4 The All In assessments

Leveraging data to achieve results for adolescents in Eastern and Southern Africa

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Introduction

As Eastern and Southern Africa (ESA) hosts 62% of the world's adolescents living with HIV, and with adolescent girls and young women continuing to be disproportionately affected by HIV, adolescents and young people contribute significantly to shaping the future course of the HIV epidemic in ESA (UNICEF, 2017a). In 2015, girls accounted for three out of four new infections among adolescents aged 15–19 in ESA (UNICEF, 2017a). There is, therefore, an urgent need to address the health and well-being of adolescents affected by and living with HIV. Yet until recently, little was known about the impact of HIV on their lives.

It is against this backdrop that we have seen a growing call for global advocacy and policy attention to adolescents and young people, which culminated in the launch of the All In to End Adolescent AIDS (All In) initiative in February 2015 (Joint United Nations Programme on HIV/AIDS, 2015a; UNICEF, 2015). All In sought to address the critical gaps in data on HIV response for adolescents, defined by the UN as the population 10–19 years of age. Through a structured systematic approach, the All In country assessments gathered national data to support the development of more effective strategies, policies, programmes and services for adolescents living with and affected by HIV (Joint United Nations Programme on HIV/AIDS and United Nations Children's Fund, 2015; United Nations Children's Fund, 2015).

Since early 2013, governments and the international community have become aware that adolescents and young people were being left behind in the HIV response and that urgent action was required. However, due to the lack of disaggregated data by age and/or sex in many countries, we have an incomplete picture of the HIV, health and social support needs of adolescents. Decision-makers do not know the extent of HIV infection and associated drivers and inequalities, making it difficult to design and implement population-specific interventions that are responsive to the particular needs of adolescents living with, at risk of and affected by HIV (UNICEF, 2016a).

Three years after All In's launch, countries in ESA have experienced far-reaching progress across multiple areas of adolescent HIV programming,

laying the groundwork for improved adolescent HIV outcomes. This chapter outlines the progress made in the All In initiative and the critical insights of its impact on HIV programming for adolescents across the ESA region. These findings have been collated through a desk review of All In country assessment reports, observations during site visits and interviews with 43 individuals including government officials, national and sub-national implementing partners, UN representatives and funding partners.

HIV evidence and programme gaps for adolescents and young people

Adolescence is a period of rapid physical, neurodevelopmental and psychosocial changes, with cognitive development and social transitions continuing into the early twenties (WHO, 2014a). These changes affect adolescents' health, decision-making, vulnerability, risk behaviour and access to services. Accordingly, age is a highly important factor in the case of adolescents because it marks differences with regard to their relative risk of HIV infection, rates of infection, and opportunities for access to counselling, diagnosis, care and treatment (WHO, 2014a). Therefore, understanding age-specific needs in adolescents is critical for generating relevant evidence to inform national health and HIV programming.

A challenge is that there are different and sometimes overlapping age bands used in collecting data on adolescents, thus masking the age-specific differences within this age group (Idele et al., 2014). Global and national data systems have historically grouped adolescents into broad age brackets, either with those age 14 and younger or with those age 15 and older (Slo-grove et al., 2017) or as part of young people (15–24 years). The lack of disaggregated data by age or sex, in particular at the sub-national level, means that sub-populations of adolescents and young people have been invisible in data-driven and evidence-informed programming efforts (UNICEF, 2016a).

Indicators across the HIV prevention and treatment cascade are missing, especially for measuring access, the use of community-based interventions and linkage between services (Idele et al., 2014). Further, important indicators are not harmonized for these adolescents. For example, national indicators related to violence utilize age bands of 13–17, whereas HIV data reporting utilizes age bands of 10–14 and 15–19. Additionally, the level of vulnerability and risk are not well understood, as definitions vary and measurements are not well established (Govender et al., 2018). Without these data, there is an incomplete picture of the health and social support needs of adolescents and young people. In turn, national responses are unable to monitor the progress of the HIV epidemic or HIV-related outcomes and, therefore, without adequate information to assess the resource needs, often the resources allocated to address HIV in adolescents and young people are inadequate.

The challenge in generating data, especially among younger adolescents, is often due to real and perceived complexities of conducting research on adolescents (Idele et al., 2014). For example, institutional ethics review board requirements deter researchers and sometimes programmes from including individuals younger than 18 years of age. This deterrent is often exacerbated in the cases of those who are particularly vulnerable (i.e. key populations) or whose behaviour is stigmatized and criminalized (Joint United Nations Programme on HIV/AIDS, 2015a). For adolescents, health data from administrative and programme sources is often limited to adolescent girls who attend family planning or antenatal care, as most adolescents are healthy and infrequently use health services (Idele et al., 2014). Additionally, in many countries, data collection systems remain weak and thus require considerable investment (Idele et al., 2014).

Road to All In – enabling change for and with adolescents

A number of factors led to the demand for an initiative that would recognize adolescents as a distinct population group, address the lack of disaggregated metrics and estimates and support effective interventions for them. Previous understanding of HIV among adolescents and young people has relied heavily on estimates and research studies often extrapolated from child or adult populations (Idele et al., 2014). UNICEF's secondary analysis of 2012 UNAIDS estimates indicated that adolescent girls and young women were disproportionately affected by new HIV infections, there was an increase in adolescents HIV-related deaths, and that sub-Saharan Africa carried the most significant HIV burden in this age group (UNICEF, 2013). Similarly, the World Health Organization's (WHO) 2013 Global Health Estimates for adolescents identified HIV as the leading cause of death for adolescents in Africa (WHO 2006, 2014a). At the same time, both qualitative and quantitative research began to highlight significant challenges for these populations compared to other age groups. Studies indicated low uptake of prevention interventions, challenges to access, low coverage (Ferand et al., 2009) and poor quality of services (WHO and KIT, 2012; Li et al., 2010), in addition to higher rates of loss to follow-up (Lamb et al., 2014; Grimsrud et al., 2014), adherence challenges (Nachega et al., 2009), poor virological outcomes and an increased need for psychosocial support for those living with HIV (Lowenthal et al., 2014; Hodgson et al., 2012; Melins and Malee, 2013).

As the magnitude of these challenges was being understood, it became more apparent that contextual evidence was needed on how HIV programmes targeted these age groups. Further, many programmes and interventions that were being implemented were not evaluated. It was clear that evidence of effective interventions was lacking for adolescents and young people. For example, a systematic review of the evidence to prevent HIV/AIDS in young people in 2010 found only four interventions showing

sufficient evidence to enable implementation to scale (Napierala Mavedzenge, Doyle and Ross, 2011). Of the available evidence, this was often found too weak and of poor quality, as outcomes measured did not include biological markers, studies did not review multiple interventions and the data analysis lacked rigour (Napierala Mavedzenge, Doyle and Ross, 2011; MacPherson et al., 2015).

Given the increased understanding of the needs of adolescents and the gaps in quality data, governments and partners in countries began to request technical support in programming for adolescents and young people living with HIV, including those from key populations. This led to an increased policy focus and advocacy efforts at the global level. UNICEF conducted a comprehensive global review of HIV infections among adolescents and young people in 2011 and in 2012 (UNICEF, 2011, 2013), together with WHO, that paved the way for the development of the first adolescent-specific global recommendations on HIV testing (WHO, 2013). WHO's (2014b) guidelines for key populations included specific consideration for young key populations and, in parallel, the Inter-agency Technical Working Group developed a series of technical briefs (Joint United Nations Programme on HIV/AIDS, 2015a). Increased attention to broader adolescent health issues was observed, with the publication of the first WHO Health for the World's Adolescents report in 2014 (WHO, 2014a). On the basis of this work, UNICEF further advocated for age disaggregation of all core HIV indicators to include children and adolescents in the WHO (2015a) Consolidated Strategic Information Guidelines for HIV in the Health Sector. In all these efforts there was a clear call for better evidence, including the disaggregation of programmatic data and targeted interventional research.

To accelerate national-level change, it was acknowledged that a focused agenda and movement was needed, with a key focus on improved data availability and quality, leading to the conceptualizing of the All In initiative in 2014 and an official launch in 2015.

All In: a global platform for country-level change

Launched in February 2015 in Kenya, All In is a collaborative initiative aimed at accelerating gains towards ending the AIDS epidemic by 2030, by ensuring that no adolescents are 'left behind' in the HIV response. All In builds on the global goals set at the June 2016 United Nations General Assembly Special Meeting on HIV/AIDS by uniting governments, youth organizations, civil society groups and researchers around three measurable targets by 2020: (1) reduce new HIV infections among adolescents by at least 75%; (2) reduce AIDS-related deaths among adolescents by at least 65%; and (3) end stigma and discrimination (Joint United Nations Programme on HIV/AIDS and United Nations Children's Fund, 2015; UNICEF, 2015). Co-convened by UNICEF and UNAIDS, the platform focused on four action areas in 25 priority countries (see Box 4.1).

Box 4.1 All In action areas

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

Priority countries for All In were identified on the basis of the level of HIV incidence in adolescents and high HIV prevalence among adults; thereafter, they were selected on the basis of ensuring global geographic representation and in which tangible results could be achieved and demonstrated over a five-year period. Of the initial 25 priority countries, 14 were in ESA, reflecting the large adolescent populations and significant HIV burden in this region (Joint United Nations Programme on HIV/AIDS and United Nations Children's Fund, 2015; UNICEF, 2015). The 14 countries are Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Eswatini, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

All In country assessments: from national to sub-national level

Central to All In is the promotion and use of evidence to support the development of effective strategies, policies, programmes and services for adolescents living with and affected by HIV. Country assessments were designed to address the critical gap of adolescent-specific HIV-related data to strengthen planning and implementation for improved outcomes for adolescents (UNICEF, 2016b). The assessments were guided by a systematic process to identify equity and performance gaps impacting on adolescent HIV programming. These gaps served to inform priority actions to improve the effectiveness of national adolescent HIV responses.

Assessments were primarily centred around HIV outcomes but included a broad and multi-sectoral range of data and analyses to assist with contextualizing the HIV-related gaps for adolescents within the broader perspective of their holistic health, protection, education and general well-being.

Figure 4.1 All In three-phase country assessment process

The country assessments adopted a three-phase approach (Figure 4.1) building on the broader UNICEF approach to equity-based programming (MoRES) (UNICEF, 2014). Phase I was a rapid assessment of the adolescent programming context. It examined data at the national and sub-national levels to define which adolescent populations were most affected, where they were located, what interventions have been implemented and where are the most significant gaps in terms of quality and extent of coverage to accelerate HIV results. It also included an assessment of the national programme enabling environment focusing on policy and legislation; planning, budgeting and coordination; and adolescent participation and monitoring systems. Phase II was an in-depth analysis of bottlenecks affecting coverage of priority HIV interventions in priority geographic locations identified in Phase I. This analysis enabled an understanding of cause-and-effect mechanisms in programming, with the recommended corrective actions. Phase III utilized the evidence generated to inform planning to implement and accelerate corrective actions to address bottlenecks and data gaps and improve intervention coverage, quality and impact (UNICEF, 2016b).

A key feature of these assessments was to encourage countries to recognize potential limitations of existing adolescent-specific data on health. This analysis was supported by a review of data from other sectors such as education, reproductive health and social protection in terms of appropriateness and quality. New sources of data were also identified and concerted efforts were made to seek it out. Personnel in monitoring and evaluation programmes were also mobilized to support data analysis and data advocacy efforts. The assessments allowed for the utilization of data to inform programming, including an in-depth analysis of service delivery level challenges, with necessary recommended actions through the development of work plans.

Standardized tools and guidance, including the Adolescent Assessment and Decision-Makers' (AADM) Tool, supported the country assessment

process (UNICEF, 2016a, 2016b), as existing tools did not provide a sufficient level of detail for HIV-specific analysis or programme planning for adolescents. This built on an earlier eMTCT Bottleneck Analysis Tool (UNICEF, 2016b) that was developed to facilitate decentralized planning towards the elimination of mother-to-child transmission. The concepts used in the eMTCT tool (i.e. using data from routine, estimate and household survey sources) were then applied to adolescent programming.

The AADM afforded countries the necessary platform and analytics to validate data, inform the review and analysis of adolescent programming gaps and facilitate the decision-making process in response. The tool collated data across multiple sectors and data sources (administrative and programme data, census data, global/national estimates, household survey data, etc.). In so doing, this process enabled professionals from different sectors and affiliations to look at data across the entire adolescent continuum for the first time. Its interactive dashboard enabled the visualization of data, optimizing data usage and the capacity to monitor the progress of key indicators. This was particularly helpful to visualize and understand the trends and HIV prevalence among the adolescent population groups (10–14 years and 15–19 years) by sex. After piloting the AADM tool, the dashboard was updated to include 20–24-year-olds in response to countries' requests to focus on adolescents transitioning into adulthood. The country dashboards typically showed patterns of very low HIV prevalence among 10–14-year-olds and then a trend of increasing new infections among older adolescents alongside disproportionate levels of HIV prevalence among adolescent girls and young women. These trends in the data allowed for discussions on the type of strategies required for specific age bands of adolescents and young people.

Although the country assessments were defined by a structured systematic approach, individual countries adapted the process and tools to reflect the local nature of HIV epidemics as well as their programmatic and geographic priorities. For example, to reflect its devolved health system structure, Kenya's entire All In assessment had a sub-national approach. In Rwanda, after the Phase I assessment, a national operational plan was immediately prioritized. Some countries did not carry out the whole process and used the AADM for programmatic assessments and analysis on adolescents (e.g. Malawi, Lesotho and Zambia). Stakeholders in these countries noted that the flexible nature of the approach supported their ownership over their assessments.

Engagement and collaboration with key stakeholders

The country assessments brought together key stakeholders within HIV and health; across sectors such as social welfare, ministries of education, youth and development, and justice; and other relevant departments in the ministries of health to coordinate activities for adolescents (UNICEF, 2016c). A number of challenges were noted in these processes. For example,

countries found the enrolment process took time to get all the stakeholders on board, stakeholders faced competing priorities, addressing adolescents was new for many and there weren't dedicated experts to lead on it, and countries had limited experience in engaging adolescents. Political will and commitment were critical in the uptake and implementation of All In, with prominent leaders involved in launching and promoting the initiative across the ESA region (UNICEF, 2016c). The government's role in convening stakeholders was instrumental and strengthened their mandate as the lead for adolescent health. They took the lead in coordinating and analysis the data with support from UNICEF, UNAIDS and engagement from UN agencies (including UNESCO, UNFPA, ILO, WHO and UN Women) and key HIV partners in country (UNICEF, 2016c). UNICEF ensured regional colleagues were regularly updated on progress being made in countries in the region, which contributed to the regional visibility and mobilization. Particularly for countries undertaking All In activities in priority districts, the assessment processes facilitated efficient work between national and sub-national departments through having dedicated time to meet and focus on adolescent programming (see Box 4.2 for lessons learnt).

Box 4.2 Lessons learnt: leadership and collaboration

- Political will and leadership from the designated ministry or national authority is critical in driving the assessment process.
- Conducting data assessments at the sub-national level increases ownership and accelerates the assessment process.
- Bringing together a wide range of stakeholders, from different departments and ministries, improves understanding and working relationships.
- Engaging stakeholders from the very beginning of the assessment process is essential to facilitate ownership and commitment.
- Collaborative working between national and sub-national stakeholders ensures sufficient technical support to build capacity and enables the effective review of relevant policies and their implementation.
- Building upon existing technical working groups strengthens leadership and collaboration.
- Engaging M&E as well as programme staff improves future data collection for adolescents.
- Aligning advocacy efforts between multiple stakeholders increases its impact and the probability of a successful response.
- Technical support from joint UN organizations increases political commitment and supports advocacy effort throughout the process.

Through multi-sectoral technical working groups (TWGs), coordinating mechanisms for adolescents were established or strengthened, often for the first time (UNICEF, 2016c; UNICEF, 2018a). The TWGs included a range of government, civil society and implementing partners. They provided a platform for partnership, strengthening knowledge and data sharing, joint planning and the implementation of work plans. Four countries (Botswana, Kenya, Namibia and Mozambique) have also established TWGs at the sub-national level. For the majority of countries where TWGs were established as part of All In, these have evolved into formalized structures to support ongoing adolescent programming and to accelerate and drive new initiatives (UNICEF, 2018a).

The multi-sectorial approach provided an opportunity to look beyond HIV-specific data and programmes and to review the broader health, policy and development context for adolescents. This approach contributed to addressing cross-cutting HIV structural drivers. For example, Ethiopia observed the inclusion of adolescent HIV in social protection programming, and in Mozambique, the process led to an evaluation of social norms that create barriers for adolescents living with HIV (ALHIV) to access services. In both Kenya and Ethiopia, other health departments and non-health sectors are starting to focus on adolescent programming (UNICEF, 2018a).

The country-level assessments were meant to complement existing HIV efforts such as the UNAIDS Fast-Track initiative (Joint United Nations Programme on HIV/AIDS, 2015b), PEPFAR's Accelerating Children's HIV/AIDS Treatment (ACT) Initiative (PEPFAR, 2014) and the Eastern and Southern Africa (ESA) Ministerial Commitment on sexuality education and sexual and reproductive health services for adolescents and young people (UNESCO, 2013); as well as new global and regional initiatives on adolescent health and HIV, including the Global Strategy for Women's, Children's and Adolescents' Health (UN, 2015), the PEPFAR DREAMS Initiative (PEPFAR, 2015), the Start Free, Stay Free, AIDS Free Fast Track Framework (PEPFAR et al., 2016) and the Global Accelerated Action for the Health of Adolescents (WHO, 2017). Working and aligning with these initiatives, All In has informed, supported and leveraged resources to expand country progress in addressing the HIV epidemic in adolescents and ensuring that they are at the forefront of the HIV response.

A key focus of All In is the engagement and mobilization of adolescents as leaders and agents of social change (UNICEF, 2016c). The country assessment process strengthened existing mechanisms to engage adolescents in programme design. To facilitate further engagement, the majority of All In ESA countries held consultations, focus groups or adolescent and youth stakeholder meetings and included adolescent representatives in the TWGs (UNICEF, 2016c; UNICEF, 2018a). Mobile technology (U-Report) was also utilized to understand views on sexual and reproductive health (SRH) and HIV interventions. In Botswana and Mozambique (see Box 4.3), the

consultations generated countrywide engagement, including from rural areas and groups working with key populations and those with disabilities (UNICEF, 2017b). The consultation held in Rwanda was the first time that adolescents engaged in policy and programming efforts at the national level. At Tanzania's youth stakeholder meetings, adolescents produced a declaration that outlined the key actions and programming requirements that they hoped to see.

Box 4.3 Catalyzing adolescent participation in Mozambique

All In brought together 28 adolescents from 11 provinces across the country to Maputo for an intense debate on improving the HIV response. Mozambique's National AIDS Committee worked to make sure that the young people were in charge of the process: they fostered a safe space for adolescent participation, including the establishment of a youth Steering Committee; selected young facilitators; and relied on local organizations to choose participants.

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

—Youth advocate and meeting facilitator, Mozambique

Source: UNICEF (2017b).

Ethiopia and Namibia leveraged existing youth networks, including those for ALHIV, and facilitated the involvement of younger adolescents, who are often overlooked. The All In process in Kenya continues to strengthen the response of the network of young people living with HIV (YPLHIV), with its members leading programming efforts at the sub-national level including HIV testing demand generation (UNICEF, 2018a).

The momentum generated by All In has contributed to and helped sustain adolescent participation in both policy and programming spaces, not only for HIV and SRH but across other health and development areas. Key lessons learnt throughout the process can now inform longer-term engagement with adolescents in the future.

All In country progress in ESA since implementation

The All In strategy has impacted multiple areas of HIV programming for adolescents. Across the ESA region, the strategy has made adolescents more

visible, calling attention to their HIV health and well-being. The implementation process was seen by some governments' officials as a breakthrough that helped galvanize attention and focus on adolescents (UNICEF, 2018a). The country assessments also generated and collated data revealing changing dynamics of adolescent epidemiology along the HIV cascade (UNICEF, 2017b, 2018a). This strategic information is now forming the basis of national HIV responses and serving as a critical advocacy tool through the development of adolescent-focused work plans and strategies. As a result, adolescent HIV issues, including the call and need for tailored approaches in accordance with specific age groups (10–14, 15–19 and 20–24 years), are now on the radar of policy-makers and decision-makers, and shifts in programming are being seen (UNICEF, 2016c). The strategic information gathered by the All In country assessments has enabled changes to data collection for adolescents, policy and plans, more targeted adolescent HIV programming and mobilized resources. The following sections describe the progress made in these four pillars of programming.

Strengthening of strategic information

The All In country assessments collated available adolescent data and generated new adolescent data for the first time. This included critical strategic information at the sub-national level that was used immediately to inform adolescent programme planning (UNICEF 2017c, 2018a).

In Kenya and Tanzania, changes were made to key data collection tools to ensure national age disaggregation of data (see Box 4.4). The revision of tools for the national Health Management Information System (HMIS) in Kenya, the Tanzania Health Indicator Survey and the Kenya Population-Based HIV Impact Assessment will ensure the routine availability of adolescent specific data to support targeted programming for this population (UNICEF 2017c, 2018a). In addition, this available adolescent data is being used to strengthen country HIV estimates through Spectrum Estimation and Projection Package modelling. The All In assessments in Botswana also strengthened the strategic information components in the new national programming framework for adolescents and young adults (UNICEF, 2018a).

Box 4.4 Case study: strengthening adolescent strategic information in Kenya – revising tools and systems for disaggregation

In Kenya, the Ministry of Health worked together with other partners to overcome data availability limitations and challenges.

Actions taken:

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

Additional actions to address data gaps:

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

This process and the results pointed to the critical need to strengthen and use strategic information for adolescents. As a result, the national HMIS data collection tools for HIV were revised to allow for age disaggregation.

Source: UNICEF (2017c).

The process was also able to accelerate advocacy efforts in Lesotho, Namibia and Zimbabwe on collecting and reporting age-disaggregated data, with a push to increase funding and capacity to strengthen data collection (UNICEF, 2018a). In Rwanda, where data collection previously allowed for age disaggregation, the data was not analyzed or reported accordingly. Country-level assessments also highlighted the need for continuous reporting of adolescent data (UNICEF, 2018a). See Box 4.5 for lessons learnt on strategic information.

Box 4.5 Lessons learnt: strategic information

- Utilizing a variety of data systems and sources, including primary data collection, provides clarity of programme coverage, needs and data gaps.
- Data gaps can be addressed by actively seeking data from alternative sources to generate new comprehensive data sets.

- The AADM tool can be successfully adapted to the availability of data and the country's context.
- Developing country-specific guidance on how to carry out the sub-national analysis (i.e. what data is available, where it comes from and potential system challenges) supports the analysis to be carried out in other districts.
- There are limitations to the data, in particular the use of denominator estimates. However, future use of the newly revised data collection tools allowing age disaggregation will reduce these limitations.
- Aligning timelines with other data or programming processes provides opportunities to share and advocate for robust data collection on adolescents.

Informing national policy and plans

All In supported the identification of adolescent sub-populations, interventions and geographic areas of focus, facilitating the inclusion of adolescents in relevant policy changes and planning. In Botswana, the process informed the development of a National Programming Framework for Adolescents and Young Adults, which in turn will direct the National HIV Strategic Framework for the next five years (UNICEF, 2018a). Likewise, in Namibia, adolescents now feature prominently in the National Strategic Framework 2017–2019, and its policy on ALHIV is being updated to account for the new data and programme changes generated (UNICEF, 2018a).

The data produced by the country assessments were instrumental in informing national plans in Zimbabwe (Accelerated Action Plan for the national scale-up of antiretroviral treatment [ART] for infants, children and adolescents), Rwanda (National Operational Plan for HIV and Sexual and Reproductive Health among Adolescents and Young Adults) and Ethiopia (Adolescent Sexual and Reproductive Health Plan) (UNICEF, 2017d, 2018a).

In Kenya, Mozambique, Namibia and Botswana, there are targeted adolescent activities planned at the sub-national level, showing that change from the national to local level can be supported (UNICEF, 2018a).

Evidence-informed programming

Given the challenges in generating evidence to inform HIV programming, the country-level assessments enabled more targeted programming for adolescents as a distinct population group with specific needs, the expansion and scale-up of existing adolescent programmes and interventions, improved collaboration for integrated adolescent interventions, better

understanding of adolescent programming and importance of age and sub-national data, increased capacity of sub-national implementers and the introduction of new adolescent personnel.

Programmatic changes have been observed across the HIV cascade in Kenya. Priority counties have increased outreach programmes to provide adolescents and young people with HIV and SRH information, expanded HIV testing beyond voluntary counselling and testing (VCT) centres by training of hospital and clinic staff, and increased the provision of psychosocial support in facilities for ALHIV (UNICEF, 2018a). Youth-friendly services have also been revitalized, with key age-specific changes being made to services for ALHIV, such as adolescent-only times or queues. Since the All In country assessment, Namibia has also expanded psychosocial support for ALHIV through support groups and is moving towards national scale-up (UNICEF, 2018a, 2018b). Tanzania has developed an integrated, multi-layered intervention called Cash Plus, which provides a comprehensive package including training, mentorship and services for all adolescents aged 14–19 alongside a cash transfer programme (UNICEF, 2018c). Box 4.6 outlines key programming lessons learnt.

Box 4.6 Lessons learnt: programming

- Scheduling Phase II of the assessment prior to district planning maximizes the impact on programming.
- Allocating sufficient time at the sub-national level to undertake the analysis facilitates joint working and capacity building.
- Adolescent programming capacity at the national level is required to sufficiently support the sub-national analysis as well as ongoing adolescent programming.
- Having a clearly established three-phase country assessment, including supportive guidance tools, offers credibility to the initiative and provides greater confidence for stakeholders invested in the outcomes of the process.
- Sharing assessment results is a critical advocacy tool for improving programmes and strategic information for adolescents.
- Availability of adolescent-specific data offers a powerful advocacy tool to leverage resources.

The capacity of service providers and others working on adolescent health has also improved in terms of their understanding of targeted interventions and the importance of age and sub-national data to inform adolescent programming (UNICEF, 2018a). In Botswana, the Phase II bottleneck analysis in priority districts played a significant role in strengthening the capacity of

sub-national level implementers (see Box 4.7) (UNICEF, 2018d). Namibia further supported their bottleneck analysis by providing additional training for both national and district teams on adolescent HIV during Phase II. Lesotho used the assessment outcomes to inform the development of adolescent-specific health and sexuality education training curriculums (UNICEF, 2018a).

A number of countries appointed additional adolescent personnel, including Kenya, Namibia and Mozambique. In Mozambique, funds were provided for technical assistance on adolescent programming to the National AIDS Council; in Namibia, an additional three positions at the national Ministry of Health were created on HIV prevention and treatment (UNICEF, 2018a, 2018b).

Box 4.7 Case study: building adolescent programming capacity at the local level in Botswana

In Botswana, the National AIDS Coordinating Agency (NACA) led the All In assessment, with technical support from UNICEF. Phase II was carried out in participation with sub-national stakeholders: the District AIDS Coordinators, District Health Management Team and representatives from the Ministry of Youth and the Ministry of Education.

Four districts were prioritized based on HIV prevalence, presence of key HIV drivers, geographic and demographic settings and performance of priority interventions. The in-depth analysis of the bottlenecks provided valuable evidence and understanding to inform future sub-national adolescent HIV programming.

Through this process, capacity was built around:

- Awareness of adolescents as a distinct population group requiring targeted programming and intervention
- The importance of age and sub-national data to inform adolescent programming
- Identifying available data and gaps
- The importance of utilizing other sector data
- Understanding of adolescent service delivery gaps and understanding of the implementation bottlenecks
- Sub-national adolescent programme planning.

Source: UNICEF (2018d).

Mobilizing resources

Since the launch of All In in 2015, international and domestic resource investment in adolescent HIV programming has increased in the countries that conducted the assessment. The All In process has assisted programmes to be more targeted and evidence informed while building in routine processes to make it easier for countries to request and allocate funds for these programmes (UNICEF, 2018a). Resources have also been leveraged to implement work plans generated as part of the All In process and for the expansion and scale-up of key adolescent interventions.

Across the region, funds from partners and donors, including UNICEF and UNAIDS, have supported key milestones of the All In country assessments. For Lesotho, partners, including Global Fund and PEPFAR, provided funds to further strengthen strategic information for adolescents (UNICEF, 2018a). In Kenya and Namibia, the integration of adolescent activities into larger international development partner operational plans and initiatives were particularly successful (see Box 4.8) (UNICEF, 2018a, 2018b). In Tanzania and Ethiopia, the All In assessment outcomes were instrumental in mobilizing additional funds for multi-sectoral programme proposals (UNICEF, 2018a). In Mozambique, Namibia and Kenya, funds have been allocated to appoint dedicated adolescent HIV personnel, increasing adolescent technical capacity at the national and sub-national levels (UNICEF, 2018a).

Additionally, All In assessments contributed to leveraging resources from country funding processes for the Global Fund to Fight AIDS, TB, and Malaria (GFATM). More specifically, the country assessment outcomes provided data and the direction to inform the adolescent components of concept notes and proposals for initiatives such as for adolescent girls and young women (AGYW) (UNICEF, 2018a). In Mozambique, assessments expanded understanding of in-school and out-of-school health services for AGYW, thus informing applications to the Global Fund for funding to improve and response to service gaps (UNICEF, 2018a). With the generation of routine adolescent strategic information and changes to key policies and plans, further domestic and international funds for adolescent HIV activities are anticipated, including resources for programme implementation (UNICEF, 2018a).

Box 4.8 Case study: leveraging funds for adolescent HIV programming in Namibia

The All In assessment findings helped Namibia leverage international and domestic resources to advance adolescent HIV programme planning and implementation.

Resources supported:

- Phase II of the assessment to be carried out
- The strengthening of national adolescent HIV technical capacity through three new positions at the national ministry
- Implementation of national and sub-national workplans, including:
 - Integration into larger international development partner operational plans;
 - Expansion and planned national scale up of support groups for adolescents living with HIV;
 - Programming for adolescent girls and young woman and for older adolescents from key populations.

Moving forward: challenges and opportunities

All In has made notable progress for adolescents and young people in ESA, catalyzing the HIV response to not only pay attention to their needs but also take targeted action. Despite this momentum, these populations continue to face barriers to receiving necessary HIV prevention, treatment and care. Most recent data indicate increasing numbers of new HIV infections as well as regional and gender disparities, highlighting the pressing need for continued and sustained efforts in this area (UNICEF, 2017a). For the adolescent HIV and health response, many programmatic challenges across strategic information, policy, planning, implementation and coordination remain.

The implementation of the All In country assessment within the ESA region has been varied. Priority countries, without routine disaggregated data, may need to repeat the initial assessment, which was completed two years ago, while other countries are only now gaining momentum and interest in conducting elements of the assessment. Non-priority countries have yet to conduct the assessments. Ideally these assessments need to be adapted and embedded in systematic monitoring and evaluation efforts that inform ongoing HIV programming for adolescents and young people across the region. The lessons from All In need to be promoted across ESA, where there is an opportunity to improve HIV programming and broader adolescent health. These assessments need to improve on processes and platforms for documenting case studies and results, in addition to facilitating intra- and inter-country peer-to-peer learning. Strengthening technical support will also be critical to building programming capacity and implementing adolescent programmes at national and sub-national levels.

All In has demonstrated the power of disaggregated data, especially at the sub-national level, showing that its routine collection and integration

within existing data systems is achievable. However, for many ESA countries at the centre of the HIV epidemic, this granular level of data is still not systematically available. Ongoing advocacy for routine age- and sex-disaggregated data remains of critical importance as an essential requirement for adolescent programming (UNICEF, 2016a, 2016b). The promotion of the AADM tool and the supportive guidance generated (UNICEF, 2016a, 2016b) by All In, together with technical support, are urgently required to strengthen strategic information for this age group. Furthermore, to guarantee meaningful analysis, additional collaborative efforts are needed with national statistics departments to ensure appropriate sample sizes are reached while surveying the adolescent population. Although All In has used programmatic data to inform adolescent HIV programming, further support to data systems specific to adolescents is needed.

Although data across the HIV cascade are becoming more available, gaps remain, with less known about other important adolescent issues that extend beyond HIV, including sexual violence, mental health and substance abuse. These issues are increasingly prevalent and data is important for developing coherent, comprehensive programmes that target this transitional period of adolescence in a more deliberate way (Vreeman, McCoy and Lee, 2017; Lundgren and Amin, 2015). However, limited systematic data collection and analysis is in place, highlighting the need for health and other sector data systems to be adapted and harmonized. This could be achieved through the development of a central data repository for adolescents that is regularly updated, maintained, analyzed and easily accessed by those by the appropriate programme managers. Additionally, new indicators need to be established, including those for adolescents' participation and empowerment, to ensure their evolving contributions and engagement are monitored. For younger adolescents (10–14 years) and adolescent key populations, data are scarce and often anecdotal. Using community-based participatory approaches or implementing community or youth advisory boards that engage adolescents as partners can support relevant, ethically and appropriate research, especially for adolescents from key populations (Auerswald, Akemi Piatt and Mirzazadeh, 2017).

As a result of All In, targeted interventions for adolescents have now been planned and implemented. It is now vital to understand which of these interventions work and why. Ongoing mechanisms for monitoring the effectiveness of programming, including implementation science, should be developed to understand aspects of feasibility and sustainability – ultimately informing on how to take adolescent-targeted interventions to scale (Indig et al., 2017). Ensuring the quality of these interventions at scale demands clear policies and plans as well as tools to facilitate implementation, such as standard operating procedures (WHO, 2015b). Most importantly, targets and benchmarks need to be set to assess progress, facilitating the monitoring of equity in access and use of services by age, sex, geography and other

socio-demographics, and programme performance for adolescents across multiple sectors.

Through All In, adolescents have become a prominent group in national policies and plans. Nonetheless, it is important that this population is not only included but that the content takes into account their distinct developmental differences, targeting its response accordingly. Such policy development is dependent on sufficient evidence from programmes and research. Academics have a key role in conducting research that is responsive to national contexts and priorities (WHO and IAS, 2017). Advocacy at the country and regional levels is essential for policies to overcome the ethical and legal challenges and age of consent barriers. These barriers limit access to essential HIV and health services and prevent data collection and analysis – a key priority for understanding and accessing adolescents, especially those between 10–14 years of age.

Coordination and engagement of stakeholders including adolescents were critical to the success of All In. The continuation and strengthening of TWGs will serve to advance collaboration and further facilitate emerging initiatives. The development of ongoing systematic processes that ensure the meaningful participation of adolescents and young people is fundamental. Achieving this demands requires investment and support for the capacity building of national and regional mechanisms and networks of adolescents and young people. Overall, for adolescent well-being – not just health or HIV – a comprehensive multi-sectoral response requires establishing a national institutional framework, as demonstrated by the National AIDS Councils for HIV. This approach could provide an accountability mechanism and platform for adolescent programme planning and house a central database.

With a competitive funding landscape for HIV, there is a need to optimize available resources. A clearly articulated case for investment supported by robust data and targeted programmes will ensure the greatest impact for this population. While All In successfully leveraged resources, there is a requirement for national ownership through domestic fund allocation, thus ensuring that adolescent programmes are embedded in government investments rather than ad hoc external funding initiatives.

Conclusion

All In has demonstrated that collating available adolescent-specific data – and in a number of countries, generating new data for the first time – is possible. The program has been at the forefront in supporting sustainable long-term change in national adolescent programming within the ESA region. This change places adolescents and young people at the centre of HIV programming and decision-making. The All In country-level assessments have indicated the need for comprehensive multi-sectoral focus on adolescents. They have catalyzed engagement and collaboration across

multiple sectors in an inclusive and coordinated way, providing a visible and structured mechanism for the engagement and participation of adolescents in HIV and SRH issues.

The data collated and generated through the country assessments initiated important discussions and led to improvements in national data collection tools to allow for routine age and sex disaggregation, including at the sub-national level. This collation of data and improvements in some national data systems catalyzed the targeting of HIV interventions, the inclusion of adolescents in programming discussions and development, the development of adolescent-specific operational plans and the inclusion of adolescent interventions in national strategic plans. It also helped make a strong case for investment in adolescent HIV and leveraged additional resources from both government and other partners.

Above all, All In facilitated a differentiated approach to HIV for adolescents and generated a momentum that must be sustained. We learned that having adolescent-specific data is critical to designing and implementing programmes that are responsive to the unique needs of adolescents living with, at risk of and affected by HIV. It is vital that we share the lessons and steps taken so that programmes review, use and generate data on adolescents to strengthen the HIV response, and that these processes are routine and systematically part of our HIV review to strengthen HIV strategies and responses. Without a persistent, coordinated response that builds upon the insights and successes of All In, improving adolescents' health and well-being and ending the AIDS epidemic for this population will not be realised by 2030.

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The chapter includes contributions from All In country assessment reports as well as in-person and virtual interviews with 43 key government

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