



Republic of Kenya

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## **MOST AT RISK ADOLESCENTS: INVISIBLE OR IGNORED?**

### ***SITUATIONAL ANALYSIS OF POLICY & HEALTH CARE FOR MOST AT RISK ADOLESCENTS IN KENYA***

**July 2016**



# MOST AT RISK ADOLESCENT: INVISIBLE OR IGNORED?

## Summary Report of a Situational Analysis of Policy & Health Care for Most at Risk Adolescents in Kenya

### Background

The 2014 Kenya HIV estimates report [1] estimated that there are 101,560 new infections annually, 88,620 among adults and 12,940 among children. According to the estimates, 29% of all new HIV infections in Kenya were among adolescents and youth. AIDS is the leading cause of death among adolescents in Africa [2] with 17% of all AIDS related deaths in Kenya being among adolescent and youth [1]. Adolescent deaths resulting from HIV continue to rise despite declines among other age groups [2, 3]. Same sex intercourse among males, sex work and drug use are known behaviors that heighten risk to HIV infection. In the Kenya AIDS Strategic Framework (KASF 2014/15-2018/19), men who have sex with men (MSM), sex workers (SWs) and people who inject drugs (PWIDs) have been identified as key populations (KP) at increased risk of HIV infection through higher-risk behaviors and that require targeted programming if Kenya is to achieve its goals of reducing new infections [4]. Literature shows that some adolescents in Kenya engage in transactional sex and use drugs e.g. 4.8% of adolescents aged 10 to 14 years reported a history of alcohol use and 1.4% of adolescents in the same age group reported drug use [5]. The 2012 Violence against children study further found that 32% females and 18% males reported history of sexual, emotional or physical violence prior to age 18 years [6]. The study reported that 24.3% females and 8.6% of males stated that their first unwilling sexual intercourse occurred prior to age 18.

According to WHO, young people who belong to one or more of the key populations groups are made especially vulnerable to HIV by widespread discrimination, stigma and violence, combined with the particular vulnerabilities of youth, power imbalances in relationships and, sometimes,

alienation from family and friends. These factors increase the risk that they may engage – willingly or not – in behaviours that put them at risk of HIV, such as frequent unprotected sex and the sharing of needles and syringes to inject drugs. It further states that in many cases, these young people are made more vulnerable by policies and laws that demean or criminalize them or their behaviours, and by education and health systems that ignore or reject them and that fail to provide the information and treatment they need to keep themselves safe [7-9].

Consultations between the Ministry of Health and partners involved in delivery of HIV services in Kenya in 2015 recommended reviewing the situation of most at risk adolescents below 19 years presenting for HIV and SRH services in the key population programs. Lack of data and detailed guidelines for programming, and concerns from health providers around legal implications of providing SRH services to adolescent key populations emerged as immediate challenges. In order to address this knowledge gap, UNICEF supported and partnered with LVCT Health and the Ministry of Health through the National AIDS and STIs Control Program (NAS COP) to conduct a situational analysis and gather evidence on most at risk adolescents (*understood in this analysis as girls engaging in sex work, boys engaging in same sex relations and adolescents injecting drugs*) to document lessons, best practices in service provision, gaps and opportunities in policy and programming. In line with Kenya's definition of key populations, HIV status of adolescents was not included as a criteria for participation in the study. The project was conducted between October 2015 and May 2016 and involved data collection from national level and three counties: Kisumu, Nairobi and Mombasa.

**Primary Objective:** To conduct a situational analysis and assess the magnitude of most at risk adolescents and any opportunities and barriers for HIV and sexual and reproductive health (SRH) services for most at risk adolescents in Kenya.

**Specific Objectives:**

1. To collect, review and analyse data from various sources to document the epidemiological (e.g. STI and HIV profiles) and behavioural data (e.g. condom use, sexual behaviour, HIV risk behaviour) among most at risk adolescents.

Data sources:

- (i) National survey data : Kenya AIDS Indicator Survey (KAIS) and Kenya Demographic and Health Survey (KDHS)
  - (ii) NASCOP key populations programme data from partners.
  - (iii) Routine HIV/SRH service data from LVCT Health programs (HTC clinic data and *one2one*<sup>®</sup> integrated digital platform data)
2. To assess the programmatic and policy environment to determine the barriers and opportunities for providing HIV/SRH care to most at risk adolescents in Kenya.
  3. To explore and document the perspectives of self-reported most at risk adolescents on HIV risk and their experiences as they seek HIV/SRH health care service in Kenya.

## Methods

The study utilized a mixed methods design involving a review of literature, quantitative and qualitative data collection and analysis methods. The literature search involved a review of globally and locally published and grey literature on adolescents' HIV and key populations programming. The review also utilized national and international guidelines and reports on adolescents and KP programs.

The quantitative study involved analysis of program data from NASCOP's Key populations, LVCT Health's HIV testing and counselling and *one2one* toll free youth hotline data. Secondary analysis of data from Kenya AIDS Indicator Survey (KAIS) 2012 and Kenya Demographic and Health Survey (KDHS) 2014 data for epidemiological and behavioural characteristics and trends among adolescents was done. However, KDHS 2014 data was not included in this report since the most at risk adolescents' respondents were too few to be generalizable.

The qualitative study was carried out in Nairobi, Mombasa and Kisumu counties, in Kenya. All data collection staff in the qualitative study were trained on data collection techniques. The study targeted most at risk adolescents, boys and girls (aged 10-19 years) including boys engaged in same sex relations, girls engaging in sex work and adolescents who inject drugs. Most at risk adolescents participants were identified in collaboration with key populations' organizations working in those counties. Snowballing method was used to get additional adolescent respondents. Health policy makers at national and county levels, key populations programme implementers and health service providers were purposively selected and interviewed. A total of 9 focus group discussions and 18 in-depth interviews were conducted with 108 most at risk adolescents' participants. Fifteen (15) key informant interviews were conducted with national and county policy makers, 18 with health service providers (clinicians and counsellors) and 18 with key populations' program implementers (program officers and managers). Quantitative data were analysed using SPSS v22 and qualitative data were analysed using the framework approach in Nvivo v11. The study followed guidelines outlined in the 2015, 'Guidelines for Conducting Adolescent HIV Sexual and Reproductive Health Research in Kenya' [10]. Ethical approval was obtained from the AMREF Ethics and Scientific Review Committee (ESRC P212/2015).

## Findings

During this study, a total of 108 self-identified most at risk adolescents including 37 female adolescents sexually exploited and engaging in sex

work, 36 adolescents' boys engaging in same sex relations, and 35 male & female adolescents who inject drugs participated voluntarily. Several of them reported to have started engaging in at risk behavior by the time they were 15 years.

**Table 1: Profile of study participants**

Demographic characteristics		Adolescent boys who have sex with boys and men	Adolescent female sex workers	Adolescents who inject drugs- female	Adolescents who inject drugs- Male
Age	10-14 years	0	2	0	0
	15-19 years	36	35	14	21
	Mean age (yrs)	17	17	18	18
Level of Education	Primary	6	20	10	12
	Secondary	21	15	4	2
	Tertiary	9	2	0	0
Number of children	0	35	15	8	16
	1	1	20	5	5
	2	0	2	1	0
Marital status	Single	35	33	12	18
	Married	1	1	2	0
	Separated	0	3	0	0

## Most at risk adolescents in Kenya

Data from NASCOP key populations programme reported that there were 120,820 key populations (FSW, MSM and PWID) offered services in the period April 2014 to March 2015, out of whom 8,363 (7%) were adolescents less than 19 years. The adolescents contributed to the total population of KPs as follows: 7% girls reporting sex work; 5% boys engaged in same sex relations; 13% girls who inject drugs; and 7% boys who inject drugs. It's worthwhile to note that the Key Populations

data from NASCOP did not disaggregate MSM and MSW. All were reported as MSM.

KAIS 2012 reported that 6.88% (n=57) adolescents have ever been given money/gifts for sex and the majority were from rural setting n=44 (77.19%).

LVCT Health's One2One data showed that of the pre-teen adolescents aged 10 to 13 years who called 19% (3% Male; 16% Female) were enquiring about Pregnancy/ birth control, 22% (12% Male; 10% Female) HIV knowledge, and 17% (8% Male; 9%

Female) on interpersonal relationships (including sexual relationships). Further adolescents calling in were asked about their preferred media in order to get information for targeted sources of information, 82.9% of the adolescents preferred television while the rest preferred radio (10.2%) and print media (7%).

A review of LVCT Health routine HTC data showed that of the adolescent boys who have sex with boys and men and female sex workers who have been accessing HTC and prevention services during outreach events and in VCT sites, 5% and 7% respectively were HIV positive, which is significantly higher than the 1.6% positivity reported for adolescents tested in the same LVCT Health data.

### **HIV risk among most at risk adolescents**

According to KAIS 2012 by the age of 15 years, 11.6% of adolescent girls and 20.2% of adolescent boys have already had sex at least once in their life time and by 18 years, 59% of adolescent girls/young women and 49.5% of adolescent boys/young men have had sex. Early sexual debut has been reported especially among boys engaging in same sex relations in global studies and shown to increase HIV risk [1]. This early age of sexual debut confirmed a systematic review by WHO/UNAIDS that reported that sexual debut among MSM was earlier than other populations. Age of sexual debut, low literacy levels, engagement in transactional sex, multiple sexual partners, age of sexual partners, low or no condom use, increased susceptibility to violence, early pregnancies amongst others were key drivers for HIV infection among at risk adolescents [5, 11]. These are similar to the findings reported by the WHO Inter-Agency Working Group on Key Populations which referenced studies from different countries globally [12].

KAIS demonstrated that condom use among youth aged 15 to 24 years was significantly lower for women and men who had their sexual debut before age 15 years (52.9% and 33.7% respectively) than for those who had their sexual debut at 15 years or older (69.8% and 64.5% respectively). 59% (346 of 585) of sexually active adolescents reported that they did not know the HIV status of their sexual partners [5].

Majority (60%) of the adolescent female sex workers who participated in this study had at least one child. Boys engaging in same sex relations reported that they had started having sex with other boys while at home resulting in them being expelled from home and school and ending up as sex workers. Several adolescent drug users reported that they had been exposed to drugs by peers and some by their parents and drugs vendors in their neighbourhoods as early as 10 years. Some were also engaged in sex work to finance their addiction. Many of the most at risk adolescents reported being defiled (sexually harassed), harassed by the police, clients and the general public.

The most at risk adolescents in sex work reported the following as factors that drove them into sex work: to escape poverty and meet financial responsibilities, such as supporting their families, parental care for their siblings and children born to teenage mothers and limited access to education among others. These findings are in line with the global findings in the WHO technical briefs on most at risk adolescents [7-9].

*"I began to use these drugs when I was 14 years and I was smoking a cocktail. When I reached 15 years I began injecting drugs because of the environment.....my friends and my mother is an injecting drug user, I decided to follow that route "*

(MSA. ADU.IDI.002)-Adolescent injecting drug user in Mombasa

## Perceptions of HIV risk among most at risk adolescents

The adolescent sex workers in this study perceived they were at risk of acquiring HIV due to exposure to unprotected sex (both consensual and non-consensual). There were mixed opinions on self-rating of HIV risk among adolescent boys engaging in same sex relations with those practicing sex work rating themselves at increased risk and the others rating themselves at low risk with reasons that they had one sexual partner and used condoms always. However there was a general feeling of increased HIV risk due to practicing anal sex and exposure to unprotected sex due to condom bursts. On the contrary - adolescents who report injecting drug use rated themselves at low risk of HIV acquisition despite reporting multiple partnerships, inconsistent condom use and overlapping vulnerabilities such as engagement in same sex intercourse, sex work and injection drug use.

*"...sometimes it is risky because you get a client and that time you are broke and you don't have condoms."*

*(MSA. MSM.IDI.001)-Adolescent MSM respondent from Mombasa*

Policy makers, health service providers, and health program officers and managers interviewed in the qualitative study identified most at risk adolescents as those engaging in sex work and injection drug use and adolescent boys engaging in same sex relations. Most argued that adolescents were at heightened risk because they were more likely to be undergoing growth and developmental (cognitive and neural) stages which increased their chances of wanting to experiment with sex and succumb to peer pressure.

## Most at risk adolescents experiences in accessing HIV and SRH services

The adolescent sex workers and adolescents injecting drugs reported having received a HIV test in the last 3 months. A few of the adolescent sex workers however said they feared a HIV positive test outcome and hence had not accessed HIV testing service. Majority of them preferred private health facilities to public facilities because of reasons such as increased confidentiality, limited stigma and discrimination, access to adequate amount of condoms, friendly services and fast tracked services. However, other participants preferred government health facilities because the services were cheaper.

*"Public hospitals discriminate and stigmatize us when we go seeking for health services. Health providers' attitude is very poor towards MSM"*

*(NAI.MSM. FGD.001) - Adolescent MSM respondent from Nairobi*

Some adolescents who inject drugs reported that negative health provider attitudes made them dislike accessing health care. Similarly, adolescent boys engaging in same sex relations reported that the negative attitudes of health providers in public facilities made them prefer accessing health services in friendly MSM centers as opposed to government facilities.

Adolescent IDUs stated that they either bought syringes, shared/borrowed from their friends, while a number of them would collect used needles from the streets and therefore the needle exchange program had been beneficial.

*"We pick the syringes on the street and use them to inject"*

*(KIS. ADU.FGD.001)-adolescent injecting drug user respondent from Kisumu*

Most health providers in the qualitative study reported providing common health services to most at risk adolescents. These services included: HIV testing, counseling and treatment, STI screening and treatment, health education, family planning, preventive measures such as VMMC and condoms, lubricants, referrals to specialized facilities such as hospitals that can offer surgery as a way of treating anal warts and other adherence measures. Organizations working with IDUs were reported in the qualitative study as providing PWID package of care that included needles and syringes exchange program. However the health providers in these organizations reported reservations about providing these services to adolescents due to lack of clear guidelines and possible legal implications. In addition, some of them mentioned that facilities do not have the right responsive measures towards health needs of adolescent who inject drugs such as rehabilitation centres, detoxification and counselling.

*“if they are not [programs] designed or geared towards those adolescents, you don’t find them or the program won’t find them...”*

(NAI.KII.008)-program implementer key informant interviewee from Nairobi

### Multi-sectoral barriers to HIV prevention and uptake of services among most at risk adolescents

Most at risk adolescents reported multi-sectoral barriers that affect their ability to lead regular lives and access HIV and SRH services as shown in the table below. These needs were mentioned as being on top of their minds and may not be exhaustive.

**Table 2: Most at risk adolescents’ perspectives on their needs**

	Adolescents PWIDs	Adolescent MSMs	Adolescent sex workers
Health services	Rehabilitation Access to clean needles and Syringes Access to methadone Health talks HTS and treatment	Prevention of HIV and STI	Prevention of HIV and STI
Education	Being taken back to school		Being taken back to school
Nutrition			Food for them and their children
Economic empowerment	Income Generating activities (IGAs)	IGAs	IGAs
Security	Protection from harassment by general public Protection from harassment by police	Protection from harassment by general public Protection from harassment by police	Protection from harassment by general public Protection from harassment and arrest by police
Stigma and discrimination		Protection from stigma and discrimination Information on dating and relationships Social networking	Protection from stigma and discrimination

*"... Some of us would like to go back to school so if there can be some sponsorship for education..."*

(KIS.ADI. FGD.001)-Focused group discussion with adolescent injection drug users from Kisumu

*"...Surgical removal of warts, TB screening and treatment ..."*

(NAI.MSM. FGD.002)-Focused group discussion with adolescent boys reporting same sex intercourse from Nairobi

*".....most young people spend a lot of time in school and therefore the school becomes a more conducive environment to integrate...SRH."*

(NAI.KII.007) -Policy maker at national level interviewee

*"...if they are girls who, probably sex workers, keeping them in school would probably stop them from engaging in unprotected sex even if they are being paid for sex using condoms."*

(NAI.KII.005) -Policy maker at national level interviewee

## **Policy environment: Opportunities and Barriers for addressing HIV/SRH needs of most at risk adolescents**

A review of existing policies showed that there exist inadequate policy and legal frameworks hindering planning, programming and development of programs that impact specifically on the health of most at risk adolescents. Data is not adequately disaggregated by age, gender, and risk behaviour to aid in planning at national and sub-national levels. Data from other sectors on adolescents HIV and SRH risk and needs is not routinely collected. In addition, policy and programming for most at risk adolescents is hampered by the fact that the behaviours they engage in such as sex work, same sex relations and drug use are considered illegal in Kenya.

Service provision to the adolescents is also affected by factors such as financial constraints by the users, lack of capacity by health personnel, regional disparities in access to services, and cultural values of health and other service providers that affect

proper implementation of services that would have reached such key populations. Research on adolescents HIV and SRH has been minimal in the country due to the fact that the 'adolescent' is not recognized as a legal age category hence hindering research, planning, programming and development of policies that impact on the health of those aged 10-17 years. This has however improved with the release of the 2015 guidelines for Conducting Adolescent HIV Sexual and Reproductive Health Research in Kenya. The ability to reach adolescents in school with HIV and SRH prevention messages and services relies on the revision of the school curriculum and inclusion of comprehensive sexuality education into the curriculum.

Opportunities for programming for most at risk adolescents that were identified include Kenya's commitment to international policies such as The Convention on the Rights of the Child (CRC) which seeks to protect the rights of children including adolescents to lead protected and safe lives and access to social services (including health) that

they require without prejudice. The constitution of Kenya and the Bill of Rights guarantees equal rights to health care while devolution of health also offers an opportunity for equitable resource allocation and prioritization of health and other services based on the needs of counties thereby increasing opportunity for access and availability of services to adolescents across the country.

The Kenya AIDS Strategic Framework (KASF) [4], the HIV prevention roadmap [13], and Fast Track plan to end HIV and AIDS among adolescents and young people [14] prioritize combination HIV prevention interventions for adolescents and key populations. Further, the country's drive towards implementing an adolescents' package of care [15] and increasing political will to support the fight against HIV is seen as an opportunity to scale up services that are tailored to meet their needs. In addition, the lowering of the age of consent for HIV testing to 15 years as provided for in the National HIV Testing Services Guidelines of 2015 [16] provides an important opportunity for HIV service delivery for adolescents and specifically those most at risk of HIV. A key gap that remains is the lack of specific guidance for provision of services to most at risk adolescents.

Different sub populations of most at risk adolescents in Kenya are at high risk of HIV and face unique challenges that affect their ability to grow up healthy and well. Factors that place adolescents at risk of HIV and negative SRH outcomes are multi-sectoral and need to be addressed holistically. From the study the adolescents reported that they started engaging or were forced to/in at risk behaviour from as early as 15 years or earlier and the different most at risk adolescents reported a mixed level of knowledge and understanding of their HIV risk e.g. sex workers were more aware of their HIV risk than drug users. Common issues from all three groups were related to addressing poverty, security and access to adolescent friendly health services.

It is critical to address the biomedical, behavioural and structural (related to environment, financial, policy and legal structures) risk factors from a multi-sectoral perspective if we are to see an end to AIDS.

HIV and SRH programmes for adolescents and minors ought to be informed by the Convention on Child Rights [17] and should be evidence based. From this situational analysis, and benchmarking with the WHO key populations guidelines recommendations for adolescent key population, the following recommendations are proposed:

**1. Address legal and policy environment that limit the most at risk adolescents human rights and access to services**

- The existing legal environment is restrictive and affects delivery of services by health providers and uptake of services by most at risk adolescents. There is need to review existing policies and legal frameworks that limit adolescents access to services based on age, those that result in criminalization of same sex behaviour, sex work and injecting drug use.
- Protection for health care workers providing HIV/SRH services to under 18 years.
- Policies at national and county level should aim at increasing access to social services for most at risk adolescents and promote the legal protection from abuse, violence and sexually exploitative adults including those in law enforcement.
- The health sector needs to update policies and guidelines on provision of services for most at risk adolescents with input from adolescents and limit the restrictions to access to services based on age and requiring parental consent.
- Increase access to legal services for most at risk adolescents to access information and assistance on their rights and receive legal redress as required.

## **2. Increase access to most at risk adolescents programs, ensuring their accessibility and affordability.**

- Refocus and invest in HIV/SRH prevention programs that target adolescents at a young age to delay their debut into at risk behaviour and provide appropriate information to minimize HIV vulnerability. This includes delivery of evidence based behavioural interventions in communities and schools as well as implementation of comprehensive sexuality education targeting those in schools.
- Provide adolescent friendly services in health facility and community settings through outreach programs. Involve adolescents in defining adolescent friendly and where possible and appropriate, providing the services.
- Scale up of services for most at risk adolescents based on geographic and target population considerations to ensure they are equitable, affordable and increase access and utilization by the most at risk adolescents.
- Train and provide continuous mentorship, supportive supervision and resources to health providers to facilitate services delivery to most at risk adolescents. Ensure health workers involved in KP and youth programs are appropriately selected to meet the needs of most at risk adolescents and minimize judgement, stigma and discrimination.
- Provide a broad range of services as defined in the KP guidelines specific to adolescents. Update the national KP guidelines to address needs of most at risk adolescents. See specific recommendations in table 3 below.

## **3. Strengthen strategic information and research**

- There are consistent data gaps in routine program data, surveillance and research on adolescents and specifically most at risk adolescents in Kenya and globally. There

is need to develop systems for collecting data on population size, demographics and epidemiology, with disaggregation of behavioural data and HIV, STI and other SRH needs by age group and sex through routine program and surveillance data systems.

- Advocate for and implement research on adolescents HIV/SRH including evaluation of health interventions and programs, laws and policies to assess their appropriateness, acceptability, relevance and effectiveness on most at risk adolescents.
- Use findings from research and strategic information to continuously improve programs and inform policy review and development.

## **4. Invest and adequately resource most at risk adolescents programs and research**

- Globally there has been significant investment in KP research, policy and programming. This has however not translated to investment in most at risk adolescents in spite of the evidence that there is a significant population of most at risk adolescents.
- There is need for increased funding from government and donors for implementation and scale-up of advocacy, research and evidence-informed initiatives addressing most at risk adolescents.
- Advocacy with donors and policy makers is required for more focused investments in critical enablers to address structural inequalities and conditions which exacerbate adolescents' vulnerability to HIV, such as HIV risk behaviours linked with gender violence, chronic poverty and lack of education among others.

## **5. Address cross cutting issues**

In addition to the specific recommendations listed above there are cross-cutting elements to be addressed to ensure the recommendations can be achieved. These include:

### **a. Multi-sectoral engagement**

- Most at risk adolescents' risk and vulnerability cannot be addressed by the health sector alone. Related sectors can address critical enablers such as shelter and housing, food security, education, life skills (at home and in the community by parents and guardians), economic strengthening and access to social services and state benefits such as cash transfers.
- There is need to engage with the education sector, children's department, local administration, police and judiciary, tourism among others to holistically address the needs of most at risk adolescents.
- The specific roles of the different sectors are outlined in table 3 below

### **b. Involvement of adolescents**

- Just like with adult KP populations, most at risk adolescents programs require the involvement of most at risk adolescents. Community consultations to understand their needs, risks, hopes and expectations for health and other social services would ensure the policies and programs developed are effective.
- Most at risk adolescents should be able to participate in research as participants and in the design of research interventions. Empowered adolescents can effectively participate in advocacy for policy change and legal rights as well as development of programs suitable for them. Trained most at risk adolescents are also instrumental in delivery of HIV prevention messages to their peers and follow up for retention in various programs.

### **c. Advocacy**

Findings from this study have shown that most at risk adolescents in Kenya have not been prioritized. They are unable to access services due to existing or perceived legal or policy restrictions and stigma

and discrimination from the public. Service access is also impeded by uncertainty in understanding their needs by health providers, policy makers and programmers.

- Concerted advocacy efforts from various groups would help to address these barriers and ensure effective HIV/SRH prevention and care programming for most at risk adolescents similar to other populations. This advocacy can ride on the existing momentum in the country to address adolescent HIV.
- The advocacy should be targeted at achieving the key recommendations listed above including improving the legal and policy environment, reduction of stigma and discrimination, provision of appropriate services, strategic information and research and sustained investment in most at risk adolescents programming.
- The most at risk adolescents, KP organizations, CSOs in health and human rights should work together to achieve these advocacy outcomes for them to be successful.

**Table 3: Specific recommendations for Kenya' most at risk adolescents programming based on the WHO KP guidelines that can be adapted to local context**

WHO KP guidelines recommendations	Local context adaptation recommendations	Sector responsible
<b>Essential health sector interventions</b>		
1. Comprehensive condom and lubricant programming.	<ul style="list-style-type: none"> <li>Allow access to condoms and lubricants for adolescents in appropriate settings</li> <li>Increase access points where most at risk adolescents can access condoms and lubricants freely especially in community settings</li> </ul>	Health
2. Harm reduction interventions for substance use (in particular needle and syringe programmes and opioid substitution therapy).	<ul style="list-style-type: none"> <li>Existing harm reduction programs should be extended to cover those less than 18 years.</li> <li>Programs should be extended to cover areas in need with limited or no access</li> <li>Address legal barriers, criminalization and victimization faced by the adolescent drug users seeking treatment</li> </ul>	Health  Police, local administration, Judiciary, community
3. Behavioural interventions	<ul style="list-style-type: none"> <li>Provide evidence based behavioural interventions (EBIs) appropriate for different age groups to ensure delayed sexual debut for those not engaged in sex, reduction of HIV risk including engaging in condom less sex etc.</li> <li>Provide interventions in community, health facility &amp; school settings as required/informed by adolescents</li> </ul>	Health  Community  Education
4. Biomedical interventions	<ul style="list-style-type: none"> <li>Freely provide post-exposure prophylaxis to those adolescents who request it following consensual or non-consensual sexual exposure</li> <li>Include adolescents at substantial risk of HIV in Pre-exposure prophylaxis interventions</li> </ul>	Health
5. HIV testing and counselling.	<ul style="list-style-type: none"> <li>New HTS guidelines lowered the age of consent for HTS to 15 years therefore there should be no restriction on testing for adolescents.</li> <li>Provide quarterly retesting for most at risk adolescents as informed by guidelines in community and facility settings</li> <li>Provide linkage to care services and prevention services as needed</li> <li>Roll out self-testing to the most at risk adolescents</li> </ul>	Health

WHO KP guidelines recommendations	Local context adaptation recommendations	Sector responsible
6. HIV treatment and care.	<ul style="list-style-type: none"> <li>● Provide adolescent friendly anti-retroviral treatment services including access to services for prevention of mother-to-child transmission in existing facilities and KP centers as per guidelines</li> <li>● Follow up closely to achieve adherence and viral suppression</li> <li>● Provide additional services such as nutrition, economic support e.g. cash transfers to enhance adherence and improve outcomes</li> </ul>	Health  Local administration, community, children's department
7. Sexual and reproductive health interventions.	<ul style="list-style-type: none"> <li>● Provide contraception, diagnosis and treatment of sexually transmitted infections, cervical screening, post-abortion care etc. to most at risk adolescents in community and facility settings.</li> <li>● Services should be non-judgemental and respect human rights</li> <li>● Screen for and provide treatment and counselling for GBV</li> </ul>	Health
8. Prevention and management of co-infections and other co-morbidities, including viral hepatitis (B and C), tuberculosis and mental health conditions.	<ul style="list-style-type: none"> <li>● Routine screening and treatment for comorbidities and co-infections in community and facility settings</li> <li>● Routine screening and management of mental-health disorders, including evidence-based programmes for those with harmful alcohol or other substance use.</li> <li>● Provide psychosocial counselling</li> </ul>	Health  Local administration  NACADA  Education
<b><i>Essential strategies for an enabling environment</i></b>		
1. Supportive legislation, policy and financial commitment, including decriminalization of behaviours of key populations.	<ul style="list-style-type: none"> <li>● Review specific national and county level laws and policies that impede access to social services for most at risk adolescents and promote the legal protection from abuse, violence and sexually exploitative adults</li> <li>● Advocate for financing specific for most at risk adolescents' HIV/SRH policies, research and programs</li> <li>● Include most at risk adolescents in social protection programs such as cash transfers</li> </ul>	All

WHO KP guidelines recommendations	Local context adaptation recommendations	Sector responsible
2. Addressing stigma and discrimination.	<ul style="list-style-type: none"> <li>● Address harmful social norms and practices that discriminate and marginalize children and adolescents based on real or perceived sex work, drug use as well as aspects around sexual orientation, gender identity.</li> <li>● Groups to be targeted include: <ul style="list-style-type: none"> <li>- Parents and communities</li> <li>- Education sector</li> <li>- Law makers (members of parliament and members of county assembly)</li> <li>- Police and judiciary</li> <li>- Religious leaders and others</li> </ul> </li> </ul>	All
3. Community participation and empowerment.	<ul style="list-style-type: none"> <li>● Empower most at risk adolescents and networks of KPs to engage in advocacy and inform policy and service delivery appropriate for their needs</li> <li>● Educate and work with communities to address social norms and stigma around most at risk adolescents and provide the necessary protection against exploitation</li> </ul>	Health Human and legal rights Community Tourism
4. Addressing violence against people (especially most at risk adolescents) from key populations.	<ul style="list-style-type: none"> <li>● Recognise that most at risk adolescents face physical and sexual violence from the community, their clients, and law enforcers. Violence includes harassment, discriminatory application of public-order laws and extortion</li> <li>● Provide appropriate trauma and assault care, including post-rape care</li> <li>● Advocacy with government, law enforcement and other perpetrators of violence, and community-led response initiatives for prevention of, and response to violence</li> <li>● Provide legal services for advocacy and assistance, including information about their rights, reporting mechanisms and access to legal redress</li> </ul>	Health Legal Law enforcement Community

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