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AIDS Free Framework to accelerate paediatric and adolescent HIV treatment

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Abbreviations

3TC	Lamivudine
ABC	Abacavir
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ART	Antiretroviral treatment
AZT	Azidothymidine (zidovudine)
CBO	Community-based organization
CrAG	Cryptococcal antigen
DTG	Dolutegravir
FBO	Faith-based organization
FDC	Fixed-dose combination
HCW	Health care workers
HIV	Human immunodeficiency virus
LPVr	Lopinavir/ritonavir
MTCT	Mother-to-child transmission
OVC	Orphans and vulnerable children
NRTI	Nucleoside reverse-transcriptase inhibitor
NVP	Neviparine
PLHIV	People living with HIV
POC	Point-of-care
SRH	Sex and reproductive health
TB	Tuberculosis
TLD	Tenofovir-lamivudine-dolutegravir
TWG	Technical working group
VMMC	Voluntary medical male circumcision

Background

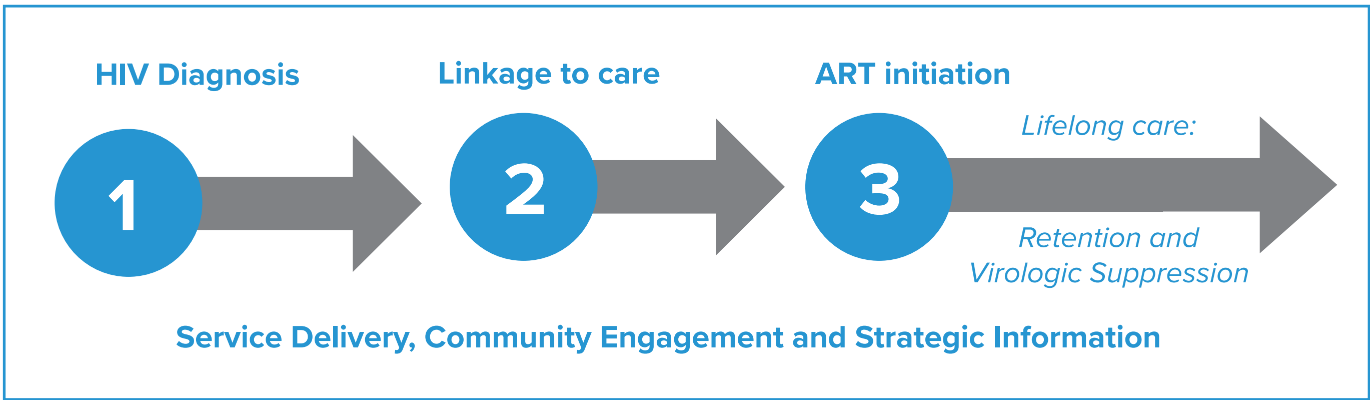
Start Free, Stay Free, AIDS Free is a collaborative framework to accelerate the end of the AIDS epidemic among children, adolescents and young women by 2020. It builds on the success of the *Global Plan towards ending new HIV infections among children by 2015 and keeping their mothers alive* and embraces the goals set by United Nations Member States in the 2016 Political Declaration on HIV and AIDS. Every child and adolescent living with HIV should have access to antiretroviral therapy (ART). The AIDS Free component of the framework has the specific goal of ensuring 95% of all children and adolescents living with HIV have access to lifelong ART by the end of 2018 [1.6 million children (aged 0-14) and 1.2 million adolescents (aged 15-19)]. These efforts will need to be sustained until 2020, when it is estimated that treating 95% of all children and adolescents living with HIV will require providing ART to 1.4 million children (aged 0-14) and 1 million adolescents (aged 15-19). These goals go hand in hand with the specific goals set by the Start Free, Stay Free components which focus on preventing new infections in infants, children and adolescents.

These ambitious targets will require urgent global and country action to identify more children and adolescents living with HIV, saving their lives by starting ART and retaining them in care. Progress continues to be observed in many high burden countries but achieving these targets within this timeframe will require significant acceleration.

What does acceleration mean?

- Keeping children and adolescents on the political agenda and correcting the misperception that paediatric and adolescent HIV is no longer an issue.
- Mobilizing the resources needed to scale up, adapt and sustain programmes for children and adolescents to better serve needs that change over time and by setting.
- Promoting retargeting exercises at national and subnational levels to establish clear and ambitious goals.
- Strengthening and improving traditional programme elements crucial for identifying, treating and retaining children and adolescents.
- Introducing innovations in a strategic and context-specific manner so that outcomes can be optimized without disrupting existing systems.
- Targeting interventions for maximum impact at national and subnational level in order to adapt programme actions and optimize resource use.
- Continuing critical reviews by maximizing data use to track progress and inform corrective actions.
- Collaborating at the global, regional and national levels to create synergy, since no one will succeed alone and all stakeholders are committed to saving the lives of children and adolescents living with HIV.

Tackling HIV in children and adolescents is not just about identification, treatment and retention in care. It is also about providing a package of care that has to change over time since it supports their physical and neuropsychological development as they survive and thrive into adolescence and adulthood. Acceleration to achieve the fast-track targets will require not just reaching these children and adolescents but also ensuring high-quality comprehensive services are delivered and adapted over time.



While tangible progress is being made in all AIDS Free priority countries, a great deal still needs to be done to achieve the super fast-track targets.

The AIDS Free agenda promotes active and continuous critical review of the implementation of the key programmatic elements that are part of the five focus themes of the AIDS Free component: identification, drug optimization, service delivery, community engagement and strategic information. Critical review should be conducted routinely with the goal of continuously improving each programme element (see box below).

Critical Review of Programme Implementation

a. Policy: Is there a policy to endorse the implementation of the intervention under review?

b. Guidance: Is there a standardized approach for implementing the intervention? Are there standard operating procedures at every level which set out clear roles and responsibilities for service providers as well as strategic integration between services? Do training packages exist for capacity building of providers?

c. Resources: Are there appropriate human resources, infrastructures and commodities to implement the intervention? If not, is there a plan to mobilize them?

d. Scale up: Is the intervention reaching the target population? Is there a plan to scale up the intervention nationally?

e. Quality: Is the quality of the intervention and its implementation routinely assessed? Is mentorship and supported supervision offered?

f. Strategic information: Are existing monitoring tools able to capture successful implementation of the intervention? Are the tools needed subjects to revision (i.e. age disaggregation)? Does a system exist for periodic analysis of data generated and its adaptation to improve the programme?

A similar analysis should be carried out and routinely repeated for each intervention

Programmatic Areas to be Accelerated

Identification

Strengthening existing interventions

1. Scale up and strengthen early infant diagnosis (EID) at 4-6 weeks:
- maximize opportunity for testing (first immunization visit);
- strengthen the capacity of laboratories and referral systems (i.e. human resources1, quality management systems, logistics and procurement, sample transport/referral, lab information systems, lab-clinic interface);
- ensure rapid turn-around-time of the results by adoption of technologies (e.g. SMS printers) or by strengthening lab information systems;
- step up ability of health care providers to communicate test results to caregivers;
- ensure confirmatory testing for infants with positive results.

Photo: Eric Bond/EGPAF, 2017

2. Track HIV-exposed infants by retaining mother-infant pairs (MIPs) to ensure appropriate care, provide co-trimoxazole prophylaxis and further testing if they fall sick.

3. Ensure final diagnosis with appropriate testing at the end of the exposure period by retaining mother-infant pairs:
- strengthen community and peer support;
- encourage campaigns to improve maternal and infant survival;
- boost integration of services for MIPs;
- providing differentiated service delivery for pregnant and breastfeeding women and their children.

4. Case finding among children and adolescents: test smart for greater impact:
- prioritize index case testing regardless of national HIV prevalence (i.e. testing should be offered to all children and adolescents living with HIV-infected parents and/or siblings, and to adolescents whose sexual partner is known to have HIV);
- test sick children and adolescents presenting at health facilities, including inpatient wards, TB and malnutrition clinics. Testing of children presenting for general outpatient care should be adapted to the country context;
- optimize strategies to test well children at immunization services and in the community (i.e. orphans and vulnerable children), ensuring age-appropriate testing strategies (i.e. prioritize testing the mothers infants under 18 months, if available) and basing these strategies on context-based information about testing value;
- test adolescents attending antenatal care (ANC), sexual and reproductive health (SRH), harm reduction and voluntary medical male circumcision (VMMC) services.

Strategic introduction of innovations

1. Adopt virological testing at birth where feasible and most beneficial:
- ensure strengthening of existing EID programme before adding birth testing (increase uptake and guarantee rapid result return);
- create capacity for testing, counselling, and referral at maternity unit by providing training and mentorship;
- guarantee confirmatory testing is undertaken for any infant with a positive result;
- confirm appropriate messages are given to caregivers and infants with negative results are tracked for repeat testing at 6 weeks and beyond as appropriate (i.e. if sick and on completion of breastfeeding);
- assure availability of appropriate ARV formulations to treat neonates at the facility unless reliable referral systems are in place.

2. Consider point-of-care (POC) EID introduction and scale up:

- plan for strategic placement (i.e. based on patient volumes, setting prevalence, facility remoteness, use of "hub-and-spoke" model);
- consider strategic selection of platform (i.e. EID alone vs multiplex testing) to maximize access and efficiency;
- optimize the patient flow to maximize the POC approach in the context of multiple use of POC platforms for TB and HIV and to ensure prompt testing and linkage to care;
- integrate service and maintenance, quality assurance and supply chain needs into current plans and laboratory systems (i.e. cartridges, reagents, etc.).

3. Innovation to reach adolescents:

- generate demand targeted at different age groups within the adolescent population: mixed media campaigns, use of mobile phone technology, popular events (i.e. sports, performing arts), and peer-to-peer outreach;
- facilitate new opportunities to for testing: mobile, outreach and venue based testing, community and home-based, school- and work-based testing;
- promote self–testing by including adolescents in national implementation plans that consider models for reaching and supporting adolescents for self-testing and link them to confirmatory testing, prevention and treatment services;
- consider technology-supported hotline and referral systems to ensure adolescents have access to care and support.

Resources

- EID POC: Novel point-of-care tools for early infant diagnosis of HIV (WHO): http://www.who.int/hiv/pub/toolkits/early-infant-diagnosis-hiv-2017/en/
- Guidelines on HIV self-testing and partner notification (WHO): http://www.who.int/hiv/pub/vct/hiv-self-testing-guidelines/en/
- Consolidated guidelines on HIV testing services (WHO): http://apps.who.int/iris/bitstream/10665/179870/1/9789241508926_eng.pdf?ua=1&ua=1
- PATA Regional Summit Day One – Finding Children with HIV: http://www.childrenandaids.org/node/438
- Promising practices and lessons learned from implementation of the ACT initiative: https://www.pepfar.gov/documents/organization/270700.pdf
- Adolescent HIV testing, counselling and care online implementation tool (WHO): http://apps.who.int/adolescent/hiv-testing-treatment/page/HIV_Testing_and_Counselling
- Reducing age-related barriers to sexual health services (UNICEF): https://www.childrenandaids.org/sites/default/files/2017-05/SAT%20toolkit_Reducing%20Age%20Related%20Sexual%20Barriers%20to%20Sexual%20Health%20Services.pdf
- Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection 2nd edition (WHO): http://www.who.int/hiv/pub/arv/arv-2016/en/
- Unitaid/WHO/Psi HIV Rapid Diagnostic Tests for self-testing , 3rd edition: https://unitaid.eu/assets/HIV-Rapid-Diagnostic-Tests-for-Self-Testing_Landscape-Report_3rd-edition_July-2017.pdf

Drug Optimization

1. Adopting WHO-recommended regimens for children and adolescents: ensure age-appropriate optimal regimens, formulations and doses are used. This implies:

- phasing out NNTRI-based regimens and replacing them with optimal regimens and formulations as outlined in the 2018 Optimal Use and Limited-use List formulary;
- in those countries where DTG is being actively promoted, a first-line DTG-based regimen should be provided to all adolescents weighing more than 25 kg (TLD for more than 30 kg), in line with national guidance on DTG use in adolescent girls of child-bearing potential;
- and rapid adoption of upcoming WHO treatment regimen recommendation updates.

Other factors to consider are ensuring functional procurement and supply (quantification, ordering, and distribution), HCW training and continuous mentorship as well as quality of care assessment.

2. Prioritizing viral load monitoring for children and adolescents: ensure access to routine viral load monitoring for all children and adolescents and a timely switchover to appropriate second-line regimens when treatment failure is identified.

3. **Set up second- and third-line programmes: ensure availability of appropriate ARVs and strengthen referral systems to ensure a timely switchover to appropriate regimens. This will require maintenance of functional procurement and supply, specific training and continuous HCW mentorship.**

4. **Ensure provision of preventive treatment and care for opportunistic infections including co-trimoxazole, as well as routine screening and preventive treatment for tuberculosis in all eligible children.**

5. **Provide a clinical package for children and adolescents with advanced disease: ensure children under 5 years as well as older children and adolescents presenting with CD4<200 receive a package of interventions which, depending on age, includes isoniazid-preventive therapy, CrAg and fluconazole prophylaxis, in line with the latest WHO recommendations.**

Resources

- Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection, 2nd edition (WHO): http://www.who.int/hiv/pub/arv/arv-2016/en/
- Fact sheet on Lopinavir and Ritonavir (LPV/r) oral pellets (IATT): http://www.who.int/hiv/pub/toolkits/iatt-factsheet-lopinavir-ritonavir/en/
- IATT Paediatric ARV Formulary and Limited-Use List, 2016: http://apps.who.int/medicinedocs/documents/s23120en/s23120en.pdf
- Adolescent HIV testing, counselling and care online implementation tool (WHO): http://apps.who.int/adolescent/hiv-testing-treatment/page/Adherence
- What's new in adolescent treatment and care: Fact sheet: http://www.who.int/hiv/pub/arv/arv2015-adolescent-factsheet/en/
- Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy (WHO): http://www.who.int/hiv/pub/guidelines/advanced-HIV-disease/en/
- PATA Regional Summit Day 2. Treating Children with HIV: http://www.childrenandaids.org/node/439
- WHO Guidelines for the diagnosis, prevention and management of cryptococcal disease in HIV-infected adults, adolescents and children, 2018: http://apps.who.int/iris/bitstream/10665/260399/1/9789241550277-eng.pdf?ua=1
- Latent tuberculosis infection: updated and consolidated guidelines for programmatic management, 2018 (WHO): http://www.who.int/tb/publications/2018/latent-tuberculosis-infection/en/

Service Delivery

1. **Improve linkages for HIV infected children and adolescents**
   All HIV-infected children and adolescents should be linked to care immediately and started on ART as soon as possible, depending on their clinical condition. Strategies to improve linkage include:

- decentralize HIV services;
- integrate HIV services within outpatient and/or MCH services;
- promote a one-stop model at the HIV testing point;
- ensure care enrolment on a daily basis (walk–in services);
- use a "patient navigator";
- provide strong counselling and psychosocial support for better acceptance of test results;
- adopt mobile technology;
- conduct data analysis and triangulation (comparing data from HTS register and HIV register);
- use unique patient identifiers;
- promote interventions to reduce stigma within health facilities.

Photo: Eric Bond/EGPAF, 2016

2. Increase access to care and treatment

- decentralize paediatric and adolescent treatment by training, mentorship and continuously supported supervision;
- facilitate targeted integration of HIV services with MCH services (i.e. minimum package for high risk) in order to decentralize paediatric treatment and improve access;
- facilitate targeted integration of HIV services with SRH and adolescent health services in order to improve access to treatment for adolescents, depending on country context.

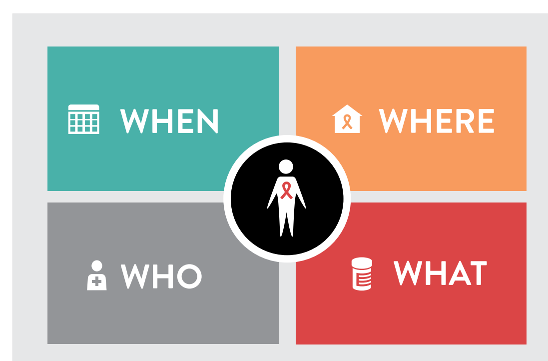
3. Support adherence and retention

ART adherence remains one of the most significant challenges, and strategies to tackle this problem include:

- form support groups for parents/caregivers;
- encourage paternal involvement in child care;
- provide an age-appropriate disclosure process;
- provide adolescent-appropriate HIV/health literacy, adherence counselling, peer-led support programmes, support groups and encouraging practical strategies (i.e. alarms and SMS).

4. Differentiated Service Delivery (DSD):

DSD is a client-centred approach that simplifies and adapts HIV services to reflect the preferences of PLHIV while reducing unnecessary burdens on the health system:



- promote integrated parents/children visits (family-centred approach);
- consider a schedule with less frequent visits (every 3 months) for children aged 2–4 years with no comorbidities and receiving ART for more than one year;
- consider adopting semi-annual visits and community refilling for clinically stable children aged 5–9 and adolescents (other examples of ART refilling include family-member refill and club refill);
- consider semi-annual visit for adolescents based on the school calendar, particularly for those at boarding school;
- consider adopting adolescent-peer supports as community mobilisers, service navigators, educators, service providers and support group or network leaders;
- integrate adolescents into community service delivery designed for adults patients, ensuring adequate psychological support (other examples of DSD for adolescents include facility-based adolescent group refill, community-based adolescent group refill, longer refilling for adolescent in boarding school, fast track).

5. Implement adolescent-friendly health services (AFHS)

AFHS have been shown to improve health outcomes, as well as uptake and acceptability of services for adolescents including those living with HIV. Providing AFHS does not imply the need for a different infrastructure and space: what has to be changed are HCW attitudes and training.

- ensure the eight global standards for quality health-care services for adolescents are adopted in order to guide HIV programmes towards necessary changes;
- train providers who are competent to treat adolescents with appropriate skills and provide them with ongoing mentorship and supportive guidance;
- modify facility characteristics including having adolescent-focused service times and waiting lines.

6. Provide a comprehensive care package through integrated or linked services

A comprehensive care package is required to support the diverse and evolving HIV and health needs of adolescents, in particular their mental health, SRH, and psychosocial well-being, as well as to develop their resilience and self-management.

Interventions should be integrated or provided through linkages: clear and established referral mechanisms help to ensure a continuum of care.

Resources

- Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection 2nd edition (WHO): http://www.who.int/hiv/pub/arv/arv-2016/en/
- Key considerations for differentiated antiretroviral therapy delivery for specific populations: children, adolescents, pregnant and breastfeeding women and key populations (WHO, IAS): http://www.who.int/hiv/pub/arv/hiv-differentiated-care-models-key-populations/en/
- Guidance and experiences from countries on differentiated care (IAS): http://www.differentiatedcare.org/Guidance
- The CQUIN Project for Differentiated Care (ICAP): https://cquin.icap.columbia.edu/about-cquin/differentiated-service/
- BIPAI adherence curriculum for parents and caregivers of HIV-positive children: http://bipai.org/adherence-curriculum
- PATA Regional Summit Day 3. Caring for children/adolescents with HIV: http://www.childrenandaids.org/node/440
- Global standards for quality health care services for adolescents (WHO): http://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/
- Building an adolescent-competent workforce (WHO): http://www.who.int/maternal_child_adolescent/documents/adolescent-competent-workforce/en/
- Strengthening the capacity of community health workers to deliver care for sexual, reproductive, maternal, newborn, child and adolescent health (WHO): http://www.who.int/maternal_child_adolescent/documents/community-capacity-h4plus/en/
- Adolescent HIV testing, counselling and care online implementation tool (WHO): http://apps.who.int/adolescent/hiv-testing-treatment/page/Service_Delivery_and_Retention: http://apps.who.int/adolescent/hiv-testing-treatment/page/Introduction: http://apps.who.int/adolescent/hiv-testing-treatment/page/Living_positively
- Adolescent HIV testing, counselling and care online implementation tool. Training toolkit (WHO): http://apps.who.int/adolescent/hiv-testing-treatment/page/training
- Core competencies in adolescent health and development for primary care providers (WHO): http://www.who.int/maternal_child_adolescent/documents/core_competencies/en/
- Best Practices for Adolescent- and Youth-Friendly HIV Services: A Compendium of Selected Projects in PEPFAR-Supported Countries (PEPFAR): https://www.measureevaluation.org/resources/publications/tr-16-134/
- Good Practice Guide: Adolescent HIV Programming. International HIV Alliance. http://www.aidsalliance.org/resources/922-good-practice-guide-adolescent-hiv-programming
- Tool kit for disclosure (PEPFAR): https://www.childrenandaids.org/sites/default/files/2017-05/how-to-keep-healthy_2012_p15_jan2_2013.pdf; https://www.childrenandaids.org/sites/default/files/2017-05/Booklet2English.pdf; https://www.childrenandaids.org/sites/default/files/2017-05/Booklet%203.pdf
- Examples of referral form. Uganda Linkage and Referral form: https://www.childrenandaids.org/sites/default/files/2017-05/Uganda_Linkages-and-Referral-Form.pdf

Community Engagement

1. **Advocate to involve community-based (CBO) and faith-based organizations (FBO)** in driving HIV literacy, reducing stigma, creating demand and providing full-range HIV services by establishing a formal framework for engagement with the national programme that properly acknowledges CBO and FBO input.

2. **Boost community awareness about paediatric care and treatment to increase demand:** media campaigns, involvement of traditional birth attendants (TBAs) and community leaders as well as high level campaigns by national figures (e.g. the Free to Shine campaign against childhood AIDS).

3. **Facilitate the participation of adolescents in national programming:** engaging with and supporting the development of national-level youth advocacy groups and SRH networks and networks serving those living with HIV can make services more appropriate and responsive, boost advocacy efforts and generate demand.

4. **Increase community literacy in order to decrease HIV-related stigma,** thereby facilitating access to tests and treatment for parents and adolescents and maintaining adherence.

Resources

- Adolescent HIV testing, counselling and care online implementation tool (WHO): http://apps.who.int/adolescent/hiv-testing-treatment/page/involving_adolescents
- GIYPA Guidebook. Supporting organisations and networks to scale up the meaningful involvement of young people living with HIV (GNP+ Y+): https://www.gnpplus.net/resources/giypa-roadmap/
- Ending the AIDS epidemic for adolescents, with adolescents. A practical guide to meaningfully engage adolescents in the AIDS response (UNAIDS): http://www.unaids.org/en/resources/documents/2016/ending-AIDS-epidemic-adolescents
- Positive Learning: meeting the needs of young people living with HIV in the education sector. (GNP+, UNESCO): http://unesdoc.unesco.org/images/0021/002164/216485E.pdf
- Global Network of Sex Work Project. Young Key Populations and HIV Technical Briefs: http://www.nswp.org/resource/young-key-populations-and-hiv-technical-briefs
- The Clinic-Community Collaboration Toolkit. Working together to improve PMTCT and paediatric HIV treatment, care and support: https://teampata.org/c3/
- Improving male involvement to support elimination of mother-to-child transmission of HIV in Uganda. A case study: https://www.childrenandaids.org/sites/default/files/2017-03/Uganda%20Case%20Study%203_15%20HR_0.pdf
- Promising practices & key operational considerations for community-facility linkages in the scale up of lifelong ART for pregnant and breastfeeding women (UNICEF): https://www.childrenandaids.org/sites/default/files/2017-04/Promising%20Practices%20%26%20Key%20Operational%20Considerations%20for%20Community-Facility%20Linkages%20in%20the%20Scale%20up%20of%20Lifelong%20ART.pdf

Photo: Andrew Marinkovich/EGPAF, 2017

Strategic Information

1. Develop tools to allow in-depth analysis:

- promote tools that allow age- and sex-data at national and subnational level in order to inform programmes and provide more accurate forecasting information for commodities;
- develop tools to capture data on testing at different entry points and its linkage to care so that optimal testing strategies can be designed at national and subnational level;
- encourage use of cohort analyses for mother-infant pairs in order to ensure their retention and data collection on the final mother-to-child transmission (MTCT) rates.

2. Promote data quality: undertake data quality assessment and triangulation in order to ensure optimal data at all levels.

3. Conduct data analysis: provide capacity building at all levels in order to ensure data analysis is able to track policy implementation and inform programme planning.

Resources

- Consolidated guidelines on person-centred HIV patient monitoring and case surveillance (WHO): http://www.who.int/hiv/pub/guidelines/person-centred-hiv-monitoring-guidelines/en/
- Adapting and implementing new recommendations on HIV patient monitoring (WHO): http://www.who.int/hiv/pub/toolkits/adapting-recommendations-on-patient-monitoring/en/
- Using unique patient identifiers for person-centred HIV patient monitoring and case surveillance (WHO): http://www.who.int/hiv/pub/toolkits/using-unique-patient-identifiers/en/
- Collecting and reporting of sex- and age-disaggregated data on adolescents at the subnational level (UNICEF): https://data.unicef.org/resources/collecting-reporting-sex-age-disaggregated-data-adolescents-sub-national-level/
- Adolescent HIV testing, counselling and care online implementation tool (WHO): http://apps.who.int/adolescent/hiv-testing-treatment/page/monitoring_evaluation_and_research
- Collecting and reporting of sex- and age-disaggregated data on adolescents at the subnational Level (UNICEF): https://childrenandaids.org/collecting-reporting-sex-age-disaggregated-data
- Guidance on strengthening the adolescent component of national HIV programmes through country assessments (UNICEF): https://childrenandaids.org/guidance-on-strengthening-adolescent-component

Country Enablers

1. **Set up a training curriculum, mentorship and supported supervision mechanisms:** this guarantees HCW training and continuous mentorship as well as providing information on the workload absorbed by testing and counselling, and thus the possible need for more human resources (i.e. lay workers, lay counsellors, peer counsellors).

2. **Ensure effective procurement and supplyof commodities:** it is important to ensure that commodities are accurately quantified, ordered and procured in a timely manner.

3. **Reduce age-related barriers:** reducing the age of consent (for testing and treatment) should be discussed by bringing together all interested stakeholders and representatives of civil society.

4. **Work with cross-sectoral and multidisciplinary technical working groups (TWGs)** in order to make HIV treatment and care an aspect of Universal Health Coverage efforts and to facilitate joint planning and programming, reduce programme overlap and encourage service integration wherever possible.

5. **Involve the education sector:** schools are important partners for health services insofar as they help to meet the needs of children and adolescents, reduce educational barriers especially relating to stigma and provide opportunities for SRH education.

6. **Involve sectors that address or support vulnerable populations:** there is a need to develop linkages and programme synergies with social services that are uniquely positioned to address the needs of persons who have experienced abuse or with disabilities as well as marginalized and criminalized subgroups.

Resources

- Global Accelerated Action for the Health of Adolescents (AA-HA!). Guidance to support country implementation (WHO): http://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/
- Strengthening the adolescent component of national HIV programmes through country assessments guidance document adolescent assessment and decision-makers' (UNICEF): https://www.childrenandaids.org/sites/default/files/2017-05/Guidance-on-Country-Assessments-91_2015_252.pdf

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