



Maximizing impact by addressing adolescents' needs in  
Global Fund concept notes

# Strategic Investments for Adolescents In HIV, Tuberculosis and Malaria Programs

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Adolescents have specific needs in terms of health care services, including access to prevention, treatment and care for AIDS, tuberculosis and malaria. Often, however, their needs are not recognized or catered for within national strategies. The Global Fund provides guidance on how to reach out to this population; information on what services are most appropriate; and points out the opportunities for involving adolescents in the design and delivery of services.

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## Acronyms and Abbreviations

ARV	antiretrovirals
MDR-TB	multi-drug-resistant tuberculosis
PMTCT	prevention of mother-to-child transmission
TB	tuberculosis
UNAIDS	United Nations Joint Programme on HIV/AIDS
WHO	World Health Organization

# Executive Summary

Adolescents have specific needs that are distinct from those of other age groups. Yet this has not been consistently recognized by the health sector. This Adolescent Information Note supports strategic Global Fund investments to improve the health and wellbeing of all adolescents. It highlights opportunities and requirements for addressing and involving adolescents during the concept note development phase of the funding cycle, and presents issues that relate to adolescents in the context of resilient and sustainable systems for health and across the three diseases, emphasizing their different needs and challenges as compared with other populations.

This information note includes:

- Suggestions for practical solutions to a range of challenges faced by adolescents that are based on existing recommendations and technical guidance;
- Guiding questions to be used as countries proceed through the funding model (country dialogue, including review of national plans and concept note development);
- Key resources for designing and planning adolescent-focused interventions.

Issues that affect adolescents more acutely than other age groups - **gender inequality-related vulnerabilities**, especially for girls; **laws and policies** that deprive adolescents of information and access to services; **criminalization of same-sex and high-risk behaviors** that affect adolescents in key populations; **exclusion from school; stigma and discrimination** - indicate areas where more targeted, strategic investments are needed, and progress toward universal health coverage requires a transition from adolescent-friendly projects to adolescent-responsive systems.

## Investing for adolescents

There are opportunities to address the needs of adolescents - as beneficiaries and as partners - throughout all Global Fund processes. During the funding application process, key approaches that support strategic investments in adolescents include:

- Support the **full participation of adolescents in Country Coordinating Mechanism processes and the country dialogue**.
- Ensure that **adolescents and their specific needs are recognized and addressed in national plans** and policies.
- Support more consistent **disaggregation of data on adolescents**, which is essential to investing more strategically in this population. These data should clarify the country-specific situation for adolescents with regard to **epidemiology** of the three diseases; **service provision** (coverage, access, barriers); **social factors** that affect adolescent health outcomes; **sexual and reproductive health** issues that most concern adolescents; the extent to which **key populations** are excluded from services and broader protections; **human rights and gender inequalities**; **social values and norms**; and **community systems** in terms of how adolescents are involved in service delivery, advocacy and decision-making.
- Review existing funding streams and initiatives that serve adolescents to **determine the specific budget allocations for adolescents and where additional investments are required**.
- Distinguish **adolescents as a separate target group** in programmatic gap analysis.

## The concept note

This information note presents World Health Organization (WHO) recommendations related to resilient and sustainable systems for health and responses to HIV, TB and malaria. These recommendations should serve as the basis for interventions that are potentially included in the concept note; some of these are specific to adolescents, and some relate to broader populations that include adolescents.

When designing and planning interventions, there are a range of considerations that are critical to ensuring that programs are responsive to the specific needs of adolescents in general or sub-groups of adolescents. This information note discusses issues that must be addressed in order to reduce the barriers to services and supportive programs that adolescents - especially girls, adolescents in key populations or who practice behaviors similar to those of key populations, or other vulnerable adolescents- often confront. These include:

### **Adolescent considerations related to resilient and sustainable systems for health**

- For adolescents more than for other age groups, access to services is closely related to where and how those services are delivered. Countries should consider new approaches or ways of adapting current **service delivery** models to meet adolescents' needs more effectively, recognizing the heterogeneity of adolescents. **Models of service delivery** that increase acceptability, affordability and accessibility of services and the **quality of services** influence uptake of services by adolescents, effectiveness of services and whether adolescents will remain engaged in care.
- Strengthening **community systems** and adolescent leadership capacities can increase access and improve the quality of services and results for adolescents.
- **Structural barriers** and determinants of health related to age, sex, gender inequality, poverty, exclusion from education and human rights pose significant challenges for adolescents, especially for adolescents in key populations and other vulnerable groups.

### **Adolescent considerations related to disease intervention areas**

#### **HIV**

**HIV prevention.** Combination prevention programs use a mix of biomedical, behavioral, and structural interventions to meet the HIV prevention needs of particular individuals and communities so as to have the greatest possible impact on reducing new infections. Combination prevention elements that are most relevant to adolescents' needs - depending on the country's HIV epidemic or whether the adolescent is in a vulnerable or key population - include:

- **Behavioral interventions** such as comprehensive sexuality education, counseling, stigma and discrimination reduction;
- **Biomedical interventions** such as HIV testing services, male and female condoms and condom-compatible lubricant, sexual and reproductive health services, voluntary medical male circumcision, immediate ARV therapy initiation for adolescents with HIV, prevention of mother-to-child transmission (PMTCT), pre-exposure prophylaxis for older adolescents at substantial HIV risk, post-exposure prophylaxis following sexual and injection exposure, prevention of sexually transmitted infections, screening and treatment, and a comprehensive harm reduction package for adolescents who inject drugs;
- **Structural interventions** that address gender, economic and social inequalities; decriminalization of same-sex behavior and sex work, drug use and use of harm reduction services; protection from police harassment and violence; legal reform, particularly regarding age of consent and parental consent laws.

**HIV treatment, care and support.** This information note discusses new WHO recommendations on **ARV therapy initiation criteria** for adolescents, **selection of ARV regimens** and composition of **the clinical care package** for adolescents, which should include cervical cancer screening and HPV vaccination<sup>1</sup>. Support for adherence to treatment and retention in care includes recommendations on **adolescent-friendly health services** and **support for disclosure** as well as advice on innovative service delivery that is more appropriate for adolescents. New recommendations on the **frequency of clinic visits** and **the differentiated care framework** are particularly relevant for adolescents.

- **TB/HIV**

Countries need to focus on strengthening health systems and community systems to **increase access to integrated services for adolescents and tailoring the “three I’s” for TB/HIV for this age group - intensified case finding, management of latent TB infection and infection control**—to reduce the burden of TB among adolescents living with HIV. Adherence support is particularly important for adolescents with comorbidities and the pill burden is even higher, increasing the potential for non-adherence.

All TB/HIV recommendations and collaborative activities are relevant for adolescents.

- **Tuberculosis**

While evidence specific to adolescents and TB is limited, the characteristics of adolescence point to the need for **innovative approaches to expand screening and contact tracing among adolescent networks, promote health-seeking behavior for TB prevention, increase awareness, diagnosis and treatment and to reduce the stigma and discrimination** that may result from disruption to normal routines when treatment is required. Additionally, increasing awareness on TB infection transmission is particularly important since adolescents not only present mostly adult-type TB, with more likely infection capacities than younger children, but also that they share more common spaces within communities, again increasing the risk of infection.

All TB recommendations for children or adults are relevant for younger or older adolescents.

- **Malaria**

In general, malaria infection in adolescents is an under-recognized problem, and the prevention, diagnosis, and **treatment of malaria should be a high priority in adolescent health programs**. Malaria in pregnancy is associated with severe maternal, fetal and neonatal consequences that are particularly relevant to pregnant adolescent girls. As first pregnancies are at highest risk for malaria infection, and in many malarial countries over 50 percent of first pregnancies are in adolescents, prevention and **treatment of malaria should be an important component of antenatal services for adolescents**.

HIV infection increases *Plasmodium falciparum* malaria prevalence during pregnancy, especially during the first pregnancy, which, in Africa, is often in adolescence; **strategies to reduce adolescent malaria or HIV should, therefore, provide a continuum of care** - before conception, during pregnancy and post-partum, including appropriate information and preventive and curative services.

All malaria recommendations for children or adults are relevant for younger or older adolescents.

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<sup>1</sup> Two HPV vaccines are licensed for use in many countries and supported by GAVI.

# I. Introduction

## 01 Overview

Ambitious new global health targets and commitments aim to reduce health inequities, increase resilience in health systems and accelerate responses to HIV, TB and malaria.<sup>i, ii, iii, iv, v, vi</sup> Addressing the needs of adolescents is essential to the success of those targets and commitments, yet they are being left out of responses to major health challenges. Global health investments have not prioritized adolescents: they are often not recognized as different from younger children and adults, they are often excluded from equal participation in society, and they seldom have a voice in political or civic engagement processes. Services tailored to adolescents' needs do not exist in many countries at the national program level, and services that are available often present many legal, social and logistical barriers to adolescents, preventing them from claiming their right to health. Understanding what is different for adolescents and how to invest more strategically in this age group will be required to realize the goals and objectives of global health agendas.

## 02 Rationale

Adolescents have specific needs that are distinct from those of younger children or adults, yet this has not been consistently recognized in the health sector. Consequently, this age group has generally not been prioritized for research, data collection or targeted interventions. Data that are available are imprecise, and, for HIV, TB and malaria, there is limited evidence about what interventions work specifically for adolescents in high-burden settings. This makes it difficult to plan programs that effectively address the challenges that adolescents face and allow them to claim their rights to autonomy and health. Legal, gender inequality-related, social, cultural, economic, institutional and human rights barriers to services also affect adolescents, especially adolescent girls, more acutely than any other age group. Furthermore, adolescents are not sufficiently involved in the work that would improve access to and quality of services and support them to remain in care.

This Adolescent Information Note supports strategic investments by the Global Fund to improve the health and wellbeing of all adolescents.<sup>2</sup> It highlights opportunities and requirements for addressing and involving adolescents during the concept note development stage of the funding cycle, and presents issues that relate to adolescents in the context of resilient and sustainable systems for health and across the three diseases, emphasizing their different needs and challenges as compared with other populations.

This information note includes:

- Suggestions for practical solutions to a range of challenges faced by adolescents that are based on existing recommendations<sup>3</sup> and technical guidance;
- Guiding questions to be used as countries proceed through the funding model (country dialogue, review of national plans and concept note development);
- Key resources for designing and planning adolescent-focused interventions.

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<sup>2</sup> The issues and interventions discussed in this information note may have beneficial impacts for the broader group of young people (10-24 years).

<sup>3</sup> Some formal recommendations issued by WHO are adolescent-specific, others have relevance to adolescents as part of broader population groups.

## Box 1. Definitions

### Adolescents

WHO defines adolescents as **people between 10 and 19 years of age**, so the majority of adolescents are included in the age-based definition of “child” adopted by the Convention on the Rights of the Child <sup>vii</sup> as a person under the age of 18 years. There are other overlapping terms defined by the United Nations, such as “youth” (15–24 years) and “young people” (10–24 years). But age is only one characteristic that delineates this period of development. A 10-year-old is very different from a 19-year-old. To accommodate the different phases of development in the second decade of life, adolescence is often divided into early (10–13 years), middle (14–16 years) and late (17–19 years) adolescence.<sup>viii</sup> Countries will need to consider those differences when planning HIV, TB and malaria prevention, treatment and care interventions for adolescents.

### Key populations

**For HIV**, key populations are defined population groups who, due to specific higher-risk behaviors, are at increased risk of HIV, irrespective of the epidemic type or local context. They often have legal and social issues related to their behaviors that increase their vulnerability to HIV. The five key populations are men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers, and transgender people.<sup>ix</sup>

Adolescents may belong to one or more of these key populations, or engage in activities associated with these populations. Widespread discrimination, stigma and violence combined with the particular vulnerabilities of youth, power imbalances in relationships and, sometimes, alienation from family and friends increase the risk that they may engage - willingly or not - in behaviors that put them at risk of HIV, such as frequent unprotected sex and the sharing of needles and syringes to inject drugs.<sup>x</sup>

It may often not be appropriate to label younger adolescents (10-14 years) as “key populations”, especially regarding sex workers. Sex work is consensual sex between adults, when money or goods are exchanged for sexual services, either regularly or occasionally; sex workers include female, male and transgender adults. The term “sex work” is used in this technical note when referring exclusively to those aged 18 years or older. When referring to adolescents below the age of 18, reference is made to sexual exploitation of children, in accordance with article 34 of the Convention on the Rights of the Child, which ensures the protection of all children from all forms of sexual exploitation and sexual abuse.<sup>vii</sup>

**For TB**, the Global Fund identifies specific groups as key populations: prisoners and confined populations, people living with HIV, refugees and indigenous populations. Other groups found to be more vulnerable to TB include miners, people who use drugs and urban slum dwellers.<sup>xi</sup>

**For malaria**, key populations are not as well defined as for HIV and TB; however, refugees, migrants, internally displaced people and indigenous populations in malaria-endemic areas (including adolescents) are often at greater risk of transmission and usually have decreased access to care and services.<sup>xii</sup>

### Vulnerable adolescents

Adolescents who are not in key populations but who may be particularly vulnerable include: orphans; those living on the streets or in child-headed households; adolescents with disabilities; those affected by poverty or exclusion from school; girls engaged in sex with older men and in multiple concurrent sexual partnerships; girls subjected to gender-based violence; and adolescents affected by sexual exploitation and human trafficking.

## Adolescence is different

Adolescence is a distinct time of life, and adolescents are different from younger children (under 10 years of age) and adults. Adolescence is a period of opportunity to foster positive and healthy attitudes, norms, decision-making skills, practices and behaviors. At the same time, adolescents are unique in the way they understand and are influenced by different types of information, and in the way they think about the future and make decisions in the present. Adolescents have evolving capacities for assessing risk and for making decisions, which, along with their emerging sexuality and autonomy, influence behaviors that can impact their immediate and long-term emotional and physical health.<sup>xiii</sup> They also have elevated health risks due to the rapid physical, neurodevelopmental, psychological and social changes of this time of life.<sup>viii</sup> These characteristics exacerbate the impact of poor-quality health services and barriers to their access and influence the way that adolescents engage with services and health providers. Adolescence is also a time of considerable social transition: identification with a peer group may become more important than connections with family, and peers become more influential on decision-making and behavior. However, family remains an important support structure for many adolescents, and this role remains integral to the health and wellbeing of adolescents.<sup>4</sup>

To a greater extent than in other age groups, adolescents are different from each other. There is significant variation in the timing of developmental milestones and in the timing and degree of changes in rates of growth during adolescence. As a result, there can be great differences in development and vulnerabilities among adolescents of the same age, and there are often significant differences between adolescent girls and adolescent boys.<sup>xiv</sup> Some adolescents identify as transgender;<sup>x</sup> others, as in adult populations, identify outside of a gender binary.<sup>xv</sup> Not all adolescents attend school. Adolescents who are on treatment for HIV or TB, or both, may be excluded from school and isolated from their peers. They live in urban and rural settings with different types and levels of services available. Some adolescents live without parental support. The heterogeneity of adolescents requires approaches that consider the broad and specific needs of sub-populations of adolescents.

Structural and social challenges affect adolescents more acutely than other age groups, having a significant impact on access to information and services. For example, criminalization of certain acts is a significant deterrent to seeking services, especially for adolescents from key populations; age-of-consent barriers prevent access to vital HIV and sexual and reproductive health information and services; and financial constraints make it impossible for many adolescents to pay fees for services. An understanding of the key determinants of adolescent health, and how they may change for different ages or sub-groups of adolescents, is important to identify which adolescents are most vulnerable; to indicate areas where targeted, more strategic investments are needed; and to facilitate the involvement of non-health sectors that influence adolescent health outcomes - e.g. education, labor, social welfare, and justice, among others. (See Box 2.)

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<sup>4</sup> In some settings, key community members such as religious, cultural or political leaders also play important supportive roles in adolescents' lives.

**Box 2. The structural and social determinants of adolescent health<sup>viii</sup>** (adapted from referenced source)

**Individual characteristics** such as age, sex, gender, marital status, disability, knowledge and aspirations, individual behaviors

**The immediate environment** including families, peers, teachers and schools, service providers and other significant adults in the lives of adolescents

**Social values and norms** including social pressures related to early marriage and stigma around sexuality, gender identities and sexual orientation

**Gender-related vulnerabilities** that lead to child marriage, violence, poverty, harmful cultural practices and sexual exploitation, especially when sex becomes a transaction to fulfill basic rights to education, health and protection

**Policies and laws**—especially regarding age of consent, mandatory reporting, and access to HIV testing and contraception—can diminish or perpetuate the social and economic disparities that undermine adolescents' health, decrease access to services and interfere with self-determination

**Criminalization** of same-sex practices, sex work, drug use and HIV transmission

**Stigma and discrimination** from health workers, school nurses, peers and community members may affect adolescents who seek sexual and reproductive health services, HIV testing, treatment and care

**Social determinants**, or the conditions in which adolescents live, grow and develop that produce inequalities and discrimination based on gender, race, class, or other characteristics

**Access to education** is protective against many negative outcomes, and often serves as an entry point to a range of health and supportive services - such as comprehensive sexuality education<sup>xvi</sup> which can be provided in and out of schools - that can provide adolescents with accurate information and education about their sexuality and about sexual and reproductive health issues, is not provided in many settings

**Financial requirements** such as fees for services and transportations costs

**The physical and biological environment**, e.g. housing and pollution, and the prevalence of malaria, water-borne helminthes or HIV

**Violence** such as gender-based violence (e.g. intimate partner violence, sexual violence, trafficking, female genital mutilation, early, child and forced marriage) as well as other forms (e.g. related to conflict, gangs, bullying, maltreatment by adults in schools or at home)

## Data on HIV, TB and malaria in adolescents

There is a significant burden of disease during the adolescent years, and in many countries adolescents have benefitted much less from decreases in mortality than children in the first decade of life.<sup>viii</sup> However, data on adolescents are limited and analysis of existing data is weak, so we do not fully understand how adolescents' needs are being addressed or neglected by health systems. Emerging evidence on HIV, TB and malaria indicates a need for urgent attention to adolescents as part of comprehensive responses to these diseases.

### *Incidence, prevalence and mortality*

**HIV.** Data show increased HIV vulnerability in the second decade of life. While HIV-related deaths are decreasing in all other population groups,<sup>xvii</sup> in adolescents they are estimated to have tripled since 2000, making HIV the leading cause of death for adolescents in Africa, and the second leading cause of death for adolescents globally.<sup>xviii</sup> Girls in sub-Saharan Africa are particularly affected by this trend;<sup>xix</sup> in 2013, an estimated 250,000 adolescents aged 15–19 were newly infected with HIV, with two-thirds of the infections occurring in adolescent girls. In the Asia-Pacific region, there were an estimated 50,000 new HIV infections among 15-19 year olds in 2014, including among young key populations, and 220,000 adolescents (10-19 years) are now living with HIV.<sup>xx</sup> Globally, every hour, 26 adolescents are infected with HIV, and an estimated 2 million adolescents are now living with HIV.<sup>xxi</sup> Where data for young key populations are available, HIV prevalence is often found to be significantly higher than among the general youth population.<sup>xxii</sup> Emerging evidence indicates that adolescents living with HIV are underserved by current HIV services and have significantly worse access to and coverage of ARV therapy.<sup>xxiii</sup> Adolescents are at high risk of loss to follow-up before and after ARV therapy initiation, while adolescent girls aged 15–19 years who are enrolled in PMTCT services attend late and have worse health outcomes. Many adolescents, particularly girls, are subjected to gender-based violence, including sexual violence, and data show that gender-based violence is associated with a higher risk of HIV.<sup>xxiv</sup>

**TB.** There were an estimated 800,000 new cases of TB among adolescents in 2012 (around 180,000 in the 10–14 age group and around 617,000 in adolescents aged 15–19 years).<sup>xxv</sup> Although the risk of TB is lower in adolescence than in middle and late adulthood, in endemic settings TB increases markedly between early adolescence and young adulthood (even in settings with low HIV prevalence), and adolescents in high-transmission settings experience a substantial burden of disease.<sup>xxvi</sup> There have been no large-scale epidemiological studies of bacteriologically confirmed TB in adolescents living with HIV, and there are persistent diagnostic challenges in this group.

Young women of reproductive age seem to be at particular risk of TB, and data on TB in pregnancy is sparse but some available data indicates that 216,500 (95 percent uncertainty range [192,100-247,000]) active TB cases were reported in pregnant women globally in 2011<sup>5</sup>. TB in pregnancy can have serious implications on the welfare of the mother and the fetus, which may result in low birthweight of the newborn, premature labor, TB transmission to the newborn and heightened maternal and infant mortality risk (especially in the context of high HIV co-infection).

Although they may represent a small proportion of all TB patients in a given country, adolescents and young adults in high transmission settings are at substantial risk of active pulmonary TB, and they may require enhanced support to access health services and remain engaged in care, including adherence support for TB and HIV treatment, and especially for multidrug-resistant TB (MDR-TB) treatment.<sup>xxvii</sup>

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<sup>5</sup> Sugarman J, Colvin C, Moran AC, Oxlade O. Tuberculosis in pregnancy: an estimate of the global burden of diseases. *Lancet Global Health* 2014; 2: e710–16.

**Malaria.** In 2005, malaria accounted for 7.4 percent of all the adolescent deaths reported to WHO.<sup>xxviii</sup> Among younger adolescents (10-14 years), malaria was the most common cause of death in 2005, accounting for 14.1 percent of deaths from all causes. Adolescent males in some regions may have higher incidence of malaria due to occupational exposure. Malaria in pregnancy, particularly in first pregnancies, can have severe negative consequences for maternal, fetal and infant health, and over 50 percent of first pregnancies in malarial countries are in adolescents.<sup>xxix</sup> The increasing HIV prevalence among adolescent females in many malarial countries is also a concern, as malaria in first pregnancies has been shown in some settings to be more common in women with HIV.<sup>xxx</sup> See Section C.1.3 on the structural determinants of health.

### **Adolescent-responsive solutions to programmatic challenges**

There are some data to support the effectiveness of interventions (especially related to HIV responses)<sup>xxxi</sup> or approaches that have the potential to address adolescents' health needs in more responsive ways (see Box 3). Advocacy with governments to address the determinants of poor adolescent health is fundamental to making national health systems more responsive to adolescents' needs, and progress toward universal health coverage requires a transition from adolescent-friendly projects to adolescent-responsive systems.

#### **Box 3. Toward adolescent-responsive health systems<sup>viii</sup> (adapted from referenced source)**

Strengthen institutional and technical capacities to generate data and evidence about what works for adolescents, so that **programming is informed by research**

Harmonization of legal and judicial measures to **ensure that specific provisions are guaranteed in national laws and policies for adolescent health**, including the possibility of medical treatment without parental consent

Services should be geared for adolescents to address their **sexual and reproductive health as well as the full range of adolescents' health and development needs**

Adoption of **quality standards** and implementation of **routine monitoring and evaluation mechanisms** to review progress over time

**Expanded coverage**, including mainstream and community health services, school health services, transition to electronic health information systems and mHealth initiatives that use mobile communication technologies to reach adolescents

Pre- and in-service training for health professionals for improved **knowledge of adolescent health and development, in all its diversity, and their implications for clinical practice**

Facilitate **involvement of community gatekeepers** to promote and support adolescent health-seeking behaviors and adolescent health programs

Universal coverage through consideration of **pooled prepaid sources of funds** to include priority services for all adolescents

This information note presents adolescent considerations throughout the Global Fund model, for resilient and sustainable systems for health and when planning, implementing and monitoring prevention, treatment and care interventions within the three disease areas.



## II. Investing for Adolescents

There are opportunities to address the needs of adolescents, as beneficiaries and as partners, throughout all Global Fund processes. This section draws upon key participation tools (See Annex 2 Section B.1) and summarizes ways that countries can ensure more strategic Global Fund investments in adolescents during the funding application stage of the funding model. Adolescent considerations are also important during grant making<sup>6</sup> and grant implementation<sup>7</sup> stages of the model.<sup>xxxii</sup>

Adolescents should participate in meaningful ways in the country dialogue, be included as target populations in national plans and policies, and be supported and empowered to contribute to the process of concept note development. Engaging with younger adolescents will require engaging with families and caregivers as well; safeguarding provisions are especially important in these cases. Box 4 highlights opportunities to strengthen adolescent participation in the Country Coordinating Mechanism, which drives all Global Fund processes at country level.

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<sup>6</sup> During grant making, country teams should work with Country Coordinating Mechanisms to refine broad programming approaches articulated in the concept note to ensure that adolescents are being addressed. Country teams should also work with the Technical Review Panel to flag adolescent-responsive strategies that may not have been included in the concept note; Technical Review Panel feedback can recommend re-allocation toward more strategic investments for adolescents.

<sup>7</sup> When grant implementation is underway, monitoring and evaluation activities (based on disaggregated data) can assess the impact of interventions on adolescent health and indicate a need to re-program funds to adjust strategies and approaches as needed. Even when programs target broader populations, adolescents should be involved in planning, decision-making, monitoring and reporting processes.

**Box 4. Opportunities for Country Coordinating Mechanisms to strengthen processes for adolescents<sup>xxxii</sup>** (adapted from referenced source)

Provide **information sessions** for Country Coordinating Mechanism members and for prospective adolescent participants on how and why to ensure meaningful engagement of adolescents in Country Coordinating Mechanism processes.

Ensure **adequate and direct representation of adolescents** on the Country Coordinating Mechanism and accountability of the Country Coordinating Mechanism for ensuring that individuals or groups that represent or address adolescent issues or conduct adolescent programming contribute directly to Country Coordinating Mechanism activities.

Ensure that there is **representative participation of adolescents affected by HIV, TB or malaria, and those who are most likely to be excluded or prevented from having a voice.**

Ensure **adequate technical capacity through training/orientation/capacity-building of adolescent representatives** to meaningfully participate (e.g. they have an understanding of Global Fund-related processes, policies, mechanisms, guidance as well as understanding programs, data and interventions).

Build **capacity of Country Coordinating Mechanism members** to support and work with adolescent representatives with sensitivity, respect and accountability; technical partners with adolescent expertise should contribute to this work.

Clearly **communicate existing guidance sub-recipient and sub-sub-recipient selection** to organizations/networks of young people.

Establish a **feedback mechanism** where adolescents can share their views on quality and satisfaction with programs inclusive of, or targeting, adolescents; feedback should also be provided to adolescents to ensure accountability to them throughout the process.

Experts or representatives of groups engaged in adolescent programmes make **presentations** to the Country Coordinating Mechanism on a regular basis to address adolescent issues and update programme data specific to adolescents.

Ensure the **country data are disaggregated** in a manner that allows data for adolescents to be made explicit, broken down by age groups and including different sub-groups of adolescents, (formal requests can be made through the agenda); data to be disaggregated by sex and 5-year age bands for the first 25 years of life.

Ensure **greater access to resources for community systems strengthening** for networks and organizations of young people/adolescents, i.e. through regional grants.

Advocate with technical partners for **lower ages of consent and appropriate training of adolescent health-care providers based on existing technical guidance<sup>xxxiii</sup>** to ensure access to adolescent-friendly prevention, treatment and care interventions for adolescents without the need for parental/guardian consent.

## 01 Country dialogue

Adolescents have a right to participate in decisions that affect their lives, to help identify ways to adapt policies and programs and to shape the design, implementation, monitoring and evaluation of interventions. They should be viewed and engaged as equal partners<sup>8</sup>, key actors, stakeholders and leaders; be aware of their right to participate; be provided with equal opportunities and given space within the process; and be empowered through training and mentorship to acquire the necessary skills to contribute to the country dialogue in meaningful ways. Adolescents' contributions need to be viewed as meaningful by the adolescents themselves and by others involved in Global Fund processes. Their opinions must be taken seriously and their involvement must have influence and be allowed to provoke change.

Participation can take different forms depending on the types of decisions that are being made; it can include ad hoc inputs, structured consultation, influence, delegation, negotiation and adolescent-run activities.<sup>xxxiv</sup>

Consultation can also take many forms to ensure broad inputs on adolescents' needs, and a transparent and fair process should be used in the selection of adolescent participants in consultations. As part of community caucusing processes, there should be opportunities and support for different sub-groups of adolescents to identify unmet needs, barriers and challenges, to formulate recommendations for addressing those needs and to take part in the country dialogue. Mechanisms for ensuring the lawful, safe and productive engagement of adolescents may require innovative thinking; for example, technology-based approaches (internet, social media, mobile solutions) can be used to reach out to adolescents in confidentiality, to initiate connections and to collect their inputs.

Tokenism should be avoided by systematically providing opportunities for adolescents to participate throughout all stages of Global Fund processes,<sup>xxxv</sup> beginning with the country dialogue. Their representation is vital to ensure that concept notes include adolescent-responsive programs. Box 5 highlights concrete ways to support adolescents from the very beginning of the process.

Technical partners have a responsibility to ensure that normative guidance related to adolescents is prioritized in Country Coordinating Mechanism discussions, and all ministries serving adolescents along with adolescent program implementers and community-based partners should be actively involved in the country dialogue.

### **Consideration of confidentiality and safeguarding mechanisms:**

All organizations should have up-to-date protection policies and safeguarding procedures that are consistently implemented. Some national regulations for safeguarding those under 18 specify the reporting of any discovery of harm or certain behaviors such as having sex under the age of consent, having sex with someone of the same sex in contexts where this is illegal, or selling sex. Country dialogue coordinators need to be aware of national laws and possible exemptions, e.g. reporting is not allowed without the adolescent's consent, or reporting is only required for certain professions. Adolescent participants should be aware of these laws prior to engaging in activities and give their permission regarding reporting.

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<sup>8</sup> An equal partner is one who is involved throughout the process, and who is provided equal opportunity to contribute to all phases of planning, implementation and evaluation.

## Box 5. Supporting adolescent participation in the country dialogue<sup>xxxvi</sup>

Adolescents need to be supported to:

*Find out **who** convenes the country dialogue, **where** it takes place, **when** the next convening will happen and **what** form the dialogue will take.*

***Consult with other adolescent-led or adolescent-focused organizations** to ensure that their voices and views are reflected in well-founded and representative recommendations.*

***Learn from other civil society groups** about their involvement in the Global Fund's processes and work, and to forge alliances that will support adolescent priorities.*

***Participate fully in the country dialogue** and report back to youth organizations and civil society partners.*

***Know their rights** to confidentiality, informed consent, voluntary participation, feedback and complaint/redress mechanisms, and information in language that is understandable to adolescents. This includes ensuring making sure that the **limits of confidentiality**, according to national safeguarding regulations, are made clear.*

*See Annex 1 for key guiding questions for country dialogue.*

*See Annex 2 for key resources for adolescent participation in the country dialogue.*

## 02 National plans and policies

Funding applications should be aligned with national plans and relevant sectorial policies that specifically address the responsibilities of countries vis-à-vis adolescents, including upholding their right to health. In some countries, disease-specific policies and plans may not mention adolescents as a separate target population or include specific recommendations or implementation considerations for this population. Broader national policies in other sectors, such as education, affect or include adolescents, but may not explicitly address health or disease-related issues. Country Coordinating Mechanism members need to make efforts to identify and address gaps in plans and policies to ensure that adolescents' needs are met. (See discussion of strategic information in Section 3.1 on establishing the country context.)

### Consideration for funding requests:

When gaps are identified with respect to the inclusion of adolescents and adolescent-specific interventions in national plans and policies, countries can incorporate adolescent-specific interventions and justifications within their overall national investment case and include the work of revising or extending national plans and policies in the funding request.

*See Annex 1 for key guiding questions for review of national plans and policies.*

*See Annex 2 for key resources for including adolescents in national plans and policies.*

## 03 Concept note development

### Country context

Strategic information informs policymaking and program design by helping to define priorities, support advocacy, guide selection of appropriate interventions and monitor coverage and quality.<sup>viii</sup> Greater investments in country-specific strategic information are needed to understand adolescents as a separate group, the particular challenges they face in accessing prevention and treatment services, remaining in care and adhering to treatment, as well as the epidemiology of the three diseases among adolescents. Retrospective data from routine surveys on adults can be used to provide some information on earlier cohorts of adolescents - e.g. age at first sexual intercourse, injecting practices, selling sex - to justify interventions among current adolescents or further research. Gaps in strategic information on adolescents are significant in most countries, but they can become opportunities through inclusion in the Global Fund grant application. Box 6 highlights ways to strengthen strategic information for adolescents.

#### **Box 6. How to strengthen strategic information for adolescents: actions and opportunities<sup>viii</sup>**

Give more attention to strategic information for the adolescent years.

Disaggregate all data on the first 25 years of life by sex and 5-year age groups.

Integrate an adolescent component into all data collection systems, including health management information systems.

Identify and respond to specific weaknesses in data collection.

Make it possible to link data collected on adolescents through expanded use of electronic systems and improved coordinating mechanisms.

Synthesize and disseminate the evidence base for action.

Strengthen research on adolescent health: problems and responses.

### ***Disease, health and community systems context***

The country-specific situation regarding adolescents has many epidemiological, systems-related, socioeconomic and behavioral dimensions. The following elements should be considered:

- **Epidemiology** for each disease and for different groups of adolescents, and the underlying determinants;
- **Service provision** information about coverage and access to adolescent-specific interventions and services (including location, integration of services, quality and responsibility);
- **Social factors** including where and how adolescents live (with parents or guardians, in child-headed households or on the street), whether they are subjected to violence and exploitation, and whether they attend school;
- **Sexual and reproductive health issues**, such as access to contraception, and whether adolescent girls in particular are married or not, have had a pregnancy or not, and whether they are subjected to gender-based violence and sexual exploitation;
- **Key populations** for each disease, and to what extent they are excluded from health services and broader protections;

- **Human rights issues**, including legal barriers and gender inequalities that affect adolescents as well as the overall quality of health and community systems that are serving adolescent populations;
- **Social values and norms** as well as the status of protective policies and their implementation;
- **Community systems**. It is important to understand how adolescents are involved in and contribute to service delivery, advocacy and decision-making as part of community systems. This should include whether community networks are making space for adolescent groups, e.g. by incorporating the priorities and participation of adolescents with HIV or who are in key populations into the work of people living with HIV or key population networks.

It is important to find and use all available country-specific data regarding adolescents. Analysis of existing program data and data from new initiatives such as *All In*<sup>xxi</sup> and *DREAMS*<sup>xxvii</sup> may help to clarify adolescents' needs at country level. Key assessment tools such as the UNAIDS and Stop TB Partnership Gender Assessment Tool<sup>xxviii</sup> may be adapted to focus on adolescents. Research that has already been carried out, such as socio-behavioral research and implementation science, may provide findings that can be applied to adolescent-specific interventions. There may be studies underway that provide a glimpse of new findings that are emerging. Identification and prioritization of gaps can inform the design of new studies that are well targeted and relevant to country-specific issues. Further understanding can be gained from experts in adolescent health and development who are invited to advise the Country Coordinating Mechanism. Data may also be found outside routine systems, e.g. in small studies, qualitative data and unpublished reports, using caution when extrapolating and generalizing the findings.

### Research gaps

There are many research gaps with respect to interventions for adolescents across the three diseases and for resilient and sustainable systems for health. This is especially true for TB and malaria prevention, treatment and control. Countries should consider developing adolescent-specific, prioritized research agendas to develop the evidence base for future investments in adolescents. An understanding of the ethical, logistical and social issues involved in collecting data and ensuring referrals for those in need is essential. It is also important to include adolescents in survey design to ensure that the instruments are relevant and accepted by the study population.

*See Annex 1 for key guiding questions regarding the country context with respect to adolescents.  
See Annex 2 for key resources to guide definition of country context with respect to adolescents.*

### **Disaggregation of data**

Many types of data are needed to understand adolescents' needs in specific settings:

- Health impact data from vital registration statistics, disease surveillance, clinical reporting systems and household surveys;
- Outcome data on health-related behaviors and service coverage from household and school-based surveys;
- Program input data from administrative sources;
- Program output data from routine facility data collection and facility assessments of services and service quality.<sup>viii</sup>

Disaggregation of data<sup>9</sup> is one of the keys to making programs more adolescent-responsive and monitoring progress, answering key questions about adolescents with regard to engagement and effectiveness of

<sup>9</sup> In general, data should be disaggregated by sex, age, key population and geographical location. (WHO recommendation, 2015.)

services.<sup>viii</sup> To reach adolescents with appropriate services, strategic information must be sensitive to population characteristics that increase vulnerability. Monitoring disease burdens and coverage of related services by age, sex, and other characteristics such as geographic locations and specific high-risk practices of key populations can assist with targeting services more specifically to the adolescent populations who need them. See Box 7 for ethical considerations when collecting data on and with adolescents.

**Disaggregation by age** is important to understand changes in prevalence and incidence, to characterize how the epidemic is evolving, to monitor equity of access to services and to support the planning of program responses in specific adolescent age groups. WHO recommends that data be disaggregated into standard age groups with 5-year age groups of 10–14 and 15–19 years for electronic systems.<sup>xxxix</sup>

**Disaggregation by sex** is vital to understanding the different impacts of specific diseases on adolescent girls and boys, and on transgender adolescents.<sup>x</sup> This facilitates planning for appropriate interventions to address the specific needs of each group, and to prioritize investments more appropriately.

**Data disaggregated by geography** to sub-national and site level is important to help focus and prioritize the response to the areas where it can have the greatest impact for adolescents. Mapping exercises have also been important for focusing outreach and prevention services on specific sites, places and populations.<sup>xi</sup>

**Consideration for funding requests:**

When countries do not have data on adolescents, or when analysis of existing data is weak, strategic information systems for data collection and analysis as well as specific projects that improve the knowledge base and understanding should be a key item in the concept note for health systems strengthening.

**Box 7. Ethical considerations**

In line with national guidelines, when collecting data on adolescents, and when including minors and adolescent key populations in data collection activities, they must be fully informed to consent, to be surveyed or to have data recorded about them, and they must be guaranteed confidentiality and access to protective services if required (See sidebar in Section B.1).

In some countries, depending on national consent policies, it may be necessary to obtain parental/guardian consent for adolescents to be involved in these activities. There may also be policies with regard to “mature minors” that cover adolescents who are married, or who live independently or in child-headed households, or others who may have the capacity to understand the implications of their health care and participate in decision-making.<sup>xli</sup>

*See Annex 1 for key guiding questions regarding disaggregation of data.*

*See Annex 2 for key resources on disaggregation of data.*

**Funding landscape**

Once the country context is understood and gaps in data and understanding are identified, the funding landscape is essential to decisions about how to prioritize adolescent-specific elements of the funding request. Existing funding streams and initiatives that serve adolescents—disease-specific or part of broader adolescent health or response areas, e.g. **treatment** or **community systems strengthening**, and other sector funding for adolescents that can affect health outcomes, e.g. **education** and **social protection**—should be reviewed to determine the specific budget allocations for adolescents and where additional investments are required.

<sup>10</sup> Disaggregation by sex does not capture the complexities of gender (in relation to gender non-conforming adolescents); the unmet needs of these adolescents should be considered in certain settings and included in Global Fund concept notes.

Some initiatives for adolescents may be evidence-based and well funded but exclude certain groups of adolescents, e.g. those who are not attending school, or who are members of marginalized groups, or who live in remote, rural or non-prioritized regions. Where there is evidence, country concept notes can address those gaps in coverage, through high-impact interventions in areas of high disease burden, some of which may need operational research to determine the best mode of implementation.<sup>xxx</sup> Quality of existing or planned services should also be assessed through in-depth consultative processes, evaluation reports and client satisfaction surveys to determine additional funding requirements.

#### **Proportionate allocations for adolescents:**

In order to determine if the allocations for adolescents are proportionate to the adolescent populations targeted, both accurate demographic baselines and separate budget lines for adolescents are needed for comparison. Joint planning between the Ministry of Health and other relevant sectors will be essential to accomplish adequate levels of investment for adolescents.<sup>xxxii</sup>

*See Annex 1 for key guiding questions regarding the funding landscape for adolescents.  
See Annex 2 for key resources for analyzing the funding landscape for adolescents.*

## **Funding request**

### ***Programmatic gap analysis***

National or sub-national coverage indicators, affected population estimates and program targets rarely take into account adolescent-specific data for each disease and within health systems strengthening. Refinements to the programmatic gap analysis process will be needed to ensure that adolescents are represented as a separate target group.

*See Annex 1 for key guiding questions when conducting programmatic gap analysis for adolescents.  
See Annex 2 for key resources for programmatic gap analysis for adolescents.*

### ***Selection of priority modules and interventions***

**In all settings**, greater focus on adolescent-health programs is needed. Based on gap analysis, countries should select modules and interventions for inclusion in the grant application that have greatest potential impact for adolescents, or those that can generate evidence to make the case for greater investments.<sup>11</sup> **In low and concentrated HIV epidemics**, or where the national or sub-national disease burdens of TB and malaria are low, **general adolescent prevention programming** may not be required. But in those settings the most vulnerable adolescents, including those in key populations, or in specific high-burden geographic locations, must be addressed.

Strengthening **strategic information on adolescents** (see Section B.3.1) ensures more appropriate prioritization of interventions within relevant modules as well as further development of national policies and plans. At the same time, every effort needs to be made to ensure that responses to HIV, TB and malaria build on and contribute to strengthening the health systems that will respond to a much wider range of health-related problems that have an impact on adolescent health.

*See Annex 1 for key guiding questions for selection of priority modules and interventions.  
See Annex 2 for key resources for selection of priority modules and interventions for adolescents.*

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<sup>11</sup> The Global Fund encourages countries to include research components in concept notes for areas where data do not provide a precise picture of disease burdens and health system weaknesses; this is especially the case for adolescents.



### III. The Funding Request

Many WHO guidelines on HIV, TB, malaria and service delivery include recommendations for all age groups, and those for adults and/or young children will be relevant for adolescents. As attention is drawn to the adolescent agenda, more guidance is emerging on how to address their particular needs. Where adolescent-specific guidance is not available, harmonization<sup>12</sup> with recommendations for adults or children should be a priority. This section highlights adolescent-specific recommendations related to resilient and sustainable systems for health and disease intervention areas. For recommendations relating to broader populations, references are provided to the guidance and important implementation considerations for adolescents are discussed.

Strategic information used to develop the country context (see Section B.3.1), along with an analysis of the funding landscape (see Section B.3.2), will influence the choices that countries need to make about which interventions should be included in the funding request.

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<sup>12</sup> Harmonization facilitates health programming by identifying synergies within existing programs, taking advantage of overlapping goals and making optimal use of limited resources.

## 01 Resilient and sustainable systems for health

Building stronger, more adolescent-responsive and more resilient health systems is at the heart of investing more strategically and effectively in adolescents, and it is fundamental to achieving universal health care coverage for this age group. Addressing adolescent-specific service delivery and quality considerations are key to encouraging and supporting adolescents to seek services, to adhere to treatment and to remain in care. Understanding and investing in community systems that provide critical outreach and serve adolescent key populations or other particularly vulnerable groups can ensure that these marginalized and often hidden populations are not overlooked, abused and left behind. It is also essential to address structural barriers - laws and policies, economic constraints, mobility, and gender inequality-related vulnerabilities including violence, stigma and discrimination—in order to reach adolescents, especially those most at risk, with the services and support they need.

### **Addressing barriers to universal health coverage:**

To address the barriers to universal health coverage for adolescents, consider activities such as: identifying financial barriers to HIV, TB and malaria services; revising prepaid pooling arrangements to maximize the number of adolescents covered by them, and expanding the range of services covered by these arrangements to include services in the country's package for adolescents; reducing or removing out-of-pocket payments at the point of use.

### **Service delivery**

#### ***Models of service delivery***

For adolescents more than for other age groups, access to services is closely related to where and how services are delivered. Countries should consider new approaches or ways of adapting current service delivery models to meet adolescents' needs more effectively (see Box 8), acknowledging the heterogeneity of adolescents (discussed in section A.2.1). It is important to recognize that services are delivered differently at different levels of the health system (i.e. primary through tertiary levels of health care), and different models and packages will be required to address the needs of adolescents being served at these different levels.

#### **Box 8. Reaching adolescents**

Most adolescents do not seek services offered in formal health systems and structures, and flexible or innovative approaches are needed to take the services to them. Health services are reaching out and meeting the needs of adolescents where they attend school, where they work and where they socialize through:

- Peer-led services;
- Home-based services;
- mHealth and mobile services; and
- Services linked to outreach through social media and networks.

## ***Integrated and comprehensive services<sup>13</sup>***

Integration is an advantage for adolescents with busy lives and limited resources who are more likely to use services when they do not have to attend multiple clinics with long waiting times.

Integration of services allows a person to access as many services as possible in one place, and ideally at one time; makes it easier for providers to deliver comprehensive, multidisciplinary and consistent care and support; and facilitates any necessary higher-level referrals. Integration has been demonstrated as effective for HIV and the full scope of sexual and reproductive health services, for HIV and TB, and is also particularly important for delivery of mental health services and psychosocial support. Box 9 provides an illustration of the importance of integration for pregnant adolescent girls.

In countries where it is not possible to deliver dedicated services for adolescents, existing systems and services should be adapted, and providers trained and supported, to be able to respond to adolescents' needs. For example, harm-reduction services can serve a range of needs for adolescents who inject drugs, who may be reluctant to seek services in more formal settings. Task shifting can also facilitate integration; this increases providers' scope of work and requires appropriate training.<sup>xlii</sup>

### **Barriers to sexual and reproductive health:**

Barriers to sexual and reproductive health information, services and care must be reduced as a priority health intervention for adolescents.<sup>1</sup> Sexual and reproductive health services also offer a vital entry point—through integration or linkage—to a range of health services that adolescents need. Strengthening sexual and reproductive health services is essential to improving access to health care and outcomes for adolescents.

### **Box 9. Good practice: Integration of sexual and reproductive health and antenatal care**

Adolescent pregnancy is a major contributor to maternal and child mortality,<sup>14</sup> and to the cycle of ill health and poverty. Babies born to adolescent mothers account for roughly 11 percent of all births worldwide, with 95 percent of these births occurring in developing countries.<sup>xliii</sup> In low- and middle-income countries, complications of pregnancy and childbirth are the leading cause of death among young women and 15-19 year old girls, and unwanted pregnancies that end in abortions for this group are often unsafe.<sup>xliv</sup>

Adolescent pregnancy is a particular concern in many countries, and integrated services are important for delivery of timely antenatal care and broader maternal care for adolescents. Integration of services for adolescent girls can facilitate access to a range of contraception choices, early pregnancy testing, support for uptake and retention in antenatal care and referral to critical services (HIV testing services, PMTCT,<sup>15</sup> and TB and malaria testing, prophylaxis and treatment). Confidentiality and privacy are critical elements of all services for adolescents, but especially for pregnancy-related services.

<sup>13</sup> For all populations, WHO recommends integration of HIV services into other relevant clinical services, such as TB, maternal and child health, sexual and reproductive health services and drug dependence treatment. (WHO recommendation, 2014.)

<sup>14</sup> While not a primary focus of this information note, targeting the needs of pregnant adolescents is closely aligned with the Global Fund's emphasis on reproductive, maternal, newborn and child health (Strategic Action 1.4 in the Global Fund strategy 2012-2016).

<sup>15</sup> ARV therapy should be initiated in all pregnant and breastfeeding women living with HIV regardless of WHO clinical stage and at any CD4 cell count. (WHO recommendation, 2016.)

## ***Linkage of services***

When it is not possible to deliver certain services in one location or at one time, it is important to establish systems to link services and to ensure appropriate sharing of information between clinics, service delivery points and individual providers. For example, HPV vaccination services for adolescent girls, tetanus vaccination for adolescent boys and girls and voluntary male medical circumcision for adolescent boys are opportunities to link to comprehensive sexuality education and to sexual and reproductive health services; sexual and reproductive health services provide an opportunity for all adolescents in high-HIV prevalence settings to be referred to HIV testing services and to be screened for TB symptoms, or for pregnant adolescent girls to be referred to appropriate maternal health services.

Linkage is especially important for adolescents who may not understand the need for certain types of services, or that services are available or their location and hours of operation. Linkage is also important for supporting transition of adolescents from pediatric to adult services.<sup>16</sup> **Linking involves informing the client about other appropriate services and having a mechanism to link them to those services in a timely manner.** Incentives can be used to encourage adolescents to take advantage of linkages, e.g. separate queues, transport vouchers, buddy/peer supporters, and use of mobile technologies for reminders or clinic information. Linkage requires strengthening of coordination and collaboration between sectors, services and providers.<sup>xlv</sup>

## ***Decentralization of services<sup>17</sup>***

Decentralizing services to primary health care facilities can have a number of benefits for adolescents. It **eases the burden on other parts of the health system**, and, like community-based services, **brings services closer to home**. Similar to integrated services, decentralization often **reduces waiting times**. Access to decentralized services may increase the likelihood that adolescents will use services and stay engaged in care. Decentralization can also improve equity by facilitating access to services in places that are easier for adolescents to reach and that may be perceived as more confidential and safer than those in higher-volume clinics.<sup>xlvi, xlvii</sup>

## ***Community-based services***

### **Specific WHO recommendation for adolescents:**

*Community-based approaches can improve treatment adherence and retention in care of adolescents living with HIV.*<sup>xxxiii, 18</sup>

Community-based services are delivered closer to where adolescents live (at schools, pharmacies and youth centers, in their homes, and through mobile clinics and outreach strategies). They can also be delivered for a specific community of adolescents with common characteristics or challenges. Community-based services can reduce gaps in access to services for adolescents: with **fewer logistical and financial constraints and with services offered in familiar, welcoming and easily accessible settings**, community-based service delivery can increase uptake of services and retention in care, which supports adherence to treatment and more consistent and timely follow-up and referral to other needed services. An added benefit is that these services allow for **closer partnerships between health providers, support groups, clients and their families**, which is especially important for adolescents. However, the scope of community-based services may be limited with regard to complex health issues, and the “familiarity” aspect of community-based services may be a disincentive for some adolescents due to concerns about confidentiality.

*See Annex 2 for key resources on models of service delivery for adolescents.*

<sup>16</sup> Efforts should be made to ensure that transition is planned and managed as appropriate to different service delivery models.

<sup>17</sup> WHO recommends decentralization of ARV therapy services specifically; decentralization of the full range of HIV prevention, diagnosis, treatment and care services for key populations can also be considered. (WHO recommendation, 2013 (ART), 2014 (KP).)

<sup>18</sup> Community-based approaches are also important for programs serving the broader health needs of adolescents, including TB and malaria services, sexual and reproductive health and psychosocial support. Community-based services can be delivered through different models such as community-based organizations, local nongovernmental organizations or community health workers.

## Quality of services for adolescents

### Specific WHO recommendations for adolescents:

*Training of health care workers can contribute to treatment adherence and improvement in retention in care of adolescents living with HIV.*<sup>xxiii, 19</sup>

*Adolescent-friendly health services should be implemented in HIV services to ensure engagement and improved outcomes*<sup>20</sup>.

Quality of services can reinforce human rights-based approaches to health;<sup>xlviii</sup> for adolescents this is one of the most important factors in determining whether they will use services and remain in care. Adolescents' health-seeking decisions have significant individual and public health implications. In general, **adolescents want services that are “adolescent-friendly”**,<sup>xlix, 21</sup> in **safe and discreet settings** with spaces that ensure **confidentiality and flexible hours**, and they want **providers who are knowledgeable, non-judgmental and sensitive to their needs**. Of particular importance is the need for health services and decision makers to ensure that **protective services and mechanisms are in place** for this age group while recognizing the growing autonomy and evolving capacities of adolescents.

**Adolescent-friendly health services** - services that are accessible, acceptable, equitable, appropriate and effective - **are proven to improve utilization of services and health outcomes for adolescents and are recommended by WHO**. To support implementation, WHO and UNAIDS have developed a set of global standards of quality health care for adolescents.

**Box 10. Global standards to improve the quality of health care for adolescents!** (adapted from referenced source)

- 1. Adolescents' health literacy:** Systems in place to ensure that adolescents are knowledgeable about their health and know where and when to obtain services.
- 2. Community support:** Systems in place to ensure family and community recognition of the importance of providing services for adolescents and to build support for utilization of services by adolescents.
- 3. Appropriate package of services:** Provision of a comprehensive package of information, counseling, prevention, diagnostic, treatment and care services in the facility or through referrals and linkages.
- 4. Providers' competencies:**<sup>li</sup> Providers should have technical competence; providers and support staff respect, protect and fulfill adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitudes and respect.
- 5. Facility characteristics:** Convenient hours, welcoming environment, privacy and confidentiality maintained; necessary equipment, medicines, supplies and technology available for effective service provision for adolescents.
- 6. Equity and non-discrimination:** Facility provides quality services to all adolescents regardless of their ability to pay, age, sex, marital status, education level, ethnic origin, religion, sexual orientation or other characteristics.
- 7. Data and quality improvement:** Facility systematically collects, analyzes and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement, and staff are supported to participate in continuous quality improvement.
- 8. Participation:** Adolescents are involved in the planning, implementation, monitoring and evaluation of health services, and in decisions regarding their own care, as well as in certain aspects of service provision.

<sup>19</sup> Training, along with support and mentoring, is also important for ensuring that the health workforce is adolescent-competent to serve the broader health needs of adolescents.

<sup>20</sup> WHO (2016). Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection : Recommendations for a public health approach - Second edition. Geneva: World Health Organisation.

<sup>21</sup> Adolescent-friendly services can improve health outcomes, utilization and acceptability of services for adolescents, including those living with HIV.

Health providers are vital in supporting adolescents' health outcomes, and training strengthens their capacity to do this. Support for an **adolescent-competent workforce** ensures that providers have the knowledge, skills and attitudes to communicate effectively with adolescents at different developmental stages with diverse needs. Adolescent-competent providers also have the necessary knowledge to apply laws and policies that promote, protect and fulfill adolescents' rights to health care, while managing their patients' clinical care.<sup>li</sup> Training for working with adolescents is a continuous process that includes a range of elements that may include formal training events, job aids, supportive supervision, training follow-up and mentorship. It needs to be integrated into existing health training curricula and programs, so that all health providers are able to respond to the needs of adolescents in an integrated, non-judgmental and non-discriminatory way.

*See Annex 2 for key resources for improving the quality of health services for adolescents.*

## **Community systems**

Strong community action is central to resilient and sustainable systems for health<sup>lii</sup> and can have a direct impact on improving adolescent-responsive services. Strengthening community systems and adolescent leadership capacities can increase access and improve the quality of services and results for adolescents. This is achieved through **expansion of community-led service delivery, and reinforcement of networks and organizations that are led by or serve adolescents, especially those in key populations.**<sup>22</sup> This work can be done outside or in partnership with national health system structures, mechanisms and processes.

Some examples of **interventions to strengthen community systems** include:

- **Community mobilization** to improve social conditions for adolescents who are marginalized or discriminated against;
- **Empowerment of adolescents (especially girls) and their organizations, to participate in advocacy, decision-making, and planning and monitoring programs** that serve their needs through knowledge and skills-building initiatives;
- **Advocacy to promote enabling policies and legal reforms** aimed at increasing access to prevention and health services and strengthening the determinants of health for all adolescents as well as more social accountability and protection of human rights.
- **Education of community members** to understand the importance of the spectrum of adolescent health programs.

*See Annex 2 for resources for community systems strengthening to expand access to quality services for all adolescents.*

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<sup>22</sup> For key populations, especially men who have sex with men, receiving services that are peer-driven or peer-led is an important factor in uptake—irrespective of age cohort.

## Structural barriers

### Specific WHO recommendations for adolescents:

*Prohibition of marriage of girls before 18 years of age.<sup>liii, xliii</sup>*

*Increase educational opportunities for girls through formal and non-formal channels to delay marriage until 18 years of age.<sup>liii</sup>*

*Punishment for perpetrators of coerced sex involving adolescent girls,<sup>23</sup> enforcement of these laws and policies in a way that empowers victims and their families, and monitoring of their enforcement.<sup>liii</sup>*

*Provision of sexual and reproductive health services, including contraceptive information and services, for adolescents without mandatory parental and guardian authorization/notification, in order to meet the educational and service needs of adolescents.<sup>liii</sup>*

Structural barriers and determinants of health (See Section I.2. Box 2) related to age, sex, gender inequality, poverty, exclusion from education and human rights pose significant challenges for adolescents, especially for adolescents in key populations and other vulnerable groups, and they should be considered when planning interventions. Grounded in the principles of human rights, there are opportunities to address these barriers through community systems strengthening, legal reform and social protection and collaboration among the many sectors that can promote the health, development and rights of adolescents.<sup>viii</sup>

### **Legal and policy reforms are essential to removing many structural barriers for adolescents.**

Consent policies and laws should be reviewed to consider revision to reduce age-related barriers to access and uptake of health services.<sup>xxxii</sup> At the same time, countries should consider the implications of lowering the age of consent and ensure that provisions for protection and safeguarding are in place. Some countries have lowered the age requirements for access to services, while some countries may recognize the “**mature minor**”<sup>24</sup> **principle** for consent to testing, treatment, sexual and reproductive health services (including affordable and accessible contraception), opioid substitution therapy, needle and syringe programs, and other health care.<sup>25</sup> Where protective laws exist that criminalize any form of violence against adolescents and that promote gender equality, they must be enforced.

Working toward decriminalization of drug use, sex work and victims of sexual exploitation, same-sex behavior and gender transition is also needed to create an enabling environment for adolescents from key populations. **Implementation and enforcement of anti-discrimination and protective laws**, as well as stigma reduction programs in the health sector, can help to encourage adolescents to seek services in safe and confidential environments. In some countries, protective laws may conflict with mandatory reporting laws; these tensions need to be considered by countries, emphasizing the importance of not discouraging or excluding adolescents from accessing essential health services. Many health systems/health workers have found pragmatic ways of providing services for adolescents from key populations that are in the best interest of the individual. **Compulsory detention and rehabilitation facilities should be closed**, and efforts should be made to **develop non-custodial alternatives to the incarceration of adolescents who use drugs, sell sex or engage in same-sex activity**.<sup>x</sup> Additionally, national policies and regulations should address other factors that act as powerful barriers to access, including child marriage and judgmental treatment by health care workers of adolescents.

<sup>23</sup> While this recommendation specifies girls, research in the Asia-Pacific region has shown that young men who have sex with men are reporting very high rates of coerced sex at an early age; stronger research is needed for this population as well as for transgender adolescents. (Personal communication, UNESCO).

<sup>24</sup> Many countries allow adolescents in specific groups or situations to be considered “mature minors”. This may include those who are living independently, are pregnant, or have no contact with parents/guardians. Exceptions may also be made for those who have a clinical condition that suggests infection with HIV, or whose knowledge of their HIV status is in the best interests of the adolescent. The mature minor principle can also apply to any adolescent that is found to be sufficiently mature in their cognitive ability and capacity to understand the test or procedure and its implications. Adopting such flexibility may offer faster means of increasing access to HIV testing than formal reviews of the legal age of consent. (WHO, 2013)

<sup>25</sup> WHO guidance does not specify age restrictions for opioid substitution therapy, needle and syringe programs or overdose management.

**The education sector has a vital role to play in supporting the health of adolescents.** Educational settings present opportunities for sharing information that is important to adolescents such as how to access health services, comprehensive sexuality education that includes content promoting gender equitable norms and relationships,<sup>26</sup> and life-skills information. Schools can go beyond health education to offer a social environment that encourages good physical and mental health, promotes gender equality and supports health-seeking behaviors.<sup>viii</sup> Alternative educational arrangements are needed to accommodate adolescents with TB when they are not able to attend classes, while adolescents living with HIV need supportive and flexible learning environments and knowledgeable teachers that provide additional support and accommodate clinic attendance.

**Financial limitations create additional barriers to services and information for many adolescents.** Elimination of fees can encourage adolescents to use services more often and more consistently. Cash incentives/transfers and other social protection measures for adolescents and their families may be effective for encouraging and supporting adolescent girls to remain in school, which is considered to have HIV preventive value. (See Section C.1 for more discussion of financial considerations.)

**The employment sector also has a responsibility to address the needs of adolescents** in the workplace. Psychosocial care and support are needed to ensure that they are linked with the services they need, while adolescents must be assured of working in safe and non-exploitative environments.

*See Annex 2 for resources for addressing structural barriers to services.*

## 02 Disease intervention areas

### HIV

#### **Prevention**

##### **Specific WHO recommendations for adolescents<sup>xxxiii</sup>**

*HIV testing and counseling with linkage to prevention, treatment and care is recommended for adolescents from key populations in all settings.*

*In generalized epidemics, HIV testing and counseling with linkage to prevention, treatment and care is recommended for all adolescents.*

*In low and concentrated epidemics, HIV testing and counseling with linkage to prevention, treatment and care should be accessible to all adolescents.*

Combination prevention<sup>27</sup> programs use a mix of biomedical, behavioral, and structural interventions to meet the HIV prevention needs of particular individuals and communities so as to have the greatest possible impact on reducing new infections. Combination prevention elements that are most relevant to adolescents' needs - depending on the country's HIV epidemic or whether the adolescent is in a vulnerable or key population - include (not a comprehensive list):

- **Behavioral interventions:** Comprehensive sexuality education, counseling, stigma and discrimination reduction;

<sup>26</sup> Comprehensive sexuality education can also be provided in non-formal settings (outside of school); this is especially relevant for key populations and other vulnerable groups of adolescents.

<sup>27</sup> Combination prevention is defined by UNAIDS as "rights-based, evidence-informed, and community-owned programs that use a mix of biomedical, behavioral, and structural interventions to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections." (UNAIDS, 2010.)

- **Biomedical interventions:** HIV testing services, male and female condoms<sup>liv</sup> and condom-compatible lubricant, sexual and reproductive health services (including sexuality and contraception information and supplies, termination of unwanted pregnancy and prevention of sexually transmitted infections), voluntary medical male circumcision,<sup>28</sup> immediate ARV therapy initiation for adolescents with HIV will significantly reduce HIV transmission, PMTCT,<sup>29</sup> pre-exposure prophylaxis for older adolescents at substantial HIV risk,<sup>30</sup> post-exposure prophylaxis<sup>31</sup> following unprotected sexual and injection exposure screening for and treatment of sexually transmitted infections, and a comprehensive package of harm reduction for adolescents who inject drugs;<sup>32</sup>
- **Structural interventions:** Interventions addressing gender, economic and social inequality; decriminalization of same-sex behavior and sex work, drug use and use of harm reduction services; protection from police harassment and violence; legal reform, particularly regarding age of consent and parental consent laws. (See Section III.1)

The choice of mix and prioritization for HIV prevention will depend on the epidemic context. Table 1 illustrates this prioritization; countries can adapt the table to suit the local context.

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<sup>28</sup> Voluntary male medical circumcision is recommended as an additional, important strategy for prevention of heterosexually acquired HIV infection in men, particularly in settings with hyper-endemic and generalized HIV epidemics and low prevalence of male circumcision. (WHO recommendation, 2014.)

<sup>29</sup> In generalized epidemic settings, ARV therapy should be initiated and maintained in eligible pregnant women and postpartum women and in infants at maternal and child health care settings, with linkage and referral to ongoing HIV care and ARV therapy, where appropriate. (WHO recommendation, 2016.)

<sup>30</sup> Oral pre-exposure prophylaxis (containing TDF) should be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination prevention approaches. (WHO recommendation, 2016.)

<sup>31</sup> See guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children. (WHO, 2014.)

<sup>32</sup> WHO strongly supports harm reduction as an evidence-based approach to HIV prevention, treatment and care for people who inject drugs and has defined a comprehensive package of 9 interventions, which includes needle and syringe programs and opioid substitution therapy. The package is also relevant for adolescents from key populations. (WHO recommendation, 2014.)

**Table 1. Prioritizing HIV prevention for key target groups according to epidemic context**

	<b>All adolescents</b>	<b>Adolescent girls</b>	<b>Young key populations</b>
<b>High prevalence generalized epidemic</b>	<p><b>HIV testing services</b> (including linkage to treatment)</p> <p><b>Condoms</b> (male and female)</p> <p><b>Post-exposure prophylaxis</b></p> <p><b>Voluntary male medical circumcision</b> for boys in 14 priority countries in eastern and southern Africa</p>	<p><b>HIV testing services</b></p> <p><b>Sexual and reproductive health</b> including enhanced programs for pregnant adolescents and access to contraception (beyond condoms) and sexually transmitted infection services</p> <p><b>Pre-exposure prophylaxis</b> could be considered for those at substantial<sup>33</sup> HIV risk as part of demonstration projects</p> <p><b>Structural interventions</b> (see below)</p>	<p><b>HIV testing services</b></p> <p><b>Prevention packages for each key population</b> as described in the WHO key population guidelines,<sup>lv</sup> including <b>harm reduction</b> for young injecting drug users</p> <p><b>Pre-exposure prophylaxis</b> could be considered for those at substantial HIV risk, especially young men who have sex with men and transgender and young injecting drug users</p> <p><b>Structural interventions</b> (see below)</p>
<b>Low prevalence epidemics</b>	<p><b>Condoms</b> (male and female)</p> <p><b>Strategic provision of HIV testing services</b> to adolescents at higher risk (National HIV testing services campaigns for adolescents are not generally warranted.)</p>		
<b>Structural interventions that will have broader health impact and may have an impact on reducing HIV infection (need to be tailored to context)</b>	<p>Social protection programs that increase retention in school for adolescent girls</p> <p>Programs that prevent and respond to sexual and gender-based violence</p> <p>Programs that address legal and other barriers to accessing services for adolescents, including young key populations</p> <p>Comprehensive sexuality education for adolescents in and out of schools</p>		

<sup>33</sup> WHO considers an incidence of ≈3 percent to be cost-effective for offering pre-exposure prophylaxis.

## ***Key considerations for adolescents***

Regarding **integration of services**, as discussed in Section III.1, HIV testing services, voluntary male medical circumcision, harm reduction and other services offer a range of opportunities for engaging with adolescents and linking them with other prevention interventions, sexual and reproductive health information and services, comprehensive sexuality education, life skills programming and social welfare services.

**For most-at-risk adolescents**, combination prevention, as outlined in the WHO guidelines for key populations, should include clinical interventions as well as critical enablers to ensure that they can safely take advantage of available services.<sup>ix</sup>

**For adolescents living with HIV**, following an HIV diagnosis, a package of support interventions should be offered to ensure timely linkage to treatment and care, and psychosocial and legal support, which will reduce morbidity and mortality and HIV transmission to sexual partners.<sup>34</sup> Timely linkage for adolescents requires mechanisms - introduced at the point of testing - such as peer-led interventions, community-based services, mobile services, call centers, support groups and innovative applications of mobile technologies and social media.

There are also some new approaches that require more understanding of the potential impact for adolescents:

- **HIV self-testing** is available in some countries and is becoming more widely available informally and formally. It may be useful for adolescents who are not currently reached by HIV testing services,<sup>lvi</sup> but careful consideration needs to be given to its introduction to avoid any potential adverse outcomes.
- **Pre-exposure prophylaxis** is expected to be an important element of combination prevention for those at substantial risk of HIV infection, in particular those from key populations.<sup>lvii</sup> However, further evidence is needed to understand acceptability issues and how best to implement this intervention for adolescents.
- **Cash transfers/incentives** and other social protection interventions may have wide benefits beyond HIV, especially if they can increase school attendance/completion by girls. In terms of reduced HIV vulnerability, these have shown - with mixed results - a possible impact on preventing HIV among adolescent girls in some settings. More research is needed to establish the evidence base for this prevention intervention.<sup>lviii</sup>

All prevention interventions for adolescents need to be delivered through integrated platforms and community-based services, (as discussed in Section III.1) and to accommodate the needs of adolescents for accessible, acceptable, affordable and comprehensive services. When biomedical, behavioral and structural interventions are delivered through adolescent-friendly, community-based services, adolescents—especially those in key populations—are more likely to use these services and remain engaged in care.

*See Annex 2 for key resources on HIV prevention.*

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<sup>34</sup> Following an HIV diagnosis, a package of support interventions should be offered to ensure timely linkage to care for all people living with HIV. (WHO recommendation, 2016.)

## **Treatment, care and support**

### **Specific WHO recommendations for adolescents:**

*ARV therapy should be initiated in all adolescents living with HIV regardless of WHO clinical stage and at any CD4 cell count.<sup>xlvi</sup>*

*As a priority, ARV therapy should be initiated in all adolescents with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and adolescents with CD4 count  $\leq 350$  cells/mm<sup>3</sup>.<sup>xlvi</sup>*

*First-line ARV therapy in adolescents should consist of two NRTIs plus a NNRTI or an INSTI. TDF + 3TC (or FTC) + EFV as a fixed-dose combination is recommended as the preferred option to initiate ART (strong recommendation, low quality evidence).*

*TDF + 3TC (or FTC) + DTG or TDF + 3TC (or FTC) + EFV400a may be used as alternative options to initiate ARV therapy (conditional recommendation, low quality evidence).<sup>xlvi</sup>*

*Adolescents should be counseled about the potential benefits and risks of disclosure of their HIV status to others and empowered and supported to determine if, when, how and to whom to disclose.<sup>xxxiii</sup>*

*In settings where malaria and/or severe bacterial infections are highly prevalent, co-trimoxazole prophylaxis should be initiated regardless of CD4 cell count or WHO clinical stage and continued until adulthood, irrespective of ARV therapy provision.<sup>xlvi</sup>*

*Cervical cancer screening should be done in sexually active girls and women as soon as a woman or girl has tested positive for HIV.<sup>lix</sup>*

*For all girls <13 HPV vaccination is recommended. For those who are HIV-positive, over the age of 13 years, and who have never had sex, the HPV vaccination would be beneficial.<sup>lx</sup>*

There are two specific groups of adolescents living with HIV: **Adolescents who acquired HIV perinatally** during pregnancy, labour and delivery or postpartum through breastfeeding, and **adolescents who acquired HIV during adolescence**, usually through unprotected sexual intercourse or injecting drug use, or less frequently through blood transfusion or sharing instruments used for tattooing or skin piercing.<sup>lxi</sup> These adolescents may have different clinical and psychosocial needs for prevention, care and support for treatment adherence and retention in care; programs need to be prepared to tailor interventions to the specific needs of both of these groups.

### **ARV therapy initiation criteria**

WHO now has specific recommendations for ARV therapy initiation for all adolescents living with HIV. This recognizes adolescence as a distinct period of life and the unique challenges they face in starting and staying on ARV therapy. Aligning with the initiation criteria for adults and children simplifies programming and **expanding ARV therapy coverage, creating opportunities to engage adolescents living with HIV in care**. Lower rates of adherence and high risk of loss to follow-up are important factors in assessing the trade-off between risks and benefits of earlier ARV therapy initiation for adolescents. **Implementation requires increased investment in initiatives that will accelerate expansion of access to and improved quality of treatment, care and support services for adolescents.**<sup>lxii, lxiii</sup>

## ***Selection of ARV regimens***

ARV regimens for adolescents need to be guided by:

- The need to use potent and forgiving first-line regimens that minimize toxicity;
- The convenience of once-daily dosing and the use of fixed-dose combinations whenever possible;
- The desirability of aligning recommended regimens for adolescents with those for adults.<sup>lxii, lxiv</sup>

New and more potent regimens can now be considered while maintaining full harmonization with adults. These regimens include DTG or EFV400 in combination with TDF/XTC.<sup>xlvi</sup>

## ***Clinical care package***

Viral load monitoring continues to be the most appropriate approach to monitoring treatment response (ref ARV guidelines).<sup>xlvi</sup> Access to viral load testing for adolescents must be ensured and potentially enhanced to ensure that treatment failures are detected earlier and drug resistance, for which adolescents are at particular risk,<sup>xlvi</sup> is minimized in order to optimize treatment sequencing.

The package of care for adolescents with HIV who start ARV therapy should include adequate monitoring and provision of CTX prophylaxis in order to reduce morbidity in settings with high prevalence of malaria and/or severe bacterial infections.<sup>xlvi</sup> Cervical cancer screening and HPV vaccination are also recommended.<sup>lix</sup>

## ***Supporting adherence to treatment and retention in care***

The recommendation to **implement adolescent-friendly health services in all HIV services** (see Section III.1 regarding quality of services for adolescents) ensures that adolescents are diagnosed and receive ARV therapy in a timely manner, and are supported to remain in care and stay on treatment.

Additionally **service delivery models beyond the facility are needed**. Peer-led interventions and community-based services can provide information, supplies, support for disclosure and adherence and psychosocial support. They can also facilitate early identification of adolescents requiring further follow-up, referrals and support.

New recommendations on the frequency of clinic visits<sup>35, 36</sup> as well as the differentiated care framework<sup>lxiii</sup> are particularly relevant for adolescents with their busy routines and competing priorities that can make frequent visits challenging. However, **close monitoring of adolescent engagement in care, rapid and proactive follow-up and implementation of strategies for re-engagement are critical**. Facilitation of independence and self-management by providers is essential for the success of differential care for adolescents.

It is especially important to recognize adolescents' evolving capacities and needs, the critical role of caregivers, the **importance of psychosocial support and access to sexual and reproductive health services**, including cervical cancer screening and HPV vaccination, services for sexually transmitted infections, contraception and safe abortion to the fullest extent of the law. See Section III.1 for more details on service delivery considerations related to support for adherence to treatment and retention in care.

*See Annex 2 for key resources on HIV treatment, care and support.*

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<sup>35</sup> Less frequent clinical visits (3-6 months) are recommended for people stable on ARV therapy. (WHO recommendation, 2016.)

<sup>36</sup> Less frequent medication pickups (3-6 months) are recommended for people stable on ARV therapy. (WHO recommendation, 2016.)

## TB/HIV

People living with HIV are 24-28 times more likely to develop TB than persons without HIV, and TB is the major cause of HIV-related death.<sup>kv</sup> Adolescents in high HIV and TB burden settings continue to experience high levels of HIV-related deaths, new HIV infections, and both TB and TB-related deaths associated with their HIV infection. **Countries need to focus on strengthening health systems and community systems to increase access to services for adolescents and tailoring the “three Is” for TB/HIV for this age group - intensified case finding, management of latent TB infection (e.g. with Isoniazid preventive therapy) and infection control—to reduce the burden of TB among adolescents living with HIV.** Adherence support is particularly important for adolescents with co-morbidities and the pill burden is even higher, increasing the potential for non-adherence.

Early identification of TB among adolescents with HIV through careful assessment of symptoms and signs, diagnosis using proper investigation (i.e. with **Xpert MTB/RIF as the first diagnostic test**) and prompt initiation of TB treatment is crucial to improve survival and quality of life.<sup>37, 38</sup>

**HIV testing for all people with TB, including adolescents, should be offered routinely.** It is important that health workers have the sensitivity and skill required for counseling adolescents in general as well as when there may be an HIV diagnosis for the adolescent with TB. Integrating TB and ARV therapy services for adolescents may improve diagnosis of both infections and improve outcomes. All adolescents with HIV should be screened for TB and immediate ARV therapy will reduce TB risk.

Early initiation of ARV therapy for patients with HIV-associated TB is critical in reducing mortality. **ARV therapy should be started in all TB patients living with HIV regardless of CD4 count within the first eight weeks of start of TB treatment.**<sup>xlvi</sup> For those with profound immunosuppression, (ie. CD4 counts less than 50 cells/mm<sup>3</sup>, ARV therapy should be started within the first two weeks of initiation of TB treatment.)

### **Box 11. Collaborative TB/HIV activities**<sup>lxvi</sup>

To address HIV-related TB WHO recommends a 12-point package of collaborative TB/HIV activities with three main focus areas:

1. Establish and strengthen the mechanisms for delivering integrated TB and HIV services.
2. Reduce the burden of TB in people living with HIV and initiate early ARV therapy.
3. Reduce the burden of HIV in patients with presumptive and diagnosed TB.

These collaborative TB/HIV activities have the objectives of creating the mechanisms of collaboration between TB and HIV programs, reducing the burden of TB among people living with HIV and reducing the burden of HIV among TB patients. It is estimated that implementation of the collaborative TB/HIV activities from 2005 to 2014 saved 5.8 million lives, but much more needs to be done to achieve universal access to these lifesaving measures and to eliminate HIV-associated TB deaths.

*See Annex 2 for key resources on TB/HIV collaborative activities.*

<sup>37</sup> Adults and adolescents living with HIV should be screened for TB with a clinical algorithm; those who report any one of the symptoms of current cough, fever, weight loss or night sweats may have active TB and should be evaluated for TB and other diseases. (WHO recommendation, 2012).

<sup>38</sup> Adults and adolescents living with HIV should be screened with a clinical algorithm; those who do not report any one of the symptoms of current cough, fever, weight loss or night sweats are unlikely to have active TB and should be offered intermittent preventive treatment. (WHO recommendation, 2012.).

## Tuberculosis

Adolescent TB differs from adults and young children due to their side effect profile and adherence-related issues. Furthermore, evidence shows that adolescents have a faster progression from TB infection to TB disease.<sup>39</sup> Programs therefore need to ensure that treatment literacy and adequate support for the adolescent patient are offered.

The specific characteristics of adolescence (as described in Section I.2) and evidence from the field points to high prevalence TB cases in adolescents not explained by HIV with a majority of these not being detected.<sup>40</sup> Another study shows that many adolescents are asymptomatic and are mainly detected through contact tracing<sup>41</sup>. Cases such as these point to the need for innovative approaches to expand screening and contact tracing among a variety of adolescent networks. Adolescents need active case finding and contact tracing. In addition, Gene Xpert should be used for diagnosis within this group as they have more extra pulmonary and smear-negative disease<sup>42</sup>. Preventive therapy to avoid TB infection progression to disease is also key.

An adolescent-centered approach should promote health-seeking behavior for TB prevention, diagnosis and treatment (including support for adherence) and reduce the stigma and discrimination that may result from disruption to normal routines when treatment is required.

## Digital health

An innovation that may be particularly well suited to adolescents is the use of information and communication technologies, or “digital health”, a key element of the End TB Strategy. Some of the functions of digital health approaches, such as patient care and “eDOT”, surveillance and monitoring and e-learning may have particular resonance with adolescents and facilitate closer links and improved engagement with health providers and services.<sup>lxvii</sup>

## TB-related stigma and discrimination

Stigmatization is a complex process involving institutions, communities, and interpersonal attitudes. It is one of the many factors thought to be hindering the end of TB by negatively affecting access to health care and treatment outcomes. TB stigma is felt more strongly in certain subpopulations, including women, refugees, individuals from rural areas, and people with lower education levels<sup>43</sup> and it is important to continue to investigate the effects of TB stigma in other subpopulations, including adolescents<sup>2</sup>, as children and adolescents can face an extra dimension of stigma<sup>3</sup>. TB-related stigma is particularly high among adolescents, which leads to delayed care seeking, non-disclosure and related issues. Anti-stigma interventions should be included in national TB strategies or workplans, measured and responded to in close collaboration with partners, including civil society and community organizations. Despite the lack of evaluated intervention studies on TB stigma, anti-stigma interventions need to be carefully crafted, targeting and engaging specific sub-populations, namely adolescents in this case, as well as their respective communities. Examples of interventions that have been regarded as successful to reduce anticipated and internalized stigma include the below, adapted for and which could be further built upon by adolescents and their respective communities.<sup>43</sup>

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<sup>39</sup> *Force of tuberculosis infection among adolescents in a high HIV and TB prevalence community: a cross-sectional observation study*. BMC Infectious Diseases, BMC series, 2011, 11:156

<sup>40</sup> Prevalence of tuberculosis in adolescents, western Kenya: implications for control programs: Videlis Nduba et al. International Journal of Infectious Diseases. 2015; 35: 11-17.

<sup>41</sup> <https://webbertraining.com/files/library/docs/152.pdf>

<sup>42</sup> [http://www.stoptb.org/wg/dots\\_expansion/childhoodtb/assets/documents/2014%20Annual%20Meeting%20Presentations/Epidemiology%20TB%20adolescents%20Kathryn%20Snow.pdf](http://www.stoptb.org/wg/dots_expansion/childhoodtb/assets/documents/2014%20Annual%20Meeting%20Presentations/Epidemiology%20TB%20adolescents%20Kathryn%20Snow.pdf)

<sup>43</sup> Tuberculosis and Stigmatization: Andrew Courtwright et al. Public Health Rep. 2010; 125(Suppl 4): 34–42.

- 1) A gender-focused qualitative study of barriers to accessing tuberculosis treatment in The Gambia, West Africa. *Eastwood SV, Hill PC Int J Tuberc Lung Dis. 2004 Jan; 8(1):70-5.*
- 2) Assessing the Consequences of Stigma for Tuberculosis Patients in Urban Zambia. Anne Lia Cremers et al. PLoS One. 2015; 10(3): e0119861.

### **Anticipated stigma (general population)**

- Educational programs that project positive images of adolescents with TB
- Health talks on TB in adolescent meeting spots, including schools
- TB rallies that engage adolescents
- Development and dissemination of information on TB, by adolescents for adolescents

### **Anticipated stigma among health care workers**

- Specific training on stigma
- Patient-centered therapy and the delivery of care in a non-stigmatizing manner towards adolescents, respecting confidentiality

### **Anticipated stigma among patients**

- TB clubs for adolescents, where they can support each other.

### **Internalized/self stigma**

- Education of adolescents on TB and their family on TB disease and its curability
- Support groups with adolescents with TB and health care workers
- Self-help groups/TB clubs for adolescents with TB

It is worth mentioning that these activities could also be applied to the realm of HIV and/or TB/HIV co-infection related stigma that adolescents suffer from.

### ***Prevention***

Contact investigation activities among adolescents may be difficult due to complicated social networks; involving adolescents in this work may create opportunities to reach isolated and marginalized groups for screening, contact tracing and referral to community-based prevention and treatment services.

### ***Diagnosis***

Adolescence is a period of increased risk of developing disease following infection with *Mycobacterium tuberculosis* compared with a relatively quiescent period from 5-10 years of age.<sup>lxviii</sup> TB in adolescents differs from TB in younger children, as adolescents are more likely to present with clinical and radiographic findings similar to adults, and are more likely to be infectious than younger children.

### ***The importance of early diagnosis for adolescents***

Older adolescents in particular may present more often with adult-type TB (with cavities and smear positivity), which implies greater capacity to transmit infection. As older adolescents are often the caregivers of younger brothers and sisters, they may expose many younger people and classmates to infection. Therefore, early diagnosis and access to treatment, as well as education on cough hygiene, are especially important for this age group. Although diagnosis of TB is easier than in younger children, adolescents with TB are more likely to be affected by stigma, which can hamper treatment adherence.<sup>lxix</sup> Unaccompanied adolescent immigrants and those displaced by humanitarian emergencies may require special attention during TB screening activities.

WHO has developed guidance for TB screening that can be applied to adolescent populations.<sup>44</sup>

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<sup>44</sup> See recommendations for systematic screening for active TB <http://www.who.int/tb/tbscreening/en/>

## **Treatment**

Involving adolescents diagnosed with TB in their treatment plans may encourage their engagement in care and adherence to treatment. Depending on the age of the patient and the complexity of the case, management of the transition between pediatric and adult services may be necessary.

*See Annex 2 for key resources on TB information and interventions relevant to adolescents.*

## **Malaria**

The burden of disease and consequences of *Plasmodium falciparum* malaria infection in adolescents are not well documented and the understanding of specific risk factors and beneficial interventions for adolescents is limited. Malaria seems to be a common cause of clinical illness, an important cause of hospital admissions, and a preventable cause of death in adolescents. Younger adolescents may be at higher risk than older adolescents because of immunological and hormonal factors, but they are often included with children in published studies. In general, malaria infection in adolescents is an under-recognized problem, and the prevention, diagnosis, and treatment of malaria should be a high priority in adolescent health programs.<sup>lxx</sup>

### ***Malaria in pregnancy***

Malaria in pregnancy is associated with severe maternal, fetal and neonatal consequences that are particularly relevant to pregnant adolescent girls.<sup>45</sup> As first pregnancies are at highest risk for malaria infection, and in many malarial countries over 50 percent of first pregnancies are in adolescents, prevention and treatment of malaria should be an important component of antenatal services for adolescents. Risks include severe anemia, low birth weight, miscarriage and stillbirth; in some studies these effects have been found to be more severe in pregnant adolescents than in older women.<sup>lxxi</sup>

## **Prevention**

Mosquito nets offer benefits to both pregnant women and fetuses. There are limited data specific to adolescents, although there is some evidence that net use is lower among adolescents and parasitaemia is higher. The goal of malaria prevention strategies is to ensure universal coverage of the at-risk population. Current deployment strategies include adolescents in the distribution and ownership of long-lasting insecticidal nets. There may be the need for targeted BBC activities in the adolescent age group to enhance usage. Malaria chemoprophylaxis or intermittent preventive treatment reduces episodes of malaria and maternal anemia, and increase birth weight, especially in first or second pregnancies.<sup>lxxii</sup>

HIV infection increases *Plasmodium falciparum* malaria prevalence during pregnancy especially during the first pregnancy, which, in Africa, is often in adolescence; strategies to reduce adolescent malaria or HIV should, therefore, provide a continuum of care - before conception, during pregnancy and postpartum - including appropriate information and preventive and curative services. Support for access to antenatal care and integrated service delivery, as discussed in section III.1, can facilitate early assessment of pregnancy in adolescents, screening for HIV and other sexually transmitted infections with referral for prevention, treatment and care as required. Developing integrated services to deliver HIV and malaria interventions is an important part of antenatal care and can act as a catalyst for addressing broader adolescent health service needs.<sup>lxxiii</sup>

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<sup>45</sup> WHO recommends the following package of interventions for the prevention and treatment of malaria during pregnancy: use of long-lasting insecticidal nets; in areas of stable malaria transmission of sub-Saharan Africa, intermittent preventive treatment in pregnancy with sulfadoxine-pyrimethamine ; prompt diagnosis and effective treatment of malaria infections. (WHO recommendation, 2015.)

## ***Diagnosis***

All suspected malaria cases should have a confirmatory diagnosis using either microscopy or a rapid diagnostic test kit. Only cases with confirmed parasitaemia should receive treatment for malaria. All diagnostic services should have an effective quality assurance system in place.<sup>lxxiv</sup>

## ***Treatment***

Pregnancy status should be assessed in adolescent girls with confirmed malaria (who may be sexually active), to guide the choice of antimalarial medicines appropriate for gestational age.

*See Annex 2 for key resources on malaria interventions relevant to adolescents.*



# Annex 1 -Key Guiding Questions

This annex suggests the type of questions that might be posed at different stages of the funding application process to ensure that adolescents' needs are being considered and included in the funding request. Countries should adapt these examples to their specific national context.

## 01 Country dialogue

Are adolescents represented on the Country Coordinating Mechanism?

Have the individuals or organizations representative of all key sub-groups in the country - adolescents in and out of school, key populations, adolescents living with HIV - been invited to join or are participating on the Country Coordinating Mechanism? Are the views and concerns of adolescents properly analyzed and captured by the writing team and technical partners?

If not, what process needs to be undertaken to involve adolescents in the country dialogue and on the Country Coordinating Mechanism?

Is capacity building required? How can this be done? Who can support it?

How do we ensure accountability of the Country Coordinating Mechanism with regard to including adolescents in the process?

Who are the partners in country that provide support to adolescent health interventions? Type and level of support?

## 02 National plans and policies

Is the right to health explicitly recognized in national strategies, policies or plans?

Is there a national strategic plan or policy for adolescent health?

- Does it indicate which adolescents are most affected by HIV, TB and malaria? Does it reference specific HIV, TB and malaria strategies or policies?
- Does it address service delivery considerations for adolescents – i.e. improving access to and quality of services for adolescents?
- Does it include adolescent-specific considerations for implementation of interventions?
- Are there national standards for delivery of health services to adolescents? If yes, do they include:
  - Clearly defined adolescent health risks?
  - Clearly defined package of services?
  - Specific groups of adolescents to whom services are delivered?
  - Training for providers serving adolescents?

If there is no specific plan or policy on adolescent health, are adolescents and their particular issues mentioned in national plans and policies?

Has the national plan been costed?

## 03 Concept note development

### **Country context**

#### ***Disease, health and community systems context***

Do we know how adolescents in this country are affected by the three diseases?

What sources are available to determine:

- Who and where are the adolescent key populations for each disease?
- What services are available for adolescents/adolescent key populations specifically, where are they being provided and by whom?
- What specific legal, human rights and structural barriers affect access to services for all adolescents including those from key populations and other vulnerable groups?

How can those barriers be reduced and who are the key actors to be engaged in this work?

Are there mechanisms for adolescents to report physical, emotional or other human rights abuses? If not, how can these be put in place and who are the key actors to be engaged in this work?

Is peer counseling available for adolescents?

#### ***Disaggregation of data***

Are adolescent data presented in the national health management information systems?

What type of data are collected on adolescents?

Are data disaggregated in order to be able to answer questions such as:

- Who are the priority adolescent populations with the greatest need to focus a response for each disease?
- What is the estimated size of this group or sub-group?
- What do we know about disease incidence in different groups of adolescents and within the adolescent age group? (girls, key populations, adolescents with HIV who were infected prenatally or during adolescence, etc)
- What percentage within each adolescent key population group is female?
- Do adolescent key populations access services in the same places as adults in the group?
- Urban/rural breakdown? What are the priority geographic locations with the greatest gaps for adolescents to focus program interventions for maximum impact?
- What are the specific data gaps on girls? On each adolescent key population?
- Marital status of adolescents?

If data are not disaggregated by age, sex and geographic location, what can be done to begin collecting disaggregated data?

If data have been collected but are not being presented for some reason (may be sensitive due to the younger age range or due to small sample sizes), what can be done to encourage disaggregation and addressing of sensitive or emerging issues?

Are age- and sex-specific targets set in order to require disaggregation of data?

Can technical partners provide some of this strategic information?

### ***Funding landscape***

What is the proportion of the national budget allocated to the Ministry of Health?

What is the proportion of the health budget allocated to adolescent health?

Are there initiatives related to building resilience in the health system planned or underway? Do they have adolescent-specific components and are there specific allocations for those components?

Are there adolescent-specific interventions or initiatives related to the three diseases planned or underway? Are there specific budget allocations for those program components?

Which groups of adolescents are targeted?

What are the sources and funding levels for these investments?

Which geographic regions are covered?

What are the gaps in terms of specific subpopulations of adolescents, types of intervention or geographic area?

### **Funding request**

#### ***Programmatic gap analysis***

Are there adolescent-specific indicators, population estimates and targets for priority interventions across the three diseases and regarding HSS?

If not, what actions need to be undertaken in order to include adolescent-specific targets?

Does the national health training program cover adolescent health? If yes, what does it look like?

- Pre-service training for students in training institutions
- In service training for health workers
- Both pre-service and in-service training

Is adolescent health and development taught as a standalone topic or included in other topics such as gynecology or pediatrics?

Is adolescent health and development seen as cross cutting and across content areas?

What is the percentage of facilities that have at least one health provider trained in adolescent-friendly health services?

### ***Selection of priority modules and interventions***

Are the priority modules selected linked with the adolescent health goals and objectives of the national program? If not, are the choices explained in a way that justifies the funding request?

Have adolescent considerations influenced selection of all priority modules (not only for the prevention module for adolescents and youth)?

What are the high-impact interventions and cross-sectorial opportunities needed to accelerate results in adolescents for resilient and sustainable systems for health and each disease?

What are the high-impact interventions needed to accelerate community system strengthening for groups/organizations led by adolescents?

## Annex 2 - Global Fund Resources

The Global Fund maintains a resource library on its website to help guide countries through the funding model and related processes. The resources include technical information on a broad range of topics related to Global Fund grants, such as resilient and sustainable systems for health, community systems strengthening, gender equity, sexual orientation and gender identities, strategic information, human rights, reproductive, maternal, newborn and child health, and disease-specific information. Please refer to the Global Fund website for these guidelines, strategies, reports, e-learning courses and other tools.

### 01 Country dialogue

1) Making the Money Work for Young People: A participation tool for the Global Fund for AIDS, Tuberculosis and Malaria. (2014)

*Part 1 for youth activists and youth organizations*

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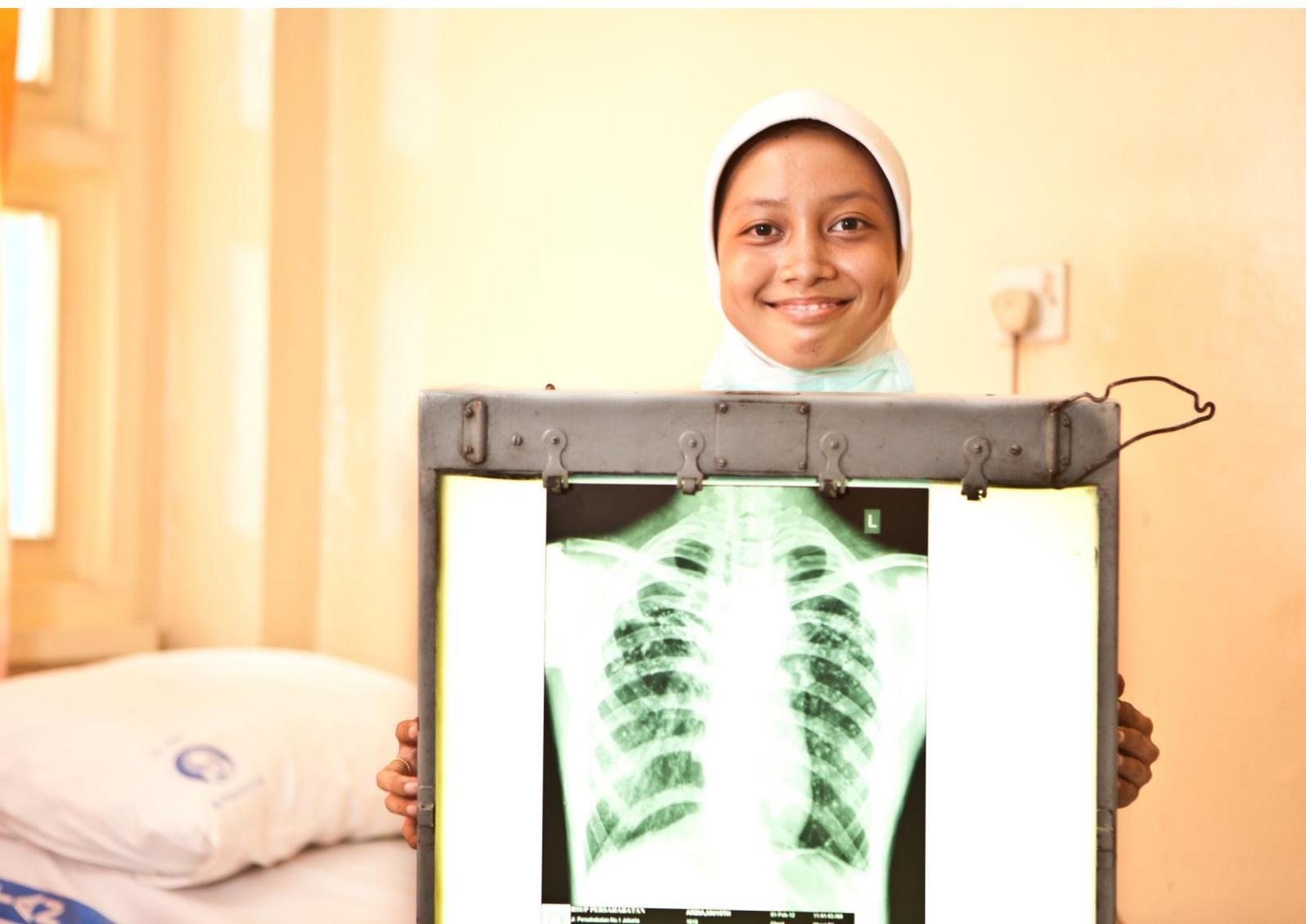
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