareness
   - Events in communities to increase HIV awareness
   - Guidance or training for program staff to meet adolescents' HIV prevention needs
   - Referring to appropriate services (e.g., HTC)
   - Monitoring HIV prevention data on adolescents/disaggregating HIV prevention data to include the adolescent age range
   - Research on prevention needs or new models of service delivery
   - Gender based violence (GBV) prevention and treatment
   - Drop-in centers for adolescents who use substances
   - Alternate livelihoods programs for adolescent sex workers
   - Other activity not mentioned above
     - Please describe: _____
   - My program does not implement HIV prevention services for adolescents
     - Please list examples of programs that are implementing HIV prevention services for adolescents (if your program implements these services, what other programs do as well?): _____

10. Is there currently a strategy (either stand-alone or related to the national strategy) related to improving access to **HIV counseling and testing (HTC) for adolescents** in your country?
    - Yes (check only one)
      - If yes as a national strategy: When was it enacted? _____

- If yes as a stand -alone strategy: Where is this enacted and is it successful? _____

– No

11. The following are ways my program is addressing **HIV counseling and testing (HTC)** for adolescents: (select all that apply)
    – HTC in adolescent-specific clinics
    – Adolescent-specific testing days in general HTC clinics
    – Mobile HTC services
    – HTC providers trained and designated for adolescent clients
    – HTC providers who see all clients trained to provide "adolescent friendly services"
    – HTC materials specifically for adolescents
    – HTC in family planning (FP) clinics
    – HTC in sexually transmitted infection (STI) clinics
    – Monitoring HIV counseling and testing data on adolescents/disaggregating HIV counseling and testing data to include the adolescent age range
    – Research on HIV testing needs or new models of service delivery
    – Other activity not mentioned above
        - Please describe: _____
    – My program is not implementing HTC services for adolescents
        - Please list examples of programs that are implementing HTC services for adolescents (if your program implements these services, what other programs do as well?): _____

12. Is there currently a policy (either stand alone or related to the national policy) related to improving access to supportive **disclosure to/by adolescents** in your country?
    – Yes (check only one)
        - If yes as national strategy: When was it enacted? _____
        - If yes as a stand-alone strategy: Where is this enacted and is it successful? _____
    – No

13. The following are ways my program is addressing **disclosure to/by adolescents**: (select all that apply)
    – Individual peer-to-peer counseling
    – Individual counseling by adult providers

- Group counseling led by ALHIV peers
- Group counseling led by adult providers
- Guidance or training for program staff to increase disclosure to adolescents
- Guidance or training for parents/caregivers to increase disclosure to adolescents
- Guidance or training for adolescents to support them in disclosure to sexual partners and others
- Research on disclosure needs or new models of service delivery
- Other activity not mentioned above
  - Please describe: _____
- My program does not implement disclosure activities for ALHIV
- Please list examples of programs that are implementing disclosure services for ALHIV (if your program implements these services, what other programs do as well?):
  _____

14. Is there currently a strategy (either stand alone or related to the national strategy) related to improving access to **HIV care and treatment for ALHIV** in your country?
    - Yes (check only one)
      - If yes as national strategy: When was it enacted? _____
      - If yes as a stand -alone strategy: Where is this enacted and is it successful?
        _____
    - No

15. The following are ways my program is addressing **access to HIV care and treatment** for adolescents: (select all that apply)
    - ART clinics specifically for ALHIV
    - Adolescent-specific days in general ART clinics
    - Guidance or training for program staff to ensure ALHIV have access to care and treatment services
    - Guidance or training for program staff to address consent and confidentiality for ALHIV
    - ART providers trained and designated for adolescent clients
    - ART providers who see all clients trained to provide "adolescent friendly services"
    - Non-ART care providers trained and designated for adolescent clients
    - Non-ART care providers trained to provide "adolescent friendly services" who see all clients
    - Care and treatment materials specifically for adolescents

- Monitoring HIV care and treatment data on adolescents/disaggregating HIV care and treatment data to include the adolescent age range
- Research on care and treatment needs or new models of service delivery
- Other activity not mentioned above
  - Please describe: _____
- My program does not implement HIV care and treatment services for ALHIV
  - Please list examples of programs that are implementing HIV care and treatment services for ALHIV (if your program implements these services, what other programs do as well?): _____

16. Is there currently a strategy (either stand alone or related to the national strategy) related to improving access to **adherence and retention for ALHIV** in your country?
    - Yes (check only one)
      - If yes as national strategy: When was it enacted? _____
      - If yes as a stand-alone strategy: Where is this enacted and is it successful? _____
    - No

17. The following are ways my program is addressing adherence and retention for ALHIV: (select all that apply)
    - Individual peer-to-peer counseling
    - Individual counseling by adult providers
    - Group counseling led by ALHIV peers
    - Group counseling led by adult providers
    - Guidance or training for program staff to address adherence and retention for ALHIV
    - Guidance or training for parents/caregivers to address adherence and retention for ALHIV
    - Guidance or training for ALHIV to address their own adherence and retention
    - Monitoring ALHIV who do not yet need ART to retain them in care
    - Monitoring HIV adherence data on adolescents/monitoring adherence failure among adolescents
    - Research on adherence support needs or new models of service delivery
    - Other activity not mentioned above
      - Please describe: _____
    - My program does not implement adherence and retention services for ALHIV

- Please list examples of programs that are implementing adherence and retention services for ALHIV (if your program implements these services, what other programs do as well?): _____

18. Is there currently a strategy (either stand alone or related to the national strategy) related to improving access to **positive health dignity and prevention (PHDP) services for ALHIV** in your country?
    - Yes (check only one)
        - If yes as national strategy: When was it enacted? _____
        - If yes as a stand -alone strategy: Where is this enacted and is it successful? _____
    - No

19. The following are ways programs are addressing **PHDP services for ALHIV**: (select all that apply)
    - Individual peer-to-peer counseling
    - Individual counseling by adult providers
    - Group counseling led by ALHIV peers
    - Group counseling led by adult providers
    - PDHP Information Education and Communication (IEC) materials specifically for adolescents
    - Guidance or training for program staff to meet prevention needs for ALHIV
    - Materials or training for ALHIV to improve prevention (e.g., condom use, avoidance of risky behaviors, etc.)
    - Monitoring HIV prevention data on ALHIV/disaggregating HIV prevention data in PHDP programs to include the adolescent age range
    - Research on prevention needs or new models of service delivery
    - Other activity not mentioned above
        - Please describe: _____
    - Programs in my context are not meeting the PHDP needs of ALHIV
    - Please list examples of programs that are implementing PHDP services for ALHIV: _____

20. Is there currently a strategy (either stand alone or related to the national strategy) related to improving access to **primary healthcare for ALHIV** in your country?
    - Yes (check only one)

- If yes as national strategy: When was it enacted? _____
- If yes as a stand -alone strategy: Where is this enacted and is it successful? _____

– No

21. The following are ways programs are **providing primary healthcare services for ALHIV**: (select all that apply)
    – Immunization services
    – Family planning services
    – Nutrition services
    – Mental health services
    – Guidance or training for program staff to address the primary healthcare needs of ALHIV
    – Monitoring primary healthcare data on ALHIV/disaggregating primary healthcare data to include the adolescent age range
    – Research on primary health care needs or new models of service delivery
    – Other activity not mentioned above
        - Please describe: _____
    – My program does not implement primary healthcare for ALHIV
        - Please list examples of programs that are implementing primary healthcare services for ALHIV (if your program implements these services, what other programs do as well?): _____

22. The following are areas in which my program **works directly with communities** to address the needs of ALHIV
    – Community sensitization
    – Direct service delivery
        - Please describe: _____
    – Outreach in the community to reduce loss to follow-up
    – Economic strengthening/livelihood programming
    – Social protection for vulnerable adolescents
    – GBV prevention
    – Other activity not mentioned above
        - Please describe: _____
    – My program does not work directly with communities to address the needs of ALHIV

23. The following are ways programs are **linking to primary healthcare services for ALHIV** in my context: (select all that apply)
    - Referrals for immunization services
    - Referrals for family planning services
    - Referrals for nutrition services
    - Referrals for mental health services
    - Referrals for GBV prevention and treatment services
    - Monitoring HIV programs for effective referrals to primary healthcare for ALHIV
    - Other activity not mentioned above
        - Please describe: _____
    - My program does not refer ALHIV to primary healthcare services
        - Please list examples of programs that are providing effective referrals to primary healthcare services for ALHIV within the health system and why they are effective (if your program implements these services, what other programs do as well?): _____

24. The following are priority areas for HIV services for adolescents in my country context (select all that apply):
    - HIV testing and counseling for adolescents with unknown status
    - Male condom distribution
    - Female condom distribution
    - VMMC for male partners of female ALHIV
    - VMMC for adolescent males with partners of unknown status
    - PMTCT services for pregnant ALHIV
    - Sexual and reproductive health services
    - Programs to address gender considerations (including prevention of GBV)
    - ART for ALHIV
    - Psychosocial support groups (including peer support groups)
    - Mental health services
    - Alcohol and substance use prevention and treatment services
    - Harm reduction services for adolescents who use substances
    - Risk reduction counseling for adolescent MSM
    - Protection services (e.g., gender-based violence prevention)

- Nutrition services
- Other priority areas that do not fit into one of the above categories
  - If applicable, please describe briefly: _____
- None of the above are priority areas for adolescent HIV services in my context

25. How are HIV services specifically targeting adolescents in your context? (select all that apply):
    - Separate clinics or services specifically for adolescents
    - Special clinic days or hours specifically for adolescents within a pediatric clinic
    - Special clinic days or hours specifically for adolescents within an adult clinic
    - Specific providers for adolescents
    - All providers are trained to provide adolescent services
    - Other approaches that do not fit into one of the above categories
      - If applicable, please describe briefly: _____
    - There are no HIV services specifically for adolescents in my context

26. Where are HIV services specifically for adolescents offered? (select all that apply):
    - National/referral hospitals
    - Provincial/state hospitals
    - Lower level public facilities
    - Private facilities run by NGOs, FBOs, etc.
    - Community-based programs
    - Other types of facility do not fit into one of the above categories
      - If applicable, please describe briefly: _____
    - There are no HIV services specifically for adolescents in my context

27. Has a Violence Against Children Survey (VACS) been conducted in your country?
    - Yes
      - If yes, please briefly describe the impact it has had on programs for ALHIV: _____
    - No
    - Not sure

SECTION 3: ADOLESCENT ACTIVITIES IMPLEMENTED BY OR SUPPORTED BY THE U.S. GOVERNMENT

1. I am aware of HIV services for adolescents implemented by or supported by the following agencies of the United States Government (select all that apply):
   - United States Agency for International Development (USAID)
   - Centers for Disease Control and Prevention (CDC)
   - State Department
   - National Institutes of Health (NIH)
   - Department of Labor
   - Peace Corps
   - Other PEPFAR agency that does not fit into one of the above categories
     - If applicable, which one(s)? _____
   - There are no USG agencies supporting HIV care specifically for adolescents in my context (Skip to # 54)

2. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is supporting the following HIV services for adolescents in my context (select all that apply):
   - HIV testing and counseling for adolescents with unknown status
   - Male condom distribution
   - Female condom distribution
   - VMMC for male partners of female ALHIV
   - VMMC for adolescent males with partners of unknown status
   - PMTCT services for pregnant ALHIV
   - Sexual and reproductive health services
   - ART for ALHIV
   - Psychosocial support groups (including peer support groups)
   - Mental health services
   - Alcohol and substance use prevention and treatment services
   - Protection services (e.g., gender-based violence prevention)
   - Nutrition services
   - Other priority areas that do not fit into one of the above categories
     - If applicable, please describe briefly: _____

- I am not aware of PEPFAR support for adolescent HIV services in my context

SECTION 4: ADOLESCENT ACTIVITIES IMPLEMENTED BY OR SUPPORTED BY OTHER FUNDING AGENCIES

1. I am aware of HIV services for adolescents implemented by or supported by the following agencies (select all that apply):
   - UNICEF
   - UNAIDS
   - Global Fund
   - Private organizations (e.g., universities, Gates Foundation, Clinton Foundation)
   - Foreign government (e.g., DFID, EU)
   - Other agency that does not fit into one of the above categories
     - If applicable, which one(s)? _____
   - I am not aware of external funding agency support for HIV services specifically for adolescents in my context (Skip to # 57)

2. UNICEF is supporting the following HIV services for adolescents in my context (select all that apply):
   - HIV testing and counseling for adolescents with unknown status
   - Male condom distribution
   - Female condom distribution
   - VMMC for male partners of female ALHIV
   - VMMC for adolescent males with partners of unknown status
   - PMTCT services for pregnant ALHIV
   - Sexual and reproductive health services
   - ART for ALHIV
   - Psychosocial support groups (including peer support groups)
   - Mental health services
   - Alcohol and substance use prevention and treatment services
   - Protection services (e.g., gender-based violence prevention)
   - Nutrition services
   - Other priority areas that do not fit into one of the above categories
     - If applicable, please describe briefly: _____

- I am not aware of UNICEF support for adolescent HIV services in my context

3. Other funding agencies are supporting the following HIV services for adolescents in my context (select all that apply):
   - HIV testing and counseling for adolescents with unknown status
   - Male condom distribution
   - Female condom distribution
   - VMMC for male partners of female ALHIV
   - VMMC for adolescent males with partners of unknown status
   - PMTCT services for pregnant ALHIV
   - Sexual and reproductive health services
   - ART for ALHIV
   - Psychosocial support groups (including peer support groups)
   - Mental health services
   - Alcohol and substance use prevention and treatment services
   - Protection services (e.g., gender-based violence prevention)
   - Nutrition services
   - Other priority areas that do not fit into one of the above categories
     - If applicable, please describe briefly: _____
   - I am not aware of external funding agency support for adolescent HIV services in my context

SECTION 5: CROSS-CUTTING AREAS AND POTENTIAL FOR INTEGRATION

1. Are there any cross-cutting initiatives or areas where HIV has been integrated into another sector (or vice versa)? (Select all that apply.)
   - Family planning and SRH services
   - MNCH
   - Malaria
   - Mental Health
   - Alcohol and substance use prevention and treatment
   - Nutrition
   - STI prevention and treatment

- Protection services (including gender-based violence prevention)
- Other activities/sectors that do not fit into one of the above categories
  - If applicable, please describe briefly: _____
- There is no cross-sector collaboration around HIV services for adolescents in my context
- In what settings have integration strategies been most successful and why?
  _____

2. HIV services for adolescents in my context could benefit from collaborations between the following activities in the health sector (select all that apply):
   - Family planning and SRH services
   - MNCH
   - Malaria
   - Mental Health
   - Alcohol and substance use prevention and treatment
   - Nutrition
   - STI prevention and treatment
   - Other activities that do not fit into one of the above categories
     - If applicable, please describe briefly: _____
3. HIV services for adolescents in my context could benefit from collaborations between health programs and the following activities in other sectors (select all that apply):
   - Educational initiatives to keep adolescents in school
   - Vocational skills training
   - Microfinance loan programs or other economic support
   - GBV prevention
   - Other activities that do not fit into one of the above categories
     - If applicable, please describe briefly: _____

SECTION 6: FUTURE ACTIVITIES

1. The following **should be priority areas (but currently are not)** to support to improve and support HIV services for adolescents in my context (select all that apply):
   - HIV testing and counseling for adolescents with unknown status
   - Male condom distribution
   - Female condom distribution

- VMMC for male partners of female ALHIV
- VMMC for adolescent males with partners of unknown status
- PMTCT services for pregnant ALHIV
- Sexual and reproductive health services
- ART for ALHIV
- Psychosocial support groups (including peer support groups)
- Mental health services
- Alcohol and substance use prevention and treatment services
- Protection services (e.g., gender-based violence prevention)
- Nutrition services
- Other priority areas that do not fit into one of the above categories
  - If applicable, please describe briefly: _____

2. Please provide additional thoughts to strengthen provision of services for ALHIV through facilities, communities, and families and examples of programs that are implementing such services:

   _____

   _____

Thank You

Thank you very much for participating in this survey! If you have any questions, please feel free to contact Malia Duffy (mduffy@jsi.com) or Jenny Albertini with USAID (jalbertini@usaid.gov).

For more information, please visit aidstar-one.com.

AIDSTAR-One
John Snow, Inc.
1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: info@aidstar-one.com
Internet: aidstar-one.com