ALL IN

#EndAdolescentAIDS

GUIDANCE DOCUMENT

STRENGTHENING THE ADOLESCENT COMPONENT OF NATIONAL HIV PROGRAMMES THROUGH COUNTRY ASSESSMENTS

Adolescent Assessment and Decision-Makers' (AADM) Tool

United Nations Children's Fund, Strengthening the Adolescent Component of National HIV Programmes through Country Assessments, UNICEF, New York, 2015.

Front Cover Photo: Nasma Rajabu throws a football that has been donated by UNICEF at the PASADA projec that is supported by UNICEF, in Dar es Salaam, Tanzania Wednesday, April 2, 2014. Nasma is HIV positive and is supported by PASADA.(Kate Holt/ UNICEF Photo/)

GUIDANCE DOCUMENT

STRENGTHENING THE ADOLESCENT COMPONENT OF NATIONAL HIV PROGRAMMES THROUGH COUNTRY ASSESSMENTS

Adolescent Assessment and Decision-Makers' (AADM) Tool

JUNE 2015

CONTENTS

ACKNOWLEDGMENTS

This guidance document was developed as part of the All In agenda to end adolescent AIDS. The production of this document was a joint effort by the HIV Section, the Data and Analytics Section and the Adolescent Development and Participation Section of the United Nations Children's Fund (UNICEF) Headquarters. Technical review and inputs were provided by UNICEF's Regional Advisors.

UNICEF would like to thank the members of the technical working group listed below who contributed to the development of this document, from the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Save the Children, the Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the World Bank and the World Health Organization (WHO).

EGPAF	Ronnie Lovich and Flavia Bianchi
GFATM	Caitlin Chandler
Save the Children	Kechi Achebe
UNAIDS	Chris Collins, Mikaela Hildebrand, Jude Padayachy, Meheret Melles, Ruben Antonio Pages and Mbulawa Mugabe
UNDP	Ludo Bok
UNICEF	Susan Kasedde, Tajudeen Oyewale, Najin Yasrabi, Priscilla Idele, Chiho Suzuki, Tyler Porth, Padraic Murphy, Sagri Singh, Vivian Lopez, Chewe Luo, and Craig McClure
UNFPA	Elizabeth Benomar and Ilya Zhukov
UN Women	Nazneen Damji and Elena Kudravtseva
PEPFAR	Nina S Hasen and Surbhi Modi
WHO	Jane Beverly Ferguson, Rachel Baggaley, Alice Armstrong and Symplice Mbola Mbassi
World Bank	Nicole Fraser-Hurt

Tajudeen Oyewale led the writing of the guidance document, with technical reviews and inputs by Susan Kasedde, Priscilla Idele, Chiho Suzuki, Tyler Porth and Padraic Murphy, and with support from Chewe Luo, and Najin Yasrebi. The development of the Adolescent Assessment and Decision Makers (AADM) excel-based tool was led by Tyler Porth.

ABBREVIATIONS AND ACRONYMS

AADM	Adolescent Assessment and Decision-Makers' Tool
ACT	Accelerating Children's HIV/AIDS Treatment (initiative)
AIDS	acquired immune deficiency syndrome
AIS	AIDS Indicator Survey
ALHIV	Adolescents Living with HIV
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
CBO	Community-based Organization
CHW	Community Health Worker
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (life)
EMIS	Education Management Information System
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
GARPR	UNAIDS Global AIDS Response Report
GBV	Gender-based Violence
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
HMIS	Health Management Information System
NA	Not applicable
ND	No data
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, Newborn and Child Health
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-child Transmission (of HIV)
PEP	Post-exposure Prophylaxis
PrEP	Pre-exposure Prophylaxis
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJT	United Nations Joint Team on HIV and AIDS
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VL	Viral Load
WHO	World Health Organization
VMMC	Voluntary Medical Male Circumcision

All In to #EndAdolescentAIDS

All In is a collaborative platform aimed at driving better results for adolescents (aged 10-19 years) through critical changes in programmes and policy. It seeks to engage adolescents and unite actors across sectors to accelerate reductions in AIDS-related deaths by 65% and new HIV infections among adolescents by 75% by 2020, thus setting the global AIDS movement on track to end the AIDS epidemic among adolescents by 2030.

Convened by a leadership group including UNICEF, UNAIDS, UNFPA, WHO, PEPFAR, GFATM, MTV Staying Alive Foundation and adolescent leaders, the platform focuses on driving forward four key action areas:

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

- Ensure adolescents' realities shape national responses to AIDS through deliberate strategies to increase meaningful adolescent participation in decision-making and in the full programme cycle
- Collaborate with, and mobilize adolescent groups to advocate for the review of laws on the age of consent for sexual and reproductive health (SRH) and HIV information and services
- Support adolescent-led social movements to address the socio-economic and policy contexts that increase adolescent HIV risk and vulnerability and provoke stigma, discrimination, and harmful gender norms

2. Sharpen adolescent elements of national AIDS programmes through improved data collection and analysis

- Identify opportunities to link adolescent-focused HIV programming to other national commitments on adolescent health and development
- Build on existing reviews and conduct new assessments to confirm priority geographic areas and adolescent populations most at risk and inform priority actions to better reduce new infections, mortality and morbidity
- Refine national strategies for priority HIV services and access to information for adolescents through strategic partner engagement and cross-sectoral linkages
- Engage national leadership to coordinate, support and lead assessments and implement prioritised adolescent elements of national programmes.

3. Foster innovative approaches for improved adolescent engagement and increased impact of prevention, treatment and care programmes

- Expand partnerships between the public and private sectors for HIV-related service delivery
- Establish continuous review mechanisms for promising approaches in scaling up programmes for adolescents
- Develop innovative community monitoring and accountability systems by and for adolescents by leveraging online technology and encouraging innovation
- Strengthen community support for adolescents living with HIV and adolescents vulnerable to HIV infection

4. Advocate at all levels to position adolescent AIDS on the agenda; communicate needs and successes effectively; and mobilize resources for efficient adolescent programmes

- Facilitate global, regional and national inter-generational dialogue between policymakers and adolescents to strengthen adolescent networks and leadership, as well as motivate positive social change to reduce HIV risk
- Conduct data-driven advocacy to optimize resource allocation, including resource gap mapping and expenditure tracking to ensure effective investments in the fight to end the AIDS epidemic among adolescents

BACKGROUND

A global level analysis indicates that adolescents (aged 10-19 years) are the only age group where AIDS-related deaths are not decreasing.[1] AIDS-related deaths among all other age groups declined by more than 40 per cent between 2005 and 2014.[2] Today, AIDS is the leading cause of death among adolescents in Africa[3] and the second most common cause of death among adolescents globally.[4] It is against this backdrop that All In was conceived to accelerate the campaign to end adolescent AIDS by 2030.

PURPOSE

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

INTENDED AUDIENCE

The guidance document is intended for use by national governments, implementing partners, UN agency counterparts, and UNICEF in support of an inclusive process that seeks to optimize multi-sectoral collaboration and engender national ownership.

KEY PRINCIPLES

Flexibility

The country assessments are organized into three phases (discussed in following section). Considerations regarding the local context, state of the epidemic, stage of the national programme, availability of data on adolescents, and strategic programme opportunities are to inform the particular process and level (national- or sub-national) at which the country assessment begins. The country assessment processes and AADM tool are designed to elicit and integrate adjustments needed to properly reflect the local epidemic and accompanying programmatic and geographic priorities.

Government Leadership and Multi-sectoral Participation

The country assessments are intended to promote multi-sectoral participation at country-level, including adolescents. A multi-sectoral team is expected to undertake data review, validation and priority setting. The team is to be comprised of the national AIDS programme or coordinating authority, relevant ministries and departments, civil society organizations, networks of people living with HIV (PLHIV) and representatives of adolescent or youth groups. In contexts where a government-led approach is not presently feasible, it is recommended that UNICEF and its partners, including UN counterparts, donor programmes, national and international non-governmental organizations, and civil society organizations, mobilize to undertake the country assessment process with a view to realizing a government-led process in the longer-term.

1 This statement draws on the global level (i.e., aggregate) analysis. Country-specific analysis on the trends of AIDS-related deaths among adolescents is part of the country assessment.

2 United Nations Children's Fund, 'Analysis of UNAIDS 2014 HIV and AIDS estimates', July 2015.

3 World Health Organization, 'Global health observatory data repository', 2012. http://apps.who.int/gho/data/view.wrapper.MortAdov?lang=en&menu=hide

4 World Health Organization, 'Health for the World's Adolescents: A second chance in the second decade', 2014. www.who.int/adolescent/second-decade

Adolescent Engagement

The country assessment process presents an opportunity to strengthen existing mechanisms to engage adolescents in programme design. Engagement with national or sub-national networks, community or peer groups, and youth clubs leading up to the national stakeholder meeting will ensure that adolescents' diverse experiences and perspectives inform the decision-making to emerge from the country assessments. An accompanying resource to this guidance document[5] is available to support countries in convening and orienting adolescents and young people on ALL IN and preparing them for a meaningful role in the assessments. Country teams may also wish to consider leveraging innovative platforms, such as community radio, mobile SMS, Twitter and other internet-based platforms, to engage adolescents creatively on a larger scale.

Results-based Monitoring

The country assessment process presents an opportunity to align national and global targets and track those results over time. Although it is recommended that tracked results are linked to the existing national HIV programme reporting cycle, the decision on the frequency of tracking results is left to the country teams.

COUNTRY ASSESSMENTS

The country assessments are designed to be implemented at the country-level in three Phases (Figure 4) through the participatory engagement of multi-sectoral teams, including representatives of adolescents and young people.

Country Assessment Phases:[6]

1. *Rapid assessment* of adolescent programme context at national and sub-national level to define who is most affected, where they are located and what interventions have the largest coverage gap and most critical to accelerate HIV results in adolescents
2. *In-depth analysis* of bottlenecks affecting coverage of priority HIV interventions in priority geographic locations identified in Phase 1
3. *Evidence-informed planning* to accelerate corrective actions to address bottlenecks, data gaps and improve intervention coverage, quality and impact

Resources to Support Country Assessments:

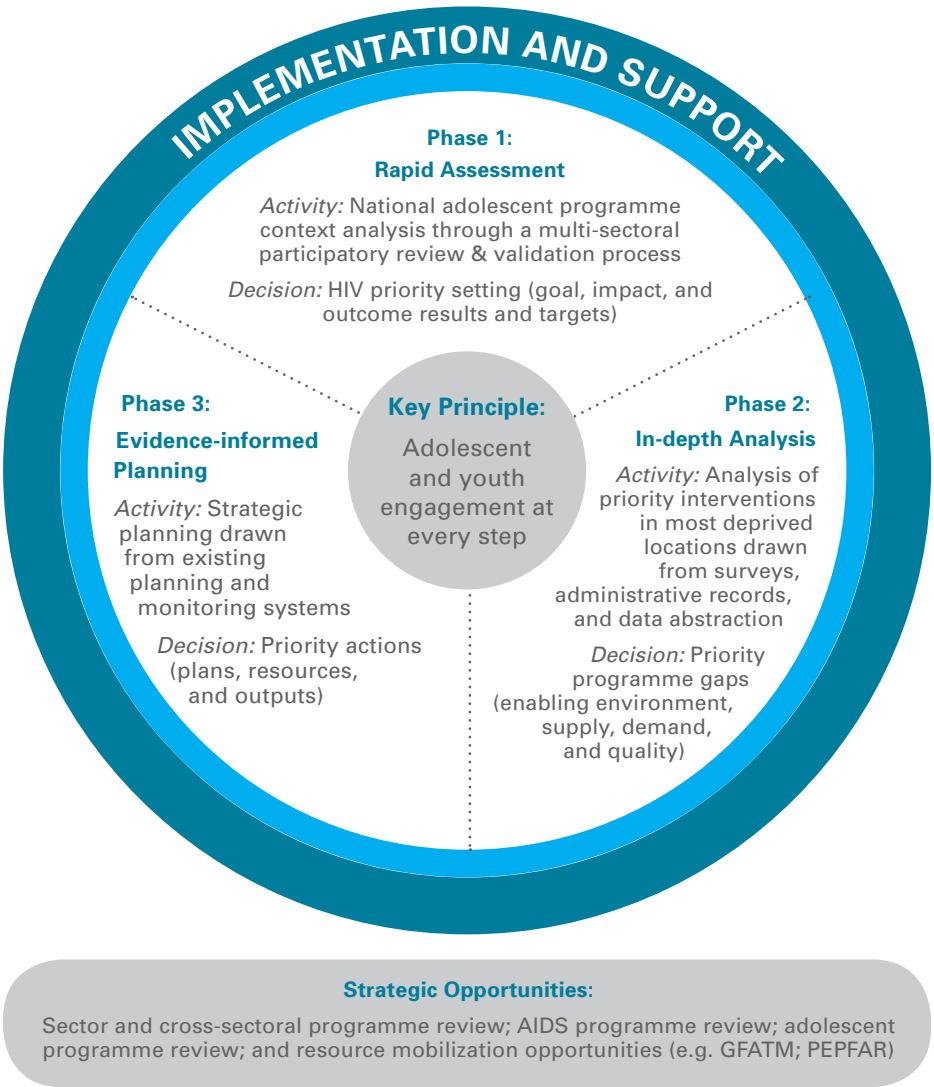
- *United Nations Joint Team on HIV/AIDS (UNJT)* and partners should be prepared to support the national process led by governments to initiate country assessments.
- *A technical working group* should be constituted to provide leadership for the assessments and supported by *a multi-sectoral national steering committee*, including adolescents to validate assessment outputs. Strategic entry points to initiate country assessments need to be considered by the technical working group to ensure the use of findings and implementation of recommendations.
- The team can be supported by a *dedicated consultant* – please see Annex 8 for the proposed terms of reference.
- *AADM tool* has been developed to provide countries with the necessary analytics to inform decision-making during the country assessments (Annex 2).
- *A checklist* to assist country teams to track the progress of the country assessment implementation is included in Annex 3.

5 UNAIDS, Assessing level and quality of adolescent and youth participation in HIV and SRH decision-making and programming cycles

6 In consideration of each country's epidemic typology, state of the national adolescent HIV programme, and degree of data availability and quality, countries may have a solid grasp of the populations, locations, and interventions to be targeted and wish to begin with the in-depth analysis in Phase 2. Additionally, the ability for countries to undertake these processes in succession or in a staggered manner will likely be determined by the level of data availability and quality of existing information on adolescents.

- *A draft template* for a schedule of data review and national stakeholder meetings for the implementation of Phase 1 is provided in Annex 9.
- *Reporting formats* for Phases 1 and 2 are provided in Annex 12 and 13.

All In Country Assessment Processes:



Strategic Opportunities:

Sector and cross-sectoral programme review; AIDS programme review; adolescent programme review; and resource mobilization opportunities (e.g. GFATM; PEPFAR)

PHASE 1: RAPID ASSESSMENT OF THE NATIONAL ADOLESCENT PROGRAMME

During this process, countries are to focus on the validation of existing data on adolescent wellbeing with the aim of defining priority populations, interventions and geographic settings to accelerate HIV-specific outcomes for adolescents. It involves an equity-based analysis of demographic and epidemiological information on adolescents, including adolescent key population groups and relevant cross-sectoral interventions on adolescents.

Note: depending on the HIV epidemic typology, national programme context, the availability of data on adolescents, and the identified strategic programme entry points, Phase 1 can be applied at the national and/or sub-national level(s). In contexts with sufficient data and where priority populations and geographical settings are already well defined, countries may decide to proceed to Phase 2.

Guiding Questions:

- Who are the adolescent populations in greatest need?
- What are the high impact HIV-related interventions and cross-sectoral opportunities needed to accelerate adolescent outcomes?
- Where are the geographic locations with the greatest programmatic gaps?

Key Indicators

Phase 1 seeks to collate a set of the following key indicators to contextualize adolescent programming at the national and sub-national levels: demographic and HIV epidemiologic information about adolescents; outcome level indicators related to HIV interventions and critical enablers; adolescent health interventions, including sexual and reproductive health; gender-based violence; social protection; and education are included in the rapid assessment (see Annex 4 for all indicators).

Note: not all indicators in Annex 4 are applicable to all countries, e.g. voluntary medical male circumcision (VMMC) and Pre-Exposure prophylaxis (PrEP). In this regard, the dashboard report from the rapid assessment distinguishes between indicators for which there is no data (ND) and those that are not applicable (NA) in that programme context.

Enabling Environment

Phase 1 also involves a broad assessment of the national programme enabling environment focusing on policy and legislation; planning, budgeting, and coordination; and adolescent participation and monitoring systems. See Annex 5 for the enabling environment assessment tool.

Key Steps:

1. Data collation, review and validation of selected indicators across multiple data sources;
2. Assess national programme enabling environment with partners and adolescents;
3. Synthesize data into a dashboard report; and
4. Identify adolescent sub-populations, interventions, and geographic areas of focus for programme acceleration

Convene Technical Working Group

1.1 Convene a technical working group under the leadership of the government or national non-governmental stakeholders, as appropriate. Nonetheless, it is recommended that the country assessments be integrated as a priority action within an existing adolescent technical working group. The technical team should include the national government, donor and implementing partners, representatives of adolescent networks, and the UNJT.

1.2 Identify strategic opportunities to advance the findings of the country assessments at the national or sub-national level.

Review and Validate Selected Indicator Data

1.3 Review existing and on-going assessments on HIV and adolescents to document what is known, ascertain gaps, and ensure complementarity.

1.4 Collate existing national and sub-national data on relevant indicators (Annex 4) on adolescents and HIV, sexual and reproductive health including other adolescent health issues, education, and gender-based violence, social protection and any other relevant adolescent priorities in the country.

Data Collection Considerations:

- It is recommended that data for the indicators be collated from existing studies, surveys and reports. This exercise might involve secondary data analysis of the source dataset to generate values for adolescents.
- Where data are not available from existing studies, surveys and reports, calculate adolescent values using the numerator and denominator descriptions provided in Annex 4. This process may involve the collection and use of programme data.

Assess the Enabling Environment

2.1 Convene a stakeholder meeting, including government and implementing partners and representatives of adolescent groups and networks, to assess the national programme enabling environment using the tool in Annex 5. It is recommended that this assessment includes members of the technical working group established at the outset of the country assessment process.

Synthesize Data

3.1 Enter the validated data into the country assessment tool (AADM). See annex 2 for the detailed description of the AADM.

3.2 Review the output of the AADM tool – a dashboard report summarizing the demographic, epidemiological and programme coverage profile for adolescents.

Define Targets

4.1 Convene a multi-sectoral stakeholders' meeting with representation from policymakers, planners and managers from relevant government agencies, donors and implementing partners, civil society organizations, traditional leaders, academia, and representatives of adolescent networks and the United Nations to review the dashboard report generated by the AADM tool.

4.2 Identify target adolescent sub-population(s) for programme acceleration based on the demographic and HIV epidemic profile.

4.3 Identify target programme interventions and entry points based on the ones with the greatest gaps in coverage. The HIV investment frameworkError! Bookmark not defined. provides guidance to inform the selection of programme interventions.

Note: Considering available evidence on reducing new HIV infections, and HIV- and AIDS-related morbidity and mortality, it is recommended that country teams prioritize interventions to accelerate HIV results for adolescents based on the local context, current national programme coverage, and existing partnerships or global initiatives (Table 2). Synergies and entry points between the priority interventions and cross-sectoral adolescent interventions should also be defined.

TABLE 2: Evidence-based HIV interventions

Core Intervention	Other Interventions
HIV testing and treatment • HIV testing and counselling • Antiretroviral treatment for adolescents living with HIV including PMTCT for pregnant and breast feeding adolescent girls **HIV prevention** • Condom use for sexually active adolescents **Social and Programmatic Enablers** • Social and behaviour change	**Combination HIV Prevention** • PreP for adolescent girls in sero-discordant relationships • Comprehensive harm reduction programme for adolescent who inject drugs • VMMC for adolescent boys in priority countries • PreP for adolescents in sex industry, MSM and TG **Social and Programmatic Enablers** • Adolescent friendly SRH services • Quality education and learning • Comprehensive sexuality education • Enabling laws, policies and practices (e.g. age of consent, stigma free and non-discriminatory, travel restriction, violence against key populations, etc.) • Social protection programmes including social transfers/ economic strengthening such as cash transfers • Prevention and mitigation of sexual violence including access to PEP

4.4 Identify target sub-national geographic locations for programme acceleration. It is recommended that the selection of geographic locations be guided by data availability (see Figure 5), as data availability at the sub-national level varies widely. Country teams may also wish consider programmatic and partner presence in the targeted locations.

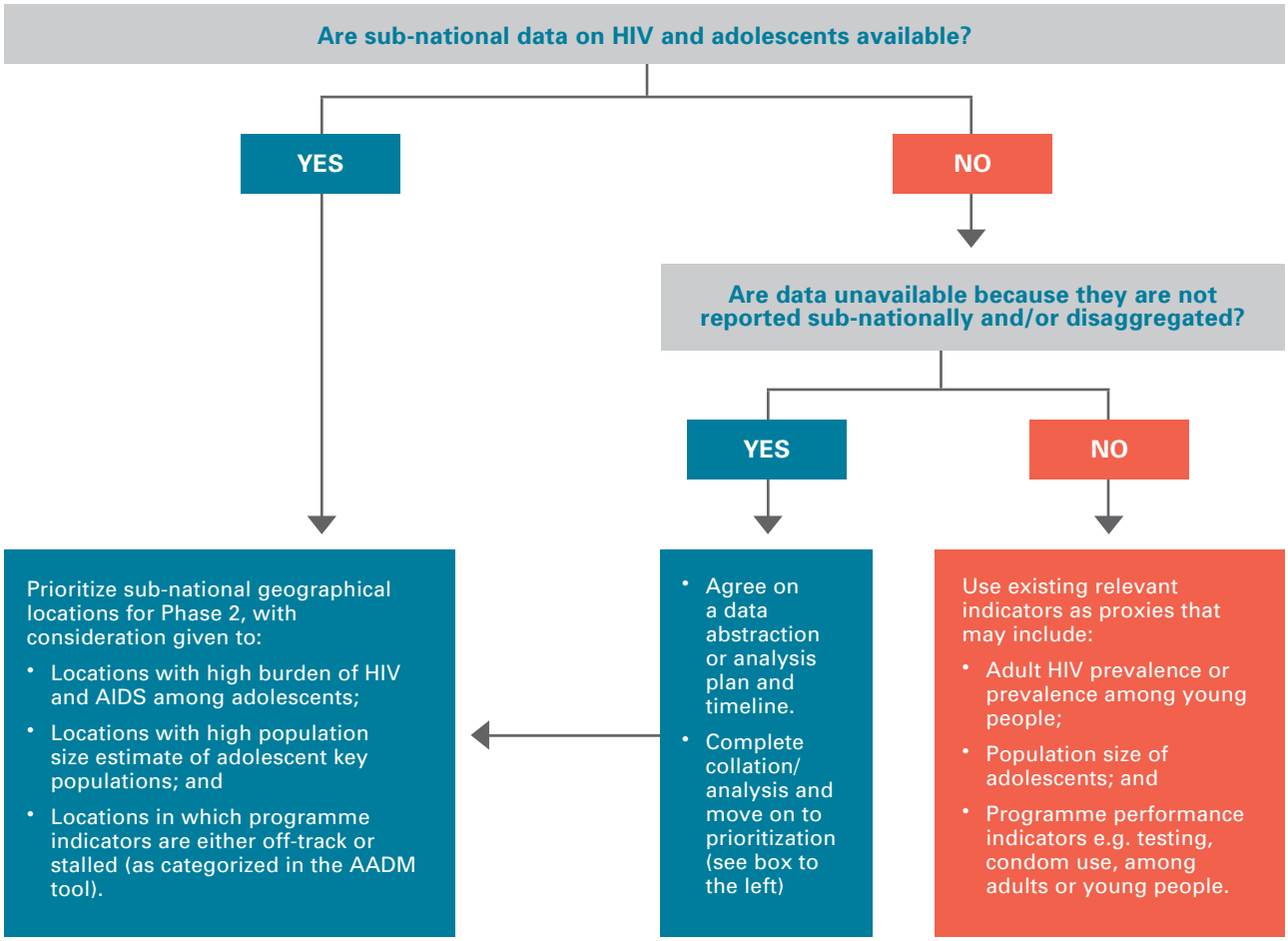
4.5 Integrate agreed actions and targets into relevant sectoral plans, programmes and resource mobilization opportunities.[7]

Key Outcomes:

1. Selected target adolescent sub-populations;
2. Selected target sub-national geographic locations; and
3. Selected target programme interventions to accelerate national programme effectiveness.

7 For example: domestic sector budgeting; funding from external sources, such as PEFPAR and the Children's Investment Fund Foundation: Acceleration of Children's HIV/AIDS Treatment Initiative (ACT Initiative); PEPFAR, the NIKE Foundation, and the Bill and Melinda Gates Foundation initiative to allow girls to live; 'Determined, Resilient, Empowered, AIDS-free, Mentored and Safe' (DREAMS), focusing on 15-24 year old girls; concept notes and grant implementation through the Global Fund to Fight AIDS, TB and malaria (GFATM); and UNJT plans.

FIGURE 5 Data Availability and Selection of Sub-national Locations



PHASE 2: IN-DEPTH ANALYSIS OF PRIORITY INTERVENTIONS

This phase of the country assessments is focused on the identification of programme gaps and bottlenecks of the selected locations and populations identified in Phase 1.[8] An in-depth examination of the enabling environment and determinants affecting the supply, demand, and quality of interventions is undertaken (see Table 3).

The following components comprise Phase 2: (1) *determinant analysis*[9,10] of key indicators of supply (commodities, human resource and accessibility), demand (utilization and continuity) and quality of interventions to identify bottlenecks; (2) *causality analysis* of the observed bottlenecks in relation to enabling environment, supply, demand and quality factors; and (3) *identification of key actions* to address the observed bottlenecks in the sub-national geographic locations for programme acceleration.

8 Countries with well-defined target populations and geographical locations may have proceeded directly to Phase 2.

9 Determinant analysis is undertaken within an analytical framework that seeks to identify bottlenecks preventing effective coverage of interventions. A bottleneck is a constraint affecting one or more determinants, thus impeding effective coverage. Effective coverage refers to the extent to which interventions reach their intended target population, as defined by the proportion of the target population that participates in or is reached by an intervention or adopts a desired behavior.

10 Tanahashi, T., 'Health Service Coverage and Its Evaluation', Bulletin of the World Health Organization vol. 56, no. 2, 1978, pp. 295 – 303. www.ncbi.nlm.nih.gov/pmc/articles/PMC2395571/pdf/bullwho00439-0136.pdf

TABLE 3: Framework for In-depth Analysis

Domain	Determinants	Description
Enabling Environment	Social Norms	Widely followed social rules of behavior
	Legislation/Policy	Adequacy of laws and policies
	Budget/expenditure	Allocation & disbursement of required resources
	Management /Coordination	Roles and Accountability/ Coordination/ Partnership
Supply	Availability of essential commodities/inputs	Essential commodities/ inputs required to deliver a service or adopt a practice
	Access to adequately staffed services, facilities and information	Physical access (services, facilities/information)
Demand	Financial access	Direct and indirect costs for services/ practices
	Social and cultural practices and beliefs	Individual/ community beliefs, awareness, behaviors, practices, attitudes
	Continuity of use	Completion/ continuity in service, practice
Quality	Quality	Adherence to required quality standards (national or international norms)

Guiding Questions:

- What are the critical bottlenecks for the selected intervention key indicators of supply, demand and quality?
- What are the underlying causes contributing to the identified bottlenecks across the enabling environment and supply, demand and quality domains?
- What are the priority actions to address the identified bottlenecks?

Depending on the interventions of interest, Phase 2 will involve data collection from facilities or service sites. Additionally, this phase requires qualitative data collection and consultation with policy makers, service providers, and adolescent clients to inform the determinant analysis, including identification of bottlenecks and corrective actions.

Key Steps:

1. Select the priority geographic areas for Phase 2 analysis among the existing sub-national areas;
2. Engage with sub-national partners to plan Phase 2 assessment in the selected geographic areas and for priority interventions;
3. Agree on indicators and undertake determinant analysis to identify bottlenecks for interventions in the selected geographic areas based on supply, demand and quality indicators;
4. Conduct causality analysis of the identified bottlenecks; and
5. Synthesize findings on key bottlenecks and reach agreement on corrective actions.

Select Sites for In-depth Analysis

As country teams will have selected a number of sub-national geographic areas for investigation in Phase 1, this phase will see the country teams identify priority sites within those selected sub-national geographic areas for an in-depth analysis. The following steps are proposed to guide country teams in selecting the areas for the in-depth analysis of priority interventions:

1.1 Select locations with a set of criteria, which include high burden of HIV and AIDS;

1.2 Focus on small but defined geographic areas that allow for easy measurement of indicators on supply, demand and quality of the priority interventions (see Annex 6 for the definition of selected indicators);

1.3 Prioritize geographic areas with programme implementation capacity, i.e. locations with on-going activities for the priority interventions;

1.4 Consider geographic spread (e.g. urban versus rural) and HIV epidemics (generalized versus concentrated) to maximize learning and application of findings; and

1.5 Consider the availability of data for the priority interventions in the selected geographic locations.

1.6 Reflect on the feasibility of undertaking Phase 2 in selected sites, particularly anticipated costs, human resource availability, timelines, and logistical support.

Considerations in Low and Concentrated HIV Epidemic Settings:

- Focus on geographic areas with high HIV prevalence among key populations
- Prioritize geographic areas with interventions for key populations

Engage with Sub-national Partners in Selected Geographic Areas

As Phase 2 analysis occurs at the sub-national level, ensuring the buy-in of key partners in the selected geographic areas is critical to generate useful analysis.

2.1 Engage with regional or district authorities and partners to agree on timelines as well as roles and responsibilities for the in-depth analysis in the identified locations. Stakeholders will include different service providers, programme managers and adolescent networks and groups.

Considerations in Low and Concentrated HIV Epidemic Settings:

- Ensure engagement of members of key population groups
- Include public sector and civil society organizations that provide interventions for key populations

Select Indicators and Undertake Determinant Analysis

This step of the assessment reviews the determinants of supply (availability of commodity and human resource), demand (utilization and continuity of use) and quality of the priority interventions. See Annex 6 for the definition of select indicators for the determinant analysis.[11]

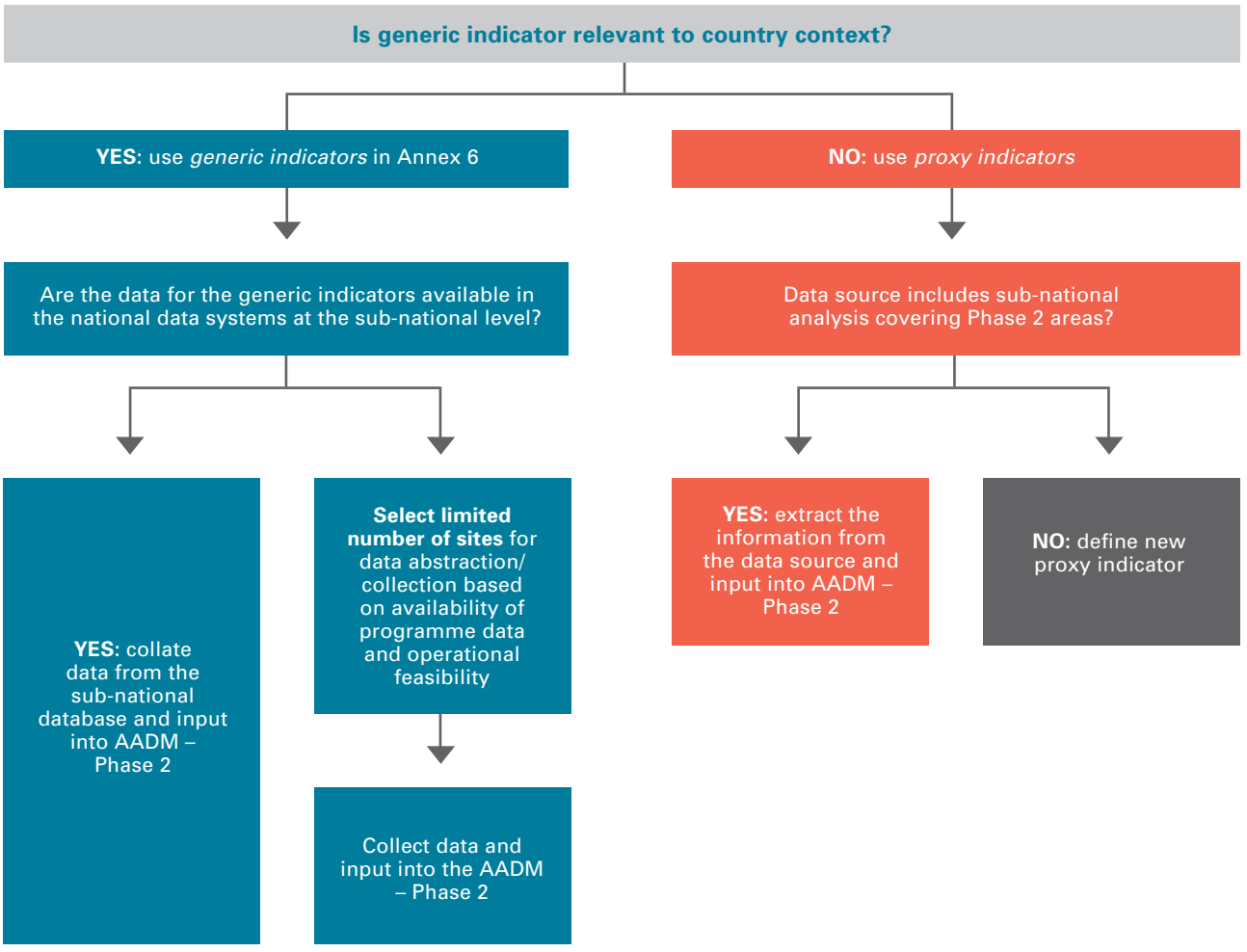
11 Note: A suggested list of indicators for interventions that are not specific to HIV (e.g., child marriage, gender-based violence, education, etc.) is not yet included here. We will draw on the existing set of indicators and approaches for Level 3 monitoring from these sectors, which will be incorporated into this process at a later time.

3.1 Engage national and sub-national partners to define indicators for determinant analysis of the priority interventions. Note: a mix of generic and proxy indicators can be used.

Determinant Analysis Examples:

- Availability of commodities - test kits and ARV
- Availability of human resources - presence of trained counsellors, teachers
- Accessibility to services - geographic location of services or knowledge of service location
- Utilization of services - uptake of first ANC visit or counselling for HIV testing
- Continuity of service – at least 4 ANC visits or taking an HIV test or taking ARVs
- Quality of service, e.g. delivery at health facility or those testing HIV positive are linked to HIV care

FIGURE 6 Flow chart for deciding service delivery coverage indicators



Considerations for Selecting Indicators for the Determinant Analysis:

- Given the state of data availability, country teams may adopt the provided generic indicators (see Annex 6) or employ proxy indicators as needed.
- It is recommended that the different service delivery platforms per selected intervention are mapped, as adolescent programmes are delivered across multiple platforms and sectors, e.g. clinical settings (health), schools (education) and in the community (outreach services). Examples of service delivery platforms for HIV prevention, treatment and care interventions for adolescents are presented in Annex 7.

Generating and Interpreting Outputs:

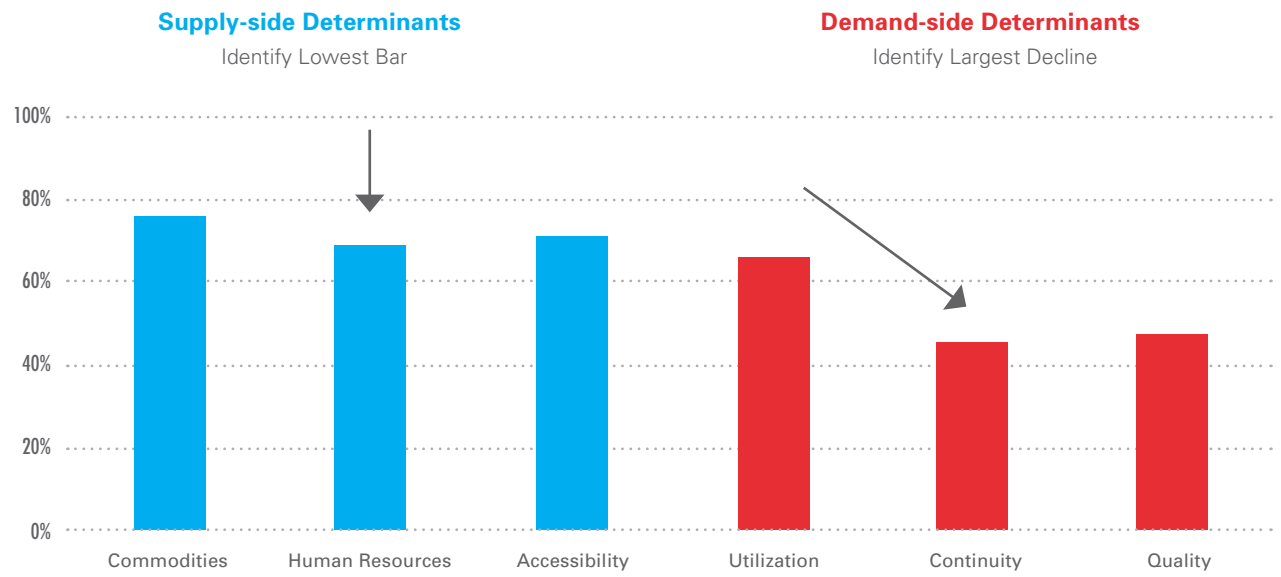
4.1 Once generic and/or proxy indicators have been selected, and corresponding data have been collected and entered into the AADM tool for Phase 2, outputs will be automatically generated in the form of bar charts. Bottlenecks across the supply (commodity, human recourse and accessibility), demand and quality domains (utilization, continuity and quality) can then be identified for further investigation during the causality analysis.

4.2 Please note that it is anticipated that some of the selected interventions will likely use demand-side indicators that lack shared denominators. To guide the interpretation of the bar charts generated by the AADM tool during this process, three scenarios with demand-side indicators that do and do not share denominators are presented below.

Scenario 1 - Coverage Indicators with Shared Denominators:

Figure 7a presents an example of determinant analysis where coverage levels reveal a bottleneck in Human Resources in the supply domain. The demand-side indicators illustrated on the right side of the chart share denominators which produce a cascade across the demand domain. As shown below, Continuity represents the largest decline in coverage, revealing a bottleneck. At this point, the team may wish to prioritize the identified bottlenecks in Human Resources and Continuity for further investigation.

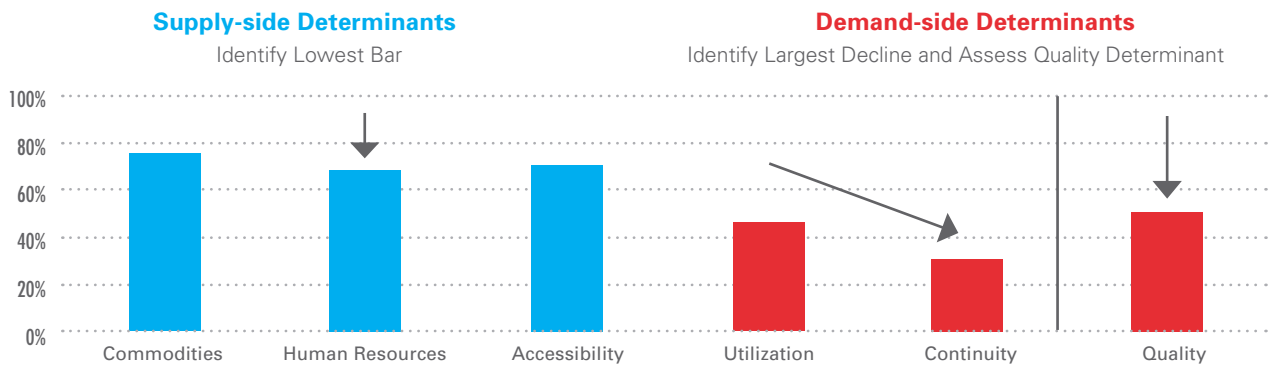
FIGURE 7A Coverage Plot of Service Delivery Indicators with Shared Denominators



Scenario 2: Coverage Indicators with Shared Denominators for Utilization and Continuity:

As shown in Figure 7b, it may be the case that the Utilization and Continuity indicators share denominators while the denominator for the Quality indicator remains distinct. For example, the demand-side indicators for out-of-school life skills based education (LBSE) only share denominators for Utilization and Continuity: Utilization – number of villages/clusters surveyed; Continuity – number of villages/clusters surveyed; and Quality – number of out-of-school adolescents. In such an instance, it is important to not only investigate a decline from Utilization to Continuity but also independently assess Quality for potential bottlenecks.

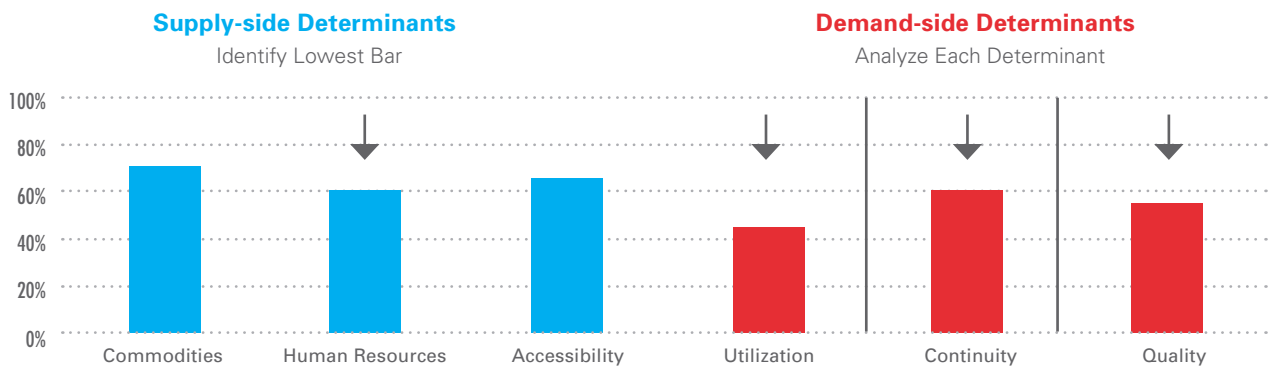
FIGURE 7B Coverage Plot of Service Delivery Indicators with Shared Denominators for Utilization and Continuity



Scenario 3 - Coverage Indicators without Shared Denominators:

In the event that none of the demand-side determinants share denominators *(Figure 7c)*, the resultant chart may not produce a cascade where bottlenecks can be more readily identified (i.e. largest decline). For example, the demand-side indicators for in-school life skills based education (LSBE) do not share denominators: Utilization – number of primary schools; Continuity – number of secondary schools; and Quality – number of in-school adolescents. As such, the resulting chart may resemble Figure 7c where a supply-side bottleneck can be identified; however, in the absence of a cascade, each demand-side determinant must be assessed independently to identify potential bottlenecks.

FIGURE 7C Coverage Plot of Service Delivery Indicators with Three Distinct Denominators



Conduct Causality Analysis

This step of the analysis is focused on understanding the previously identified bottlenecks. The analysis will involve focus group discussions or key informant interviews (KII) with service providers, adolescent networks and groups, and community members. Where appropriate, information may be sought from existing formative research, behavioral surveys and opinion of thematic experts.

4.1 For each of the observed bottlenecks, ask the following questions during the focus group discussion with service providers, adolescent networks and groups, and community members, and thematic experts.

a. What are the causes of the observed barriers and bottlenecks and why?

- It is recommended that this pattern of questioning be repeated at least five times for each coverage level, i.e. once for commodity, human resource, accessibility, utilization, continuity and quality.

b. For each of the ensuing responses it is suggested to inquire as to:

- What are the related structural barriers, i.e. policy and legislation, budget, logistics, and social norm, to be addressed?
- What are the related management weaknesses to be addressed?

4.2 Input the findings from the qualitative exercise into the AADM Phase 2 tool. Example of bottlenecks and possible causes are provided in Table 4.

TABLE 4: Examples of Bottlenecks and Underlying Causes

Type of Bottleneck	Example	Underlying Cause/s
Low Initial utilization of ANC services	Financial barriers	• Family cannot afford to pay user fees or to travel long distances to facilities
	Socio-cultural barriers and gender dynamics	• Mothers must obtain permission from others in household prior to seeking care • Witchcraft • Stay 40 days at home after birth (indoor)
Low continued utilization of ANC	Loss to follow-up/ drop-outs	• Lack of active follow up systems • Negative experience with provider/facility
Ineffective coverage in ANC	Low quality Not timely Not complete Not appropriate	• Regular standards: not developed, not approved, and not used • Inadequate staffing and skills in quality of care • Service organization: overload, inadequate equipment and supply

Synthesis of Findings and Corrective Actions

This step of the analysis seeks to identify corrective actions for the identified bottlenecks. It is recommended that solutions to the observed bottlenecks should be explored as part of the focus group workshop and KII of service providers, adolescent networks and groups, and community members in the last step.

5.1 Based on the identified bottlenecks, what are the key actions needed to address the observed bottlenecks? The following questions may help in identifying solutions:

- Is the proposed solution likely to have an impact?
- Is the proposed solution feasible? - consider policy and existing capacity
- Is the proposed solution cost-effective? - consider affordability, funding availability, cost-benefit?
- Is the proposed solution acceptable by key stakeholders and beneficiaries?
- Is the proposed solution going to help reach those populations with the highest unmet need?

5.2 Validate the proposed actions with the government and a team of technical experts, policy makers, programme managers, service providers and adolescent representatives, as appropriate.

5.3 Input the findings from this qualitative exercise into the AADM tool.

Key Outcomes:

1. Identification of key barriers and bottlenecks limiting effective coverage of priority HIV programme interventions for adolescents related to supply, demand, quality and structural factors
2. Agreement on the priority activities needed to address the identified bottlenecks.

PHASE 3: EVIDENCE–INFORMED PLANNING AND MONITORING

This Phase of the country assessments will harmonize decisions and outputs from Phases 1 and 2 into a multi-sectoral plan for adolescents and HIV, and facilitate development of plans to improve programme implementation at sub-national level. Phase 3 includes strategic engagement with relevant sectors, funding and implementation partners, the UN agencies and adolescents/youth groups to integrate identified priorities into existing plans and programmes.

Guiding Questions:

- How will the corrective actions to address observed bottlenecks be implemented?
- How will the observed data gaps be addressed?
- What are the roles and responsibilities of key partners in the implementation of the corrective actions and improvement of data systems?
- How will progress be tracked?

Where feasible, Phase 3 should involve the development of joint work plans. In reaching this agreement, country teams should consider the governance and accountability framework in the country, comparative advantage and mandates of the different partners and sectors and the potential that lies in meaningful engagement and participation of adolescents and young people in programming.

Key Steps:

1. Consolidate the corrective actions into a sub-national micro-plan;
2. Develop data improvement plan; and
3. Track progress for the implementation of activities, reduction in bottlenecks and achievement of objectives.

Develop Sub-national Micro-plans

In this stage of the country assessment, country teams will develop sub-national plans that reflect corrective actions for the selected interventions. This stage involves the following:

1.1 Review of corrective actions for the selected interventions from Phase 2 by a team comprised of policymakers, planners and managers from relevant government agencies, donors, implementing partners, representatives of adolescent networks and the UNJT. It is recommended that this consultation be undertaken at the sub-national level.

1.2 Define objectives, outputs and activities for the sub-national micro-plan that is informed by the previously selected corrective actions. It is essential that the objectives defined in the micro-plan are related to the Phase 1 intervention outcomes, the Phase 2 outputs regarding bottleneck reductions, and the corrective actions identified in Phase 2. Table 5 provides examples of how to define objectives, outputs and activities in the micro-plan and their relationship to Phases 1 and 2. Please note that the activities, outputs and objectives should be specific, measurable, achievable, realistic and time-bound (SMART).

Relationship between Phase 1 & 2 Outputs and the Micro-plan:

- *Objectives* are related to intervention outcomes in Phase 1;
- *Outputs* are related to reduction in observed bottlenecks in Phase 2; and
- *Activities* are related to the corrective actions in Phase 2.

TABLE 5: Examples of Micro-plan Objectives, Outputs and Activities

Objectives	
• Expressed as a change in the coverage of the selected intervention	• Coverage of HTC among adolescents aged 10-19 years increased from 50% to 90% by December 2015
Outputs	
• Expressed as the reduction of the identified bottlenecks in coverage determinants	• % of health facilities with any stock-out of HIV test kits over the last 3 months reduced from 90% to 45% by December 2015
Activities	
• Defined and expressed as the actions to be undertaken to achieve the outputs	• Develop new HTC register by June 2015 • Train district and health facility staff in stock management by June 2015 • Establish incentive mechanisms for stock-out free health facilities by June 2015

1.3 Input the objectives, outputs and activities into the micro-plan template (Table 6) and agree on partner roles and responsibilities, including resources, strategic partnerships, and monitoring and evaluation.

TABLE 6: Micro-plan Template (HIV Testing and Counselling Example)

SUB-NATIONAL LOCATION FOR PHASE 2		INSTITUTION AND RESPONSIBLE PERSON	Timeline (months)												Indicators (when necessary)
			1	2	3	4	5	6	7	8	9	10	11	12	
Objective: Coverage of HIV testing and counselling among adolescents aged 10-19 increased from 50% to 90% by 2015															
Output 1: % of health facilities without any stock-outs of HIV test kits over the last 3 months reduced from 45% to 90% by December 2015															
Activities	Develop new HTC registers														
	Train district and health facility staff in stock management														
	Establish incentive/reward mechanisms for stock-out free health facilities														
Review of output from Phase 2	Observation:														
	Recommended action(s):														
Output 2: Age of consent for HIV testing reduced below 18 years															
Activities	Review policy and legislation on access to HIV and SRH services														
	Development of policy paper on lowering age of consent to HIV testing														
	Policy advocacy with policy makers														
Review of output	Observation:														
	Recommended action(s):														

Develop Data Collection and Improvement Plan

One of the key objectives of the country assessment is to identify data quality issues and gaps so that a data collection and improvement plan can be developed. The following steps are provided to guide that process:

2.1 Identify key data gaps and quality issues from Phase 1 and Phase 2 of the country assessment;

2.2 Map scheduled and on-going surveys, studies and monitoring systems that can contribute to addressing the observed data gaps; and

2.3 Develop a data collection and improvement plan that outlines partner roles and responsibilities and a time frame.

Track Implementation Progress

To ensure the micro-plan activities are leading to expected change, it is important to track progress in activity implementation, reduction of bottlenecks and coverage of interventions. This process involves the following:

3.1 Track implementation of the activities defined in the micro-plan using routine activity monitoring systems. This can be done monthly, quarterly, or as defined by the implementation partners.

3.2 Review reduction of bottlenecks to inform any adjustment of the selected activities. It is recommended that change in bottlenecks be tracked every 6 months or as defined by the country teams. Table 7 presents the framework to assist with reviewing progress in the reduction of bottlenecks. As shown in Table 8 below, a summary dashboard can be used for tracking purposes.

Considerations for Tracking Bottleneck Reductions:

- Phase 2 of the assessment should be repeated regularly to verify the reduction or elimination of bottlenecks, as well as focus the microplan on actions that contribute to the elimination of bottlenecks and improved progress towards the adolescent results.
- Where *generic indicators* were used, it is recommended to repeat the exercise in every 6 – 12 months or as defined by the country teams.
- Where *proxy indicators* were used, it is recommended to repeat the exercise once new information is available per proxy indicator.
- It is recommended that routine monitoring systems that generate data for generic indicators be mainstreamed into programme implementation settings where proxy indicators were used.

TABLE 7: Framework for Reviewing Reduction of Bottlenecks

		Implementation Monitoring	
		Activity on track (Adequate implementation)	Activity off track (Inadequate implementation)
Bottleneck Monitoring	Objective on track (Bottleneck reduced)	Continue implementation	Review implementation barriers and make modifications and/or accelerate implementation
	Objective off track (Bottleneck NOT reduced)	Re-run causality analysis and suggest new solutions and/or activities	Review implementation barriers and make modifications and/or accelerate implementation

TABLE 8: Micro-plan Template (HIV Testing and Counselling Example)

	Threshold		National target	District		Sub-district A		Sub-district B	
Intervention: Prevention, care & treatment	Lower	Upper	%	Base	+6 months	Base	+6 months	Base	+6 months
Commodities: Stock out of HIV test kits in last 3 months	50	80	90						
HR: Availability of trained nurses in adolescent friendly services	50	80	90						
Access: Adolescent within <5km of testing site	50	80	90						
Utilization: Adolescents tested for HIV	30	60	80						
Continuity: Adolescents on ART	60	90	95						
Quality: Adolescents virally suppressed	50	85	90						

= below threshold = in-between threshold = above threshold

3.3 Review the achievement of objectives, i.e. the change in coverage of the selected interventions, to inform any adjustments needed for the selected activities. Table 9 presents the framework to support the progress review for the selected interventions. This process enables the monitoring of progress for coverage of priority interventions in the selected sub-national geographic areas. Using information gleaned from this process, the country teams can then update Phase 1 of the country assessment where an updated sub-national profile of interventions can be generated in the AADM tool. This exercise can also be done across different sub-national locations. At the district level, a dashboard should be generated to assess progress in closing the gap in intervention coverage across different sub-district areas, as show in Table 10. Through these processes, improved monitoring and disaggregation of data will lead to greater availability and quality of national and sub-national data for planning and decision making on adolescents.

TABLE 9: Framework for Tracking Progress of Selected Interventions

		Status of Bottleneck
		Bottleneck reduction on track
Monitoring Objectives	Objective on track (Coverage increased)	Continue implementation
	Objective off on track (Bottleneck NOT reduced)	Re-run bottleneck analysis and suggest new solutions and / or activities

TABLE 10: Progress Dashboard for Intervention Coverage across Sub-districts

	Threshold		National target	District		Sub-district A		Sub-district B	
Intervention: Prevention, care & treatment	Lower	Upper	%	Base	+6 months	Base	+6 months	Base	+6 months
HTC coverage	50	80	90						
Pre-ART	50	80	90						
ART coverage	50	80	90						
Retention coverage	30	60	80						
Viral suppression	60	90	95						

= below threshold = in-between threshold = above threshold

Key Outcomes:

1. Priority action plans defined;
2. Data needs for adolescent programming defined; and
3. Accountabilities across stakeholders (e.g. national government, level of care and partners), including timelines and mechanisms to track progress, are identified.