Strengthening National Responses to HIV and Adolescents in Emergency Situations

Lessons Learned from Côte d’Ivoire and Haiti

April 2013
# Table of Contents

**ACKNOWLEDGEMENTS**  
3

**ABBREVIATIONS/ACRONYMS**  
4

**EXECUTIVE SUMMARY**  
5

**BACKGROUND AND RATIONALE**  
7

**OBJECTIVES**  
8

**METHODOLOGY**  
9

**HIV, ADOLESCENTS AND EMERGENCIES: AN OVERVIEW**  
10

**SYNTHESIS OF KEY FINDINGS FROM THE COUNTRY REVIEWS**  
12

**LESSONS LEARNED FROM THE COUNTRY REVIEWS**  
14

**OVERALL RECOMMENDATIONS**  
19

**ANNEX: GENERIC QUESTIONS FOR KEY INFORMANT INTERVIEWS AND FOCUS GROUP DISCUSSIONS**  
23

**CÔTE D’IVOIRE REVIEW**  
25

1. **Setting the Scene**  
25
2. **Key Informant Interviews**  
26
3. **Focus Group Discussions**  
34
4. **Lessons Learned**  
35
**Annexes**  
39

   **Annex 1: Agenda, Cote d’Ivoire, 24-29 September 2012**  
39
   **Annex 2: Focus Group Discussions**  
42
   **Annex 3: PNLS and Young People**  
45
47

**HAITI REVIEW**  
49

1. **Setting the Scene**  
49
2. **Key Informant Interviews**  
51
3. **Focus Group Discussions**  
53
4. **Lessons Learned**  
54
**Annexes**  
58

   **Annex 1: Agenda: Haiti, 3-9 June 2012**  
58
   **Annex 2: Focus Group Discussions**  
62
Acknowledgements

The Côte d'Ivoire and Haiti country reviews that form the basis for this report were carried out in collaboration with the staff of UNAIDS, UNHCR, UNICEF, UNFPA, IOM, WFP and a range of government Ministries, NGOs and young people. Without their active engagement, insights and support with the identification of documents and the planning and facilitation of the in-country assessments, neither the country reviews nor the synthesis report would have been possible.

Bruce Dick carried out the country reviews and was responsible for writing this report, under the overall guidance and support of Gary Jones, UNAIDS RST ESA, and Sarah Karmin, UNICEF NYHQ. The UN teams in Côte d'Ivoire and Haiti reviewed the country assessments for accuracy and omissions.

Special thanks to Kate Spring (UNAIDS Haiti), Youssouf Sawadogo (UNICEF Haiti), Isabelle Kouame (UNAIDS Côte d'Ivoire), Cecile Mazzacurati (UNFPA New York), Sarah Karmin, Gary Jones and Diane Widdus for their helpful comments and suggestions on previous drafts of this report.
Abbreviations/Acronyms

ALHIV  Adolescent living with HIV/AIDS
ASRH  Adolescent sexual and reproductive health
DRC  Democratic Republic of the Congo
EC  Emergency contraception
FGD  Focus group discussion
GBV  Gender-based violence
HMIS  Health management information systems
HTC  HIV testing and counselling
IASC  Inter-agency standing committee
IATT  Interagency task team
IAWG  Interagency working group
IDP  Internally displaced populations
IEC  Information, education and communication
IOM  International Organization for Migration
LGBT  Lesbian, gay, bisexual and transsexual
MINUSTAH  United Nations Stabilization Mission in Haiti
MOY  Ministry of Youth
MSM  Men who have sex with men
NGO  Non-governmental organization
PEP  Post-exposure prophylaxis
PLHIV  People living with HIV
PMTCT  Prevention of mother to child transmission
SCF  Save the Children Fund
SRH  Sexual and reproductive health
STI  Sexually transmitted infection
UCO  UNAIDS country office
UN  United Nations
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNFPA  United Nations Fund for Population Activities
UNHCR  United Nations High Commissioner for Refugees
UNICEF  United Nations Children's Fund
UNOCI  United Nations Operation in Côte d'Ivoire
WFP  World Food Programme
WHO  World Health Organization

Adolescent living with HIV/AIDS
Adolescent sexual and reproductive health
Democratic Republic of the Congo
Emergency contraception
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Health management information systems
HIV testing and counselling
Inter-agency standing committee
Interagency task team
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Internally displaced populations
Information, education and communication
International Organization for Migration
Lesbian, gay, bisexual and transsexual
United Nations Stabilization Mission in Haiti
Ministry of Youth
Men who have sex with men
Non-governmental organization
Post-exposure prophylaxis
People living with HIV
Prevention of mother to child transmission
Save the Children Fund
Sexual and reproductive health
Sexually transmitted infection
UNAIDS country office
United Nations
Joint United Nations Programme on HIV/AIDS
United Nations Fund for Population Activities
United Nations High Commissioner for Refugees
United Nations Children's Fund
United Nations Operation in Côte d'Ivoire
World Food Programme
World Health Organization
Executive Summary

Young people (10-24 years) comprise an important segment of populations affected by emergencies and other causes of humanitarian responses, both in terms of their numbers and also in terms of their vulnerability. They face many challenges in such situations that undermine their human rights and that have a serious impact on their mental and physical health and development. Factors that negatively affect them in non-disaster times frequently become more severe, in terms of access to education, health services and decent work, for example, and the determinants that underlie high-risk behaviours, disease, disability and death are often aggravated.

Among the many challenges that young people face in such situations is HIV, in terms of the prevention of transmission and the treatment and care for young people living with HIV. For the most part, the same factors that compound the problem of HIV also increase a range of health and social consequences related to young people’s sexual and reproductive health.

The importance of responding to the needs of young people in emergencies has been understood for many years, and a growing number of organizations are including a focus on young people, HIV/ASRH and humanitarian settings into their work. Within the UN there have been concerted efforts to strengthen the overall response to HIV in emergencies through the Inter-Agency Standing Committee Guidelines for Addressing HIV in Humanitarian Settings, and in terms of adolescents (10-19 years) and youth (15-24 years) there are now a number of programme support tools available to help countries respond to their specific needs.

Despite this, however, there is on-going concern that young people in general, and adolescents in particular (10-19 years) do not receive sufficient attention in humanitarian settings, and that this has both important immediate implications for their health during the emergencies, and also much longer-term implications for them, their families and their communities.

Among young people (10-24 years), adolescents may be particularly vulnerable and particularly ignored, falling between the cracks of programmes for children and programmes for adults. Despite their evolving capacities they have usually not made the transitions to adulthood (reproduction and production), and remain dependent on adults for protection, provision and support. Furthermore, the challenges of this phase of rapid development are significant: puberty, brain development and changes in their social roles and responsibilities. It is easy for programmers and policy makers to shrug their shoulders and say, “of course adolescents are covered by existing programmes”. But there is both anecdotal information and research to indicate that this is far from the case.

This report aims to respond to these concerns. It is based on a review of global documents and programme support tools, and an assessment of the activities that were implemented in response to HIV and young people in two humanitarian settings (Côte d’Ivoire and Haiti), in order to learn lessons that might have wider implications and contribute to strengthening national responses. The countries were selected...
opportunistically, and the rapid assessments included a review of key documents, key informant interviews and focus group discussions with young people. In addition to providing an overview of the two country reviews, the report includes a synthesis of the main findings and lessons learned from the two reviews, and some overall recommendations.

The key findings highlight the similarities and differences between the humanitarian situations in the two countries; the fact that in both countries there was a combination of acute/chronic natural/man-made emergencies; that adolescents are often vulnerable even before the emergencies; and that their vulnerability is exacerbated with the onset of the emergency, in terms of the problems that they face and the response, both generally and also specifically in relation to HIV and ASRH.

Lessons learned from the country reviews include the importance of:

- Explicitly focusing on adolescents in humanitarian settings;
- Involving young people in the development, implementation and monitoring of the response;
- Understanding the factors that make young people vulnerable to HIV in such settings and appreciating the important links between HIV and adolescent sexual and reproductive health;
- Having consensus about the critical core interventions that need to form the basis of any response;
- Ensuring that there is adequate planning and preparedness;
- Providing strong advocacy for adolescents, HIV and ASRH
- Developing effective coordination systems and clarity about strategic approaches;
- Collecting, analyzing and disseminating age-disaggregated strategic information;
- Linking disasters and development in order to respond to the challenges of sustainability.

The overall recommendations highlight the need for strong leadership, clarity about the priorities for action, and possible approaches to strengthening guidance and support for action in countries.

It is hoped that this report will be seen as a contribution to improving the response to HIV/ASRH and adolescents in humanitarian settings. It is not intended to be an end in itself, but rather a stimulus for dialogue and debate, and that although it focuses on HIV/ASRH it will provide an entry point for raising the broader issues of young people’s health and development in humanitarian settings, including their mental health, which in general remains seriously neglected in terms of prevention and response (e.g. psychosocial support).
Background and Rationale

Adolescents (10-19 years) and youth (15-24 years) represent a significant proportion of populations affected by natural and man-made humanitarian emergencies - in some of the countries affected more than 60% of the population may be under the age of 25 years. They are also likely to be particularly adversely affected by the changes that take place during emergencies, including the breakdown of cultural and social systems and structures; family disruption and separation from parents; violence, including sexual violence, and a loss of protection; the closure of schools and disruption of health services and commodities; and lack of food, money and other resources.

The many changes that take place in emergencies, at individual level and in their physical and social environment, may increase young people's vulnerability to a range of high-risk behaviours (such as unsafe sex, alcohol and substance abuse) and undermine their physical and mental health, including their sexual and reproductive health (SRH). In all situations, but particularly in generalized HIV epidemics, these changes also increase the likelihood of HIV transmission and compound the challenges for adolescents living with HIV (ALHIV).

Many of the interventions that young people (10-24 years) need in such situations are similar to those needed by small children and adults: food, clothing, shelter, protection from exploitation and abuse and the provision of basic services. However, during all phases of humanitarian actions adolescents need special attention, in preparedness, response and recovery, because this is a period of rapid development and changing capacities, that affect adolescents' roles and responsibilities, how they cope in the present and think about the future; they often lack information and skills; and even in the pre-emergency situation they constitute a segment of the population whose needs are frequently overlooked and neglected.

Not only is there concern about the fact that strategies that respond to the specific needs of adolescents and youth are frequently not well developed in humanitarian settings, but programmes directed to the prevention and treatment of HIV are also often suboptimal. For young people in such situations, this double neglect may further increase their vulnerability and risk of acquiring HIV.

The overall architecture of coordination mechanisms within the UN for HIV and young people in humanitarian/emergency settings is outlined in the IASC Guidelines. In addition, there are a number of guidance documents dealing with young people and HIV or adolescent sexual and reproductive health (ASRH) in emergency settings. However, despite the availability of these programme support tools, concerns remain that adolescents do not receive sufficient attention during emergency responses, in general, but more specifically in terms of their increased vulnerability to HIV and their needs for prevention, treatment and care. Despite the coordination mechanisms outlined in the IASC Guidelines, it has proven to be difficult sometimes to integrate HIV into humanitarian responses. Integrating HIV into weak or non-existent adolescent programmes is equally challenging.
Objectives

In order to strengthen the response to the prevention and care of HIV among young people\(^1\) in emergency and humanitarian settings, UNAIDS and UNICEF, in collaboration with UNHCR, WFP, UNFPA and other key partners and existing consultative mechanisms, carried out a review of two major on-going humanitarian responses (Haiti and Côte d’Ivoire), to:

1. Provide an overview of the needs of young people in the two selected humanitarian/emergency situations, with a specific focus on their needs for HIV-related responses.
2. Review the programmatic response that has been explicitly designed to meet the HIV-related needs of young people, through a range of sectors (e.g. health, education, social protection) and a review of what has been done that indirectly addresses HIV needs/priorities.
3. Assess whether available guidance has been used, whether this has helped develop the response, what the gaps are in terms of the availability of support and resources to turn global guidance into context-specific guidance and action.
4. Support the development of a limited number of strategic activities for each of the Clusters (sectors) that build upon and strengthen their existing response to young people and HIV\(^2\).
5. Assess the effectiveness of existing coordination mechanisms that have an impact on the response, including the humanitarian cluster system, the UN Joint Team and the UNAIDS Division of Labour and assess coordination with national stakeholders.
6. Synthesize the experiences from the two humanitarian response programmes in order to identify overall lessons learnt and make recommendations for improving future responses.
7. Develop key elements to supplement existing guidance and outline next steps for meeting the programme support challenges identified during the country reviews.

The review:

- Focused primarily on adolescents, and aimed to ensure that the gender dimensions of both the needs and the responses were given adequate consideration.
- Gave particular attention to the IASC Guidelines for Addressing HIV in Humanitarian Settings, while taking into consideration other available guidance materials and programme support tools.

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\(^1\) Young people are defined as 10-24 years, incorporating adolescents (10-19 years) and youth (15-24 years). Age is only one of the factors that define the segment of the population that are “no longer children and not yet adults” (although it needs to be noted that the majority of adolescents are children in terms of the under-18 years definition of child adopted by the Convention on the Rights of the Child). Adolescents are frequently particularly vulnerable within the overall group of young people, and are often the most neglected in programmes that are designed more broadly for young people. While the primary focus of this report is adolescents, in parts of the report the focus is more generally on young people, for a number of reasons including the lack of age disaggregated data or the need to respond to the problems of the entire age group of young people.

\(^2\) Inter-Agency Standing Committee (2010): *Guidelines for Addressing HIV in Humanitarian Settings*
• Linked with existing collaborative mechanisms within the UN and with other key partners (i.e. IASC, IATT/YP, Inter Agency Working Group on Reproductive Health in crisis).
• Built on and linked to existing reviews and projects that have focused on young people in humanitarian settings, both in the selected countries and also more generally.
• Engaged and worked with staff on the ground in the two countries included in the review, Haiti and Côte d’Ivoire (the UCOs and the clusters playing a key role).
• Ensured that young people participated in the review and provided a lens to understand how HIV could be more effectively mainstreamed/integrated into the overall humanitarian response.
•Focused on HIV, but at the same time explored the linkages to young people’s health and development more generally in humanitarian responses, including their sexual and reproductive.

**Methodology**

The review consisted of a review of key global documents and programme support tools, two country reviews, and a synthesis of the lessons learned.

The reviews of Côte d’Ivoire and Haiti consisted of:

1. A review of key documents relating to the response to HIV and young people within the overall humanitarian response;

2. Key informant interviews carried out with UN partners (technical focal points of the inter-agency group), government Ministries and NGO partners, either individually or in small groups;

3. Focus group discussions with young people, 15-20 years of age; the focus group discussions were facilitated by people in the countries experienced in working with young people in the settings from which they came.

A set of generic questions were developed for the key informant interviews and the focus group discussions that were subsequently revised/refined for the different country reviews with input from the staff of UNAIDS and key partners (see Annex 1).

In Haiti the review was limited to a range of partners based in Port au Prince, and adolescents living in IDP camps in and around Port au Prince. In Côte d’Ivoire interviews were carried out with key informants in Abidjan and humanitarian actors in the West of the country where many of the internally displaced populations had moved following the post-election violence. Focus group discussions (FGDs) were also carried out with adolescents in both Abidjan and also in Duékoué in the West of the country.
HIV, Adolescents and Emergencies: an Overview

In 2011, 336 natural disasters and 234 technical disasters were reported worldwide, affecting an estimated 209 million people. In the same year UNHCR recorded over 15 million refugees worldwide and over 26 million internally displaced people. Based on the demographic profiles, particularly those of low and middle-income countries where the impact of disasters and population displacements are generally most serious, over 30% of the people affected by these humanitarian situations will have been young people.

In the same year, while there was cause for optimism in relation to the global HIV/AIDS pandemic, there were an estimated 34 million people living with HIV, of whom about 5 million were in the 15-24 year age group, and 2-5 million new infections, with 40% of new infections in people over the age of 15 years taking place in young people 15-24 years of age. Emergency-affected populations are often at increased risk of HIV transmission. Furthermore, in terms of sexual and reproductive health more generally, it is salutary to note that in 2010, while 60% of the global maternal mortality occurred in ten countries, nine out of ten of the countries with the highest rates of maternal mortality were countries that were currently or had recently been in a state of war or civil unrest. Again, in these populations young women are likely to bear the brunt of both the factors undermining sexual and reproductive health and the failure to respond effectively.

Where disasters happen, for example rural or urban settings, and where and how displaced populations move have implications in terms of accessibility, community support and social cohesion, family structure and social roles, and the needs for humanitarian assistance. All of these factors have an impact on the needs of adolescents and the humanitarian response.

The importance of focusing on young people in emergencies and other humanitarian situations is not a new one. At the same time, since the early days of the HIV pandemic it has been clear that humanitarian disasters have important implications for HIV in

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10 UNFPA (2010): State of World Population Report 2010 - From Conflict and Crisis to Renewal: generations of change. The countries are: Afghanistan, Bangladesh Democratic Republic of the Congo, Ethiopia, India, Indonesia, Nigeria, Pakistan, Sudan, United Republic of Tanzania
12 Graca Machel (1996): The Impact of Armed Conflict on Children, United Nations
general\textsuperscript{13}, and that young people are at the centre of the pandemic in terms of vulnerability, transmission and impact\textsuperscript{14}. Furthermore, the changes that take place during humanitarian crises compound the factors that underlie young people’s vulnerability to HIV. This has implications for all young people affected by emergencies, but particularly for those living in countries with generalized epidemics or for young key affected populations.

Many organizations include a focus on adolescents and youth, humanitarian situations, HIV among young people and adolescent sexual and reproductive\textsuperscript{15} 16 17 18 19 20 21 22. In addition there are a number of studies that highlight the specific needs of adolescents in humanitarian situations, and a range of advocacy and programme support materials and training programmes have been developed to strengthen and improve the response to young people, HIV and ASRH in emergencies\textsuperscript{23} 24 25 26 27 28 29 30 31 32 33 34 35 36.

\textsuperscript{13} IFRC (2008): World Disasters Report – Focus on HIV and AIDS
\textsuperscript{14} Advocates for Youth: Youth and the Global HIV Pandemic – reaching key affected populations and empowering a generation http://www.advocatesforyouth.org/publications/publications-a-z/2054-youth-and-the-global-hiv-pandemic
\textsuperscript{15} http://www.unicef.org/adolescence/index_40442.html
\textsuperscript{16} http://www.unfpa.org/emergencies/people.htm
\textsuperscript{19} http://ippf.org/our-work/what-we-do/adolescents
\textsuperscript{20} 21 www.unfpa.org/hiv/iatt/docs/humanitarian.pdf
\textsuperscript{21} For example DFID is incorporating aspects of ARSH into the new regional ESA strategy on humanitarian settings
\textsuperscript{22} UNHCR, Women’s Refugee Commission: Work with Young Refugees to Ensure their Reproductive Health and Wellbeing – its their Right and our Duty – a field resource for programming with and for refugee adolescents and youth www.rhrc.org/resources/unhcr_paper_new.pdf
\textsuperscript{23} Women and Commission for Refugee Women and Children (2000): Untapped Potential – adolescents affected by armed conflict: a review of programs and policies. This report states: “The international response to [the Graca Machel Study’s] adolescent-specific findings is an important test in all follow-up efforts and future initiatives”
\textsuperscript{24} Women’s Refugee Commission (2011): Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations – a distance-learning module
\textsuperscript{25} UNFPA, IPPF, UNSW (2008): Training on the minimum initial service package (MISP) for sexual and reproductive health in crises – a course for SRH coordinators
\textsuperscript{26} Global Round Table Working Group on Youth: Youth and the State of the World http://www.advocatesforyouth.org/publications/455/task=view
\textsuperscript{27} UNICEF (2009): A Practical Guide to Developing Child-friendly Spaces
\textsuperscript{28} UNICEF (2005): Emergency Field Handbook – a guide for UNICEF staff
\textsuperscript{29} http://rayharris57.wordpress.com/2012/08/07/new-training-module-on-adolescents-and-youth-programming-in-emergencies/
\textsuperscript{30} Inter-agency Working Group on Reproductive Health in Crises (2010): Inter-agency Field Manual on Reproductive Health in Humanitarian Settings
\textsuperscript{31} SCF, UNFPA (2009): Adolescent Sexual and Reproductive Health Tool-Kit for Humanitarian Settings – a companion for the inter-agency field manual on reproductive health in humanitarian settings
\textsuperscript{32} UNAIDS, Inter-Agency Task Team on HIV and Young People (2008): Global Guidance Brief on HIV Interventions for Young People in Humanitarian Emergencies. New York, UNFPA,
\textsuperscript{33} UNFPA, UNICEF, GSG (2006): Executive Summary Expert Group Meeting on Young People in Emergency and Transitional Situations
\textsuperscript{34} Global Youth Action Network (GYAN), UNFPA. UNICEF, Women’s Commission for Refugee Women and Children (2008): “Will you listen?” young voices from conflict zones
\textsuperscript{35} UNHCR (2010): Establishment of Multi-purpose Youth Friendly Centres for Young Refugees in Nepal.

11
However, the combination of young people, HIV/ASRH and humanitarian situations continues to fall between the cracks. Even among organizations that focus on adolescents, HIV and humanitarian settings it is not always clear how these issues come together, rather than remaining in their different “boxes”: sometimes where the SRH and humanitarian settings are dealt with young people are not mentioned, or where adolescents and HIV/ASRH are mentioned there is no focus on humanitarian settings. Added to this are the complex determinants and linkages between emergency and development situations, the heterogeneity of young people, and the on-going need to question current orthodoxy.

Synthesis of Key Findings from the Country Reviews

Similar despite the differences
Despite the major causes of the emergency situations being dissimilar, with Haiti being primarily the result of hurricanes, floods, landslides, a major earthquake and a subsequent cholera epidemic, and the emergency in Côte d’Ivoire essentially resulting from civil unrest and violence, they had many characteristics in common: they increased the vulnerability of young people in similar ways, and the impact on adolescents and youth had many commonalities.

Acute and chronic emergencies combined
In both countries there was a combination of man-made and natural causes of the emergencies: in Haiti for example, in addition to the earthquake and the cholera epidemic there was an on-going presence of MINUSTAH, the United Nations Stabilization Mission in Haiti; and in Côte d’Ivoire part of the conflict in the West of the country has been related to long-term land disputes. In addition, in both countries while there have been recent acute emergencies, these have taken place in the context of chronic emergency situations, with the conflicts in Côte d’Ivoire stemming from political unrest during the past twenty years and the recent emergencies in Haiti taking place against a background of both civil conflict over many years and frequent natural

40 WHO (2012): *Integrating sexual and reproductive health into health emergency and disaster risk management*
41 UNAIDS (2011) *Securing the Future Today Synthesis of Strategic Information on HIV and Young People*
42 In general there are many missed opportunities to better link the reporting of individual-level indicators to data relating to the context, especially relevant in view of the focus on combination prevention and the inclusion of structural interventions
47 It should be noted that both Haiti and Cote d’Ivoire have on-going civil unrest and violence requiring the presence of the UN Department of Peace Keeping Operations (MINUSTAH in Haiti and UNOCI in Côte d’Ivoire), both of which were established in 2004.
disasters. This has a number of implications for both the preparation and the response to the recent emergencies in both countries.

**Adolescents vulnerable even without the emergencies**

Even in the pre-emergency situation in both countries adolescents were vulnerable to HIV and ASRH-related problems, such as STIs and unwanted pregnancy, with poor access to services, high unemployment, poverty, and unsupportive social values and norms. These and other determinants of poor sexual and reproductive health affect both the general population of adolescents and also particularly vulnerable groups of adolescents, such as adolescents living on the streets, young girls who were sexually exploited and young men having sex with men (MSM). In addition, both countries face a generalized epidemic with a significant amount of transmission taking place in young people 48, 49.

**Increased adolescent vulnerability in IDPs**

There were several other ways in which the emergencies in Côte d’Ivoire and Haiti were similar, despite their differences. First, they caused major population displacements, with many of the people displaced ending up in camps for internally displaced populations (IDPs). In these camps, in both countries, there was social and family disruption, with ensuing lack of protection and parental support, resulting in, among other things, the exposure of adolescents, particularly adolescent girls to significant sexual violence including rape, and to many other factors that increased their vulnerability to HIV 50 and undermined their SRH: poverty, lack of schools and other amenities, lack of health services 51 and commodities, including condoms. Although all the camps had closed in Côte d’Ivoire by the time of the review, a number of camps in Haiti were still in existence more than two years after the earthquake in 2010. Even when people moved out of the camps many of them found themselves in situations that continued to increase their vulnerability to HIV and undermined their SRH.

**Lack of attention to adolescents, before and during the emergencies**

In both countries there was relatively weak disaster preparedness and contingency planning in terms of the response to adolescents and youth, both in general and also with respect to HIV and ASRH in particular, despite the fact that both countries are experiencing chronic emergency situations that make young people particularly vulnerable. There were a number of reasons for this, not least the fact that the overall planning and response to adolescents and HIV/ASRH in the pre-emergency situation was often not particularly well developed, even if individual NGOs and UN agencies were implementing or supporting the implementation of activities (although these were mostly small-scale and project-based).

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48 For example, the 2012 DHS preliminary report in Haiti provides the following prevalence estimates: 15-19 years: Total 0.4; M: 0.2; F: 0.5; 20-24 years: Total 1.5; M: 0.7; F: 2.1; 25-29 years: Total 2.8; M: 1.1; F: 4.2


50 For example, in Haiti the 2012 DHS estimates the national HIV prevalence as 2.2 for the general population (males 1.7; females 2.7) and 3.9 in the internally displaced population camps (males 2.0; females 5.7)

51 Adolescents are a relatively ignored segment of the population even in non-humanitarian settings, and the lack of attention to this age group in the health service delivery life-course continuum has implications in both emergencies and non-emergency situations. This applies similarly to other groups of the population that are excluded from the primary focus of many governments and NGOs: services for children under 5 and reproductive health services for women.
Weak coordination explicitly around adolescents and HIV/ASRH
Although the Cluster System for UN coordination functioned in both settings, there was little explicit coordination around the response to adolescents. Adolescents were one of the many items on the overall coordination agendas, and were the focus of discussions during meetings from time to time. But there was no system for monitoring follow-up, no specific forum for ensuring that those people from the different UN partners with a responsibility for young people met on a regular basis, and no setting through which the range of partners responding to the needs of young people could meet with the relevant government departments to share information and programme support tools, or collaborate around planning and monitoring for this important segment of the population\(^{52}\).

Lessons learned from the Country Reviews

1. **Ensure a focus on adolescents**
   When directing interventions to young people (10-24 years) there may be a tendency to focus on the older age groups (e.g. 20-24) at the expense of adolescents (10-19 years), who may often not only be more vulnerable but are also likely to pose more challenges for programme planning and service providers (i.e. in terms of issues such as informed consent, the importance of parental support, and community attitudes to adolescents accessing HIV/ASRH information and services/commodities, including condoms). In addition, in some settings it may be easier to reach out to young men/boys rather than girls, especially younger adolescent girls, all the more so if they are already particularly vulnerable and not easily accessible to programmes because they are hidden in their communities (e.g. heads of households, domestic workers, already married).

2. **Involve adolescents/youth:**
   Facilitating the participation of adolescents and youth is important for many reasons – to ensure that their perspectives are given adequate consideration, their ideas are incorporated into the interventions that are developed, they contribute to implementing the programmes (important both for the interventions and for the adolescents’ individual development), and they are involved in monitoring what is being done. Involving young people helps to ensure that the interventions are relevant, as was made clear during the Focus Group Discussions, and that they achieve their desired outcomes. However, in order to achieve this it is necessary to both provide adequate training and support for the young people, and ensure that service providers and others have the capacity to facilitate such participation in full respect of safety and ethical standards\(^{53}\) and to ensure that young people’s suggestions are subsequently reflected in policies and programmes.

\(^{52}\) The lack of attention to adolescents within the Clusters is a reflection of the fact that at global level there is also no specific focus on adolescents/youth in the Cluster system. "Age" is one of the “cross-cutting issues” but this has not translated into any concrete platform (contrary, for example, to the Gender sub-working group) or development of technical guidance. Some Clusters should naturally be expected to include a focus on adolescents (e.g. Health, Education, Child Protection) but in fact this is not the case. This is a major limitation of the Cluster approach overall.

3. **Appreciate how emergencies increase the factors that make young people vulnerable to HIV**

Although there is not strong consistent evidence that the incidence of HIV increases during emergencies, there is anecdotal evidence that other adolescent sexual and reproductive health problems increase in the wake of emergencies (e.g. STIs and pregnancy) and that emergencies tend to compound the pre-existing problems facing young people and increase their vulnerability to HIV (e.g. by increasing the dislocation of families and communities, sexual violence, survival sex, and the challenges of accessing condoms).

4. **Emphasize the important links between HIV and adolescent sexual and reproductive health**

A number of high-risk behaviours and health problems facing adolescents in emergencies have common determinants, and are linked together in terms of cause and effect (e.g. unprotected sex, alcohol and substance use, depression/anxiety, violence). At a minimum it is important in emergency responses to link HIV and adolescent sexual and reproductive health (ASRH), in terms of advocacy (to be able to make a stronger compelling case, in terms of numbers requiring prevention and treatment/care); for support to priority proximal interventions (e.g. condom promotion/distribution, protection from sexual violence including rape, access to services); and for more distal interventions (e.g. education, safe spaces for adolescents, and organizing adolescents to contribute to activities being carried out in the camps). This is equally true in the pre and post-crisis contexts.

5. **Generate consensus about the critical core interventions**

Responding to the needs of adolescents and HIV/ASRH in emergency humanitarian settings is very challenging for a number of reasons. Many things need to be done. It is therefore important to ensure that there is clarity and consensus about the critical core elements of the response: the promotion and distribution of condoms (and the knowledge and skills to use them); protection from sexual violence, including sexual abuse/rape; and access to basic services that should be provided to everyone but that adolescents are likely not to be able to access (e.g. PEP, EC, ARVs, STI treatment, pregnancy care and treatment of common endemic diseases). At the same time, adolescents need to be organized, to have things to do that both contribute to the emergency response and to their own development, and to have protected places where they can meet, talk, share experiences, have access to information and peer support, and add some elements of “normality” into their lives (e.g. schools and safe spaces). While there is a need to avoid being too prescriptive, it is likely that in most emergency situations, particularly those in generalized epidemics, that this core set of interventions should be the focus for planning and training, and that these programme elements will pull other interventions behind them.

6. **Give adequate attention to planning and preparedness: integrate emergencies into routine programming**

While some emergencies are unforeseen, many take place in countries and communities where there is a history of natural disasters, civil unrest and population displacements. To a large extent the capacity to respond is dependent on the pre-emergency situation, in terms of attitudes towards adolescents and HIV and existing experiences with the development and implementation of policies and programmes.

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54 Note that the IASC Guidelines on Gender and GBV are now being reviewed and present opportunities for addressing ASRH
Disaster planning and preparedness built on these on-going experiences and taking into consideration likely emergency scenarios is central to an effective response. In the planning of interventions for adolescents during non-emergency times, it is important to consider how emergencies could potentially effect the implementation of programmes that are developed and how these effects could be mitigated. In disaster-prone countries therefore, there needs to be a significant focus on adolescents and HIV/ASRH prior to the occurrence of major emergencies, in order to identify good practice and available programme support materials, map the current activities of NGOs (in terms of focus/content, resources and geographic presence) and support the government to identify/develop appropriate coordination mechanisms to guide and support proximal and distal interventions for adolescents in terms of HIV and ASRH, in a coherent way that engages a range of sectors.

7. Review routine interventions in emergencies
Development programmes need to include some focus on emergencies, particularly in countries prone to emergencies. They need take the context into account, including fragility, previous and potential emergencies, and ensure that there is some scope for the re-allocation of resources and for adjusting and adding to programmes as needed: development programmes need to be more disaster resistant and more flexible. At the same time, in emergency situations, with the limitations of access, personnel and resources, interventions cannot simply be lifted complete off the development-situation-shelf. For example, while HIV testing may be an important intervention for channeling adolescents into prevention and treatment/care in normal times, it may not be a priority in emergency settings if there is insufficient information and counselling available, or if there is limited access to treatment.

8. Advocate for adolescents, HIV and ASRH
Neither adolescents nor HIV/ASRH are generally particularly high on people's priority lists in responding to emergencies. Advocating for greater attention to adolescents in humanitarian responses is therefore essential, focusing on: why it is important to give specific attention to adolescents; what needs to be done (what is different from adults, what needs to be done differently); and how to do and monitor what needs to be done. Prior to, and during emergencies it is likely to be important to advocate for a stronger focus on adolescents and youth within HIV programming; a stronger focus on adolescents and youth in relation to programming for the overall disaster preparedness and emergency/recovery response; and a stronger focus on HIV/ASRH within the general planning, implementation and monitoring of interventions directed to young people during emergencies. While prevention is a core element of programming for all age groups in emergency situations, for adolescents this requires particular emphasis, and this needs to be incorporated into the overall advocacy.

9. Support effective coordination
Adolescents are likely to be particularly vulnerable in emergency and humanitarian situations, and represent one quarter to one third of the population. Many sectors

55 In Haiti, the support to adolescents was mostly through NGOs, and this support was often well planned and executed, because they had prior experience of working with/for adolescents and they were accountable to funding partners. This type of response is not, however, national in scope as it is based on available funding and capacity. At the same time, there is always the risk of planning at national level with a focus on coverage, with subsequent limited implementation, because of lack of government funds.
and a range of different partners will need to contribute to the response to adolescents and HIV/ASRH, to meet their needs and protect, respect and fulfill their rights. There is therefore a need not only for there to be a strong focus on adolescents and youth within the different humanitarian clusters (and there may be a need for additional guidance on the “how?” rather than the “what?” of programming for adolescents within the clusters, and clear entry points for strengthening the focus on adolescents, see point 5 above); but also for there to be an effective coordination mechanism across the IASC Clusters: to carry out joint assessments and surveys, which, depending on the resources and the phase of the humanitarian response, may focus explicitly on adolescents or simply ensure that adolescents are adequately incorporated into more general assessments; strengthen the coverage and quality of the response (including the development of standards and their dissemination to implementing partners); orient partners (both internal and external); and share information, experiences and programme support materials, and plan together in order to make it easier for the different partners and sectors to be able to work together in a joined-up way. Coordination and collaboration needs to take place both between people working at a policy level, and the technical staff/focal points of the key partners supporting and implementing interventions for adolescents and HIV/ASRH.

10. Develop clarity about strategic approaches
Although adolescents require specific attention in emergencies, this does not mean that it is necessary to set up different and parallel structures for them. There are of course some interventions/strategies that should be specifically directed to adolescents (e.g. schools, safe spaces, peer networks/programmes). However, the majority of the interventions required for the prevention, treatment and care of HIV/ASRH among adolescents are much the same as those needed by adults (e.g. condoms, protection, STI and ARV treatment) and they need to be provided in an integrated way. None-the-less, if adolescents are to have access to them and take advantage of them these interventions need to take into consideration adolescents’ phase of development, in particular their knowledge and abilities. A balance therefore needs to be found between giving specific attention to adolescents and, at the same time, ensuring that adolescents benefit from an integrated approach to the delivery of priority interventions. For example, in health facilities, health workers and others need to know how to respond if the person in front of them is 16 years of age, and not 36 or 6 years old. Ideally such training should take place prior to the emergency so that health workers are able to rapidly ensure that the health services that are provided are “adolescent-friendly”. In those settings where such training is not being carried out, some minimum training to strengthen health workers’ capacity to respond effectively to the needs of adolescents should to be incorporated into all training for health workers working in the humanitarian response. This has important implications for the planning and monitoring that takes place through the Cluster system, and also in those situations where the government is leading the response.

56 At a minimum this requires the training of health workers and other clinic staff; making some small changes in the facilities such as ensuring privacy for consultations, the availability of materials designed for the adolescent age group and possibly specific times for young people; and generating demand and community support.
57 Similarly, in condom programming, the specific needs of adolescents in terms of knowledge, skills and access to condoms need to be given specific attention: adolescents need to know where they can obtain information and commodities, and a range of people contributing to the response need to understand that it is their responsibility to make this happen.
11. Disaggregate strategic information
Age/sex disaggregation of data collection, analysis and dissemination is essential for advocacy and planning the response to adolescents and HIV/ASRH in emergency situations. The absence of age-disaggregated data makes adolescents invisible because they become mixed with younger children or young adults. Every effort should be made to disaggregate the available data by internationally agreed upon age groups: 10-14, 15-19 and 20-24 years. In the initial rapid assessments and in the on-going monitoring of the response (coverage and quality), data that are collected need to be disaggregated by sex and age: this is crucial to adolescents being seriously considered in the emergency response and in on-going efforts to meet the needs of adolescents who are displaced. More generally there is a need to be clear about the most useful/collectable adolescent-related indicators to use in such situations, both during the emergency phase and also in the recovery phase, as the situation and response moves along the continuum from emergency to development. As with other aspects of the emergency response, there may be opportunities to use the experiences gained to shift the thinking more generally about how data are disaggregated in the routine HMIS.

12. Link disasters and development: the challenge of sustainability
Emergencies have an impact on adolescents and HIV/ASRH long after the acute phase, and attention therefore needs to be given to sustaining the core interventions. They need to be linked to development programmes and the overall routine implementation of policies and programmes designed to meet adolescents' rights to health and development. Disasters may provide an entry point for thinking and acting differently in relation to adolescents, HIV and ASRH. Sustaining interventions for young people in chronic emergencies remains a challenge: while some emergencies are relatively short-lived and move rapidly to a recovery phase, many, such as those in Côte d'Ivoire and Haiti, continue in a phase of semi-emergency for long periods of time. It is important to make every effort to ensure that adolescents living in such situations continue to receive the basic interventions for HIV prevention and ASRH after the acute emergency spotlight is turned off, and that particular efforts are made to scale up national programmes so that adolescents in emergency-affected areas are able to access them.

13. Methodology for the country reviews
A number of lessons were learned from the two country reviews. The main limitation was time: staff working with UN agencies, government departments and NGOs in countries that experience on-going emergencies and complex post-emergency situations are extremely busy, and every effort therefore needs to be taken to limit the amount of time that they are required to support the review. Security considerations may also pose unexpected restrictions of access to people and places. In addition, these reviews took place sometime after the acute emergencies had taken place, which had a number of implications, not least, the fact that in Côte d'Ivoire the IDP camps had closed (although it was possible to identify young people who had been living in the camps for the FGDs). Meeting key informants in groups, rather than individually has both positive and negative implications. On the positive side, it brings people together to discuss issues of common concern, and saves time for the person carrying out the review. On the negative side, key informants may be reluctant to express concerns that relate to other people seated around the table. The generic questions that were developed
proved to be useful, but required sufficient time and discussion for adaptation to the country context. The FGDs provided very important insights into the needs of young people during the emergency and another perspective on the adequacy of the response (for the FGDs, it is important to provide a briefing for the people leading the discussions, even for people with experience of working with young people). Lastly, the two reviews would have benefitted from more than one external person being involved in the assessments, to provide different perspectives and explore issues from different viewpoints.

**Overall Recommendations**

1. **Strong leadership**

There is a need for strong leadership to ensure that adolescents receive adequate attention during emergency responses; that HIV and SRH are given adequate attention in emergencies, including a specific focus on adolescents; and that a focus on adolescents and HIV/ASRH is not only included in the emergency response but that there is sufficient disaster preparedness - that development programmes include some focus on emergencies, particularly in countries frequently confronted by natural disasters and civil unrest. This has implications for political leaders and a range of government Ministries, for the senior staff of UN organizations and NGOs, at national, regional and global levels, and for the IASC Clusters. It should be possible to respond much more effectively to this vulnerable segment of the population, and to use their energy and ideas much more productively.

2. **Clarity about Priorities for Action**

All emergencies have differences in terms of causes and response. However, there are some broad generalizations that are likely to be relevant to all emergencies in all settings.

2.1 First, all programme planning for adolescents (and adolescents and HIV) should include some attention to potential emergencies, and planning for emergencies (and emergencies and HIV) should include adequate attention to adolescents.

2.2 Second, in terms of HIV and SRH, there are a number of interventions that need to be implemented that will be central to prevention and response and can form a core around which additional interventions can be developed:

- Sensitizing/informing adolescents about HIV and ASRH: increasing knowledge and skills
- Services and commodities
- Safe spaces and schools
- Support and something to do (young people can contribute to the response, and being involved in the response can contribute to their protection and development)

In terms of services and commodities, there needs to be a focus on:
• Promotion and distribution of condoms (and the knowledge and skills to use them)
• Protection from sexual violence including sexual abuse and rape
• Provision and use of basic services/kits to facilitate treatment and care, including: PEP, EC, HIV testing/ARVs, STI treatment, pregnancy testing/care, and the treatment of common endemic diseases (e.g. malaria)\textsuperscript{58}

2.3 Third, the following questions can provide a framework for being clear about priority actions/strategies in different situations and in different phases of the response:

*Is everything that needs to be done being done?* (See 2.1 and 2.2 above)

- **Yes**: monitor coverage and quality (and cost) and start planning for the next phase
- **No**: find out why not (carry out surveys, key informant interviews, FGDs)
- **Don’t know**: start finding out (map, monitor, share information)

If “no”, why not?

- Don’t know that adolescents need special attention - *action*: advocacy
- Know that adolescents need special attention but don’t know what needs to be done - *action*: “what?” guidance, technical assistance and training
- Know what needs to be done for adolescents but don’t know how to do it - *action*: “how to?” guidance, technical assistance, capacity development
- Know what to do and how to do it, but lack the resources to make it happen - *action*: strengthen advocacy and coordination mechanisms; ensure that adolescents and HIV are including in available funding mechanisms.

3. Guiding and Supporting Action

With the exception of the section on Education, adolescents and youth receive relatively little explicit mention in the IASC Guidelines. Is there a need for additional guidance to be developed to assist governments; UN agencies and NGOs strengthen their preparedness and response to HIV and ASRH among adolescents in emergencies?

In terms of content (answering the “What needs to be done?” type of questions), there appears to be sufficient guidance available and, in some situations, significant in-country expertise. However, there are a number of areas where guidance would be useful, and the focus needs to be primarily on answering the “How to do what needs to be done” type questions:

- Data collection (for planning and monitoring)
- Linking prevention/treatment of HIV among adolescents and ASRH
- Priority setting: focusing on a few high-priority interventions
- Coordination/collaboration/sharing tools and experiences
- Advocating for a specific focus on adolescents (making a compelling case, being clear about what needs to be done, demonstrating that it is do-able)
- Orienting key people responsible for policies and programme implementation

In order to support this there needs to be:

\textsuperscript{58} Kits are likely to require the incorporation of a number of specific components for testing, prevention, treatment and care, for example kits for survivors of sexual assault: PEP, EC, HIV/STI/pregnancy testing and subsequently treatment as necessary.
• An easy-access portal with annotated programme support tools: type of tool (guidance, training materials, etc.), language, who it is designed for/audience, where it has been used and by whom, core content, evaluations (if any), contact persons and comments
• Better documentation of successful programmes (how was it done?) using standardized reporting formats
• Documentation and guidance on effective collaboration/coordination around the response to adolescents
• Preparation of briefs, for adaptation, to support advocacy for a focus on adolescents.
• Outline of a one day briefing workshop for policy makers and programmers to orient them to the needs of adolescents: what and how
• Do’s and don’ts of ensuring the meaningful and on-going participation of adolescents in data collection and analysis, and programme planning, implementation and monitoring (including how to run and benefit from FGDs).

4. Supporting countries

4.1. Develop/mobilize global partnerships

At the global and regional levels, HIV and young people in humanitarian settings should be a crosscutting issue for a number of IATTs: the IATT on emergencies; on young people (which has already developed a Policy Brief on HIV Interventions for Young People in Humanitarian Emergencies\(^59\)) and on PMTCT/pediatric AIDS. These IATTs should identify ways to provide technical support in a more systematic way to emergency affected/fragile countries, particularly those with generalized epidemics, in collaboration with regional IAWGs, and ensure that a focus on adolescents and HIV in emergencies is integrated into the routine work of all IATTs – this should not just be seen as the responsibility of the IATT on Emergencies.

Similarly, a focus on young people in emergency and humanitarian programmes provides an important opportunity to combine HIV with ASRH, in terms of both prevention and response. This should also stimulate closer collaboration between the HIV and ASRH communities and strengthen their collective capacity to provide technical support and capacity development, and to support the integration of an emergency component into on-going HIV/ASRH programmes in countries.

4.2. Strengthen capacity for planning and response

Developing guidance to support countries is only the first step towards improving the response to adolescents and HIV/ASRH in emergencies. Additionally it is important that countries know about available programme support materials and have the capacity to use them.

\(^59\) [www.unfpa.org/hiv/iatt/docs/humanitarian.pdf](http://www.unfpa.org/hiv/iatt/docs/humanitarian.pdf) As with all policy and programme briefs developed at global, regional and national levels it often remains a challenge to ensure that the substance of the brief is included in work-plans; preparedness, risk assessment and emergency affected populations need to be built into the joint activities of the IATT/YP, and this is especially important because many of the priority countries for the IATT are affected by/prone to emergencies.
Every effort should be made to strengthen the capacity in countries facing frequent emergencies or facing fragile situations due to chronic emergencies to: incorporate an emergency component into national plans focusing on adolescents, HIV and ASRH; set up collaboration mechanisms that provide a forum for a range of partners to work together to improve the response to young people and HIV/ASRH before, during and after acute emergencies; know about, and be able to select/use/adapt those programme materials that are available and that would be most appropriate for strengthening the response; and be able to effectively involve young people in planning and implementation.

In both Côte d’Ivoire and Haiti there are forthcoming opportunities to strengthen and develop their post-emergency response, and potentially link this to the overall national policies and approaches to adolescents and HIV/ASRH. Every effort should be made not only to support such efforts, but also to document them for wider dissemination (e.g. workshop agendas, presentations, outcome documents).

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60 Countries should review their development programmes in order to identify how they might need to be adjusted in times of crisis: Will supplies be available? If not, how can they be stockpiled? Will there likely be population movements? If so, to where? What additional materials are required in potential host communities? The aim of this is not to set up a parallel emergency programme, but to agree on ways to adapt programming that is already taking place to present to respond more effectively to the needs of communities in times of crisis.
Annex: Generic questions for Key Informant Interviews and Focus Group Discussions

Questions for key Informants

In relation to preparedness, minimum and expanded responses in Haiti, the discussions with key informants would aim to:

1. Obtain an overview of the response to adolescents and HIV within the overall humanitarian response: prevention (e.g. information/life skills, condoms, protection, education), testing and treatment/care (including PEP) – what have been the main problems facing young people (that might have an impact on HIV), what was done explicitly with/for adolescents, when and by whom with what funds/technical assistance/disaggregated data collection?
2. Identify the lessons learned from the specific response to adolescents within the overall HIV/SRH component of the humanitarian response (e.g. as above plus treatment of STIs, contraception/EC, management of pregnancy, PMTCT, prevention/response to GBV) – what were the achievements/successes, and challenges/obstacles (planning, monitoring, collaboration/coordination, integration); were then any specific interventions for young key populations?
3. Assess how the available guidance was used to support the response to HIV/ASRH/adolescents – which guidance tools were used, what was helpful, what was missing, what would have made it easier to use the global/regional/national guidance that is available?
4. Outline priorities for strengthening the guidance on adolescents/HIV/ASRH and for improving the support for using the guidance that is available (preparedness, capacity development, technical assistance, etc.)

Questions for focus group discussions with service providers

1. What were the main problems facing young people before the earthquake (girls and boys)?
2. What were the main health problems facing young people before the earthquake (girls and boys)
3. What were the main problems facing young people following the earthquake (girls and boys)
4. What were the main health problems facing young people following the earthquake (girls and boys)?
5. How did the earthquake increase adolescents vulnerability to HIV and ASRH problems? Which groups were most vulnerable, and why? How did the needs of girls and boys differ?
6. How have young people’s health problems and their vulnerability to HIV and ASRH problems changed over time (including alcohol/substance use)?
7. How did the health services respond to the needs of adolescents for HIV prevention (IEC, condoms), diagnosis (testing), treatment and care - at facility level and at community level?
8. How much were young people involved in planning and implementing the response?
9. What interventions were carried out to decrease young people’s vulnerability to HIV (education, protection); were there any specific interventions for key affected populations?

10. What guidance was available/used to help guide/strengthen the response? What was useful/not useful? What programme support tools/guidance would have helped improve the response to HIV/ASRH (in terms of speed, quality, access, appropriateness, etc.)?

11. What have been the challenges of implementing HIV/ASRH interventions - integration, human resources, capacity, funding and supplies?

Questions for focus group discussions with young people

1. What were the main problems (in general and specifically in relation to health) facing young people in Haiti before the earthquake; what was specific to adolescent boys and adolescent girls?

2. What were the major problems that young people faced following the earthquake, and how have these changed over time?

3. How did the earthquake affect young people’s physical and mental health, including ASRH and HIV?

4. What was done before and immediately after the earthquake, and to increase young people’s access to IEC, condoms/contraception, testing, treatment and care for HIV and STIs, pregnancy care, protection and education?

5. What is currently being done to increase young people’s access to these interventions?

6. What worked well, what didn’t work well, what should have been done differently?

7. How much were young people involved in planning and implementing the response?

8. What are the main challenges facing young people in Haiti today

9. Which groups of young people are most vulnerable to HIV and ASRH problems, and why? What needs to be done to decrease their vulnerability?
Côte d’Ivoire Review

1. Setting the Scene

Côte d’Ivoire presents a complex humanitarian situation, with several crises taking place simultaneously over many years\(^{61}\).

Following independence there was significant social and economic progress and stability in the country. However, there was an economic crisis that started in the 1980s, related to a number of factors including the prices of commodities on which the country depended (cocoa and coffee); a coup d’état in 1999; a civil war in 2002, which grumbled on, particularly in the West of the country, until the late 2000’s, related to a number of underlying factors, including land ownership (the UN came in for some very negative attention during this period which undermined its efforts); and the more recent conflict following the elections of 2010.

In addition to an already difficult situation in the country, the 2010 post-election violence caused major social upheaval and the displacement of an estimated 1.5 million people\(^{62}\), particularly in the West of the country, both from other regions and from towns within the Western region itself. Twelve camps were organized for these internally displaced people (IDP), although not everyone who was displaced was accommodated in these camps. At the present time all IDP camps have been closed, and there is relative (some would say “fragile”) calm in the country, although there is still a strong UN peacekeeping presence, again particularly in the West.

In addition to the civil unrest, Côte d’Ivoire has the highest HIV prevalence rates in West Africa, with rates particularly high in the West of the country\(^{63}\). Many factors contribute to high prevalence of HIV among young people\(^{64}\): early sex, forced sex, gender-based violence, low condom use, negative attitudes to condoms, illegal abortion, breakdown of health services and schools,\(^{65}\) At the same time, many of the determinants that increase young people’s vulnerability and negatively affect HIV and adolescent sexual and reproductive health more generally, have been compounded by the humanitarian crises\(^{66}\)\(^{67}\). Côte d’Ivoire is one of first wave countries for the UNAIDS Business Case on Empowering Young People to Protect Themselves from HIV\(^{68}\).

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\(^{62}\) UNHCR, UNAIDS (2011): Rapport de la mission conjointe d’évaluation sur le VIH/SIDA au sein des personnes déplacées internes et de leurs communautés hôtes dans les localités de Duekoué, Guiglo, Man et Danane


\(^{66}\) Humanitarian Country Team Côte d’Ivoire (2011): Impact of the socio-political stalemate in Côte d’Ivoire on the population and on vulnerable groups in particular

\(^{67}\) UNICEF, ONUSIDA, UNFPA, PUMLS (2011): Analyse De La Vulnérabilité Au Sida Et De La Réponse Chez Les Adolescents Et Les Jeunes En Cote D’Ivoire

\(^{68}\) UNAIDS (2010): Empowering Young People to Protect Themselves from HIV, Outcome Business Case Draft
A National Youth Policy has recently been developed, although the section on HIV and health in general is brief and not particularly detailed (it should be noted however that many of the other sections deal with structural determinants that underlie the transmission of HIV in young people). A specific plan has also been developed on HIV and young people, although there are no explicit linkages with emergency-related activities in the plan, which has possible implications for future humanitarian responses.

2. Key Informant Interviews

2.1. Young people prior to the 2010 humanitarian emergency: status and services

“Young people were in a crisis even without a crisis” and faced many problems, both structural (e.g. high rates of unemployment, poor access to schools and health services, negative social attitudes and norms, including those related to gender-based violence, abortion, the provision of condoms to young people less than 18 years and stigmatisation around HIV and HIV testing); and also individual (e.g. early sexual activity, early pregnancy, high rates of STIs and HIV, low use of condoms, and girls being in a weak position to negotiate consistent condom use).

There is no focal point for young people in the Ministry of Health and in the National Health Plan for 2008-2012 adolescents and youth are barely mentioned. There is a range of activities being implemented by different government departments, but nothing that really pulls them together, although the Ministry of Youth (MOY) has a coordinating role for interventions for out-of-school youth. There is a National Youth Policy, 2011-2015, much of which was developed through processes that took place during the period of instability. Although the impact of the post-election emergency is highlighted frequently in the Situation Analysis of the Youth Policy, and the prevention of young people from becoming involved with armed conflicts and the prevention of HIV are both included in the Policy, there is nothing explicit about emergency preparedness or contingency planning. UNFPA and other UN organizations have contributed significantly to strengthening the MOY, which has primary responsibility for young people out of school. There is an on-going need for such support.

In the same vein, the 2008-2010 national strategic plan on HIV and STIs in young people was very much positioned within the context of the chronic emergency in Côte d’Ivoire, dealing explicitly with gender based violence and sex workers. However, there

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72 It is not always clear how useful the concepts of “in school” and “out-of-school” are for the development of programmes for young people – often both groups of adolescents need the same interventions, for example health services, and, at the same time, adolescents who do go to school are not in school for much of the day and also need access to safe spaces, peer educators, and other programmes developed for out of school youth.

was no explicit mention of emergencies or preparedness: how to respond and re-
allocated resources should one arise.

Different organizations have worked with young people through different settings (youth networks, sports, health clubs in the schools), but the activities are mostly somewhat project based, with relatively little collaboration between organizations and challenges in terms of sustainability. There was a sense from a number of key informants that there is need for organizations focusing on young people to come together regularly to share experiences (with themselves and with young people), which currently does not happen; an on-going need for advocacy (young people are not a priority for most funders) and a coherent strategy that incorporates different outcomes, actors and sectors.

Pre-existing developments with young people include the 13 Centres Conviviaux and adolescent-friendly health services (supported by UNFPA, working with young people in many ways, in collaboration with NGOs), and a number of organizations have been identifying, developing and working with youth networks (including identifying them through existing social structures, such as le grain de thé), and training/supporting peer educators.

At community level, other activities included: HIV/AIDS awareness interventions, working with/through NGOs using a range of strategies (sports, mechanics, hairdressers, an HIV/AIDS bus that visited different localities to provide information about HIV); support for PMTCT and testing, treatment/care of ALHIV.

In schools there has been support for developing health clubs, training teachers (there was an extensive Life Skills programme in the country) and strengthening school health services. There were also school feeding programmes in some districts (an important intervention in terms of structural determinants: keeping poor girls at school). In terms of structural determinants, improving employment for young people is one of four priorities for the World Bank. For the most part, however, for all of these interventions monitoring and evaluation data are weak.

In addition to supporting specific projects, UNICEF had worked with the Ministry of Health (MOH) to develop a strategic framework for disaster planning. Although there is a national youth development policy, this has a very large number of activities and it is not clear how fundable or sustainable it will be – a challenge that has plagued previous youth policies in the country. While there had been some opportunities for young people’s inputs into existing programmes and policies, in general their involvement does not seem to have been systematic or well integrated, although there is a Ministry of Youth National Policy for Civic Service (despite this policy having been developed in

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74 “Youth” is defined up to the age of 35 years in Côte d’Ivoire, although most UN organizations and NGOs primarily focus on the 10-24 year age group

75 An existing social structure through which young people come together to meet and discuss issues

76 In one peer programme in the West of the country, the emphasis has been on explaining the challenge of HIV and getting young people to think through what could be done (e.g. how many young people in the district, main modes of transmission, what to do?). The peer educators were carefully selected and while not all carried out activities, many did, in a range of settings, from schools to hairdressers (and as an indication of their effectiveness, when the mobile phone companies came to the region to identify young people to work on supporting their advertising etc. the peer educators were snapped up!)

response to the post-emergency situation, it does not include any mention of disaster-preparedness or contingency planning, or HIV).

2.2. Impact of the crisis on young people

The post-election violence increased young people’s vulnerability and risk to HIV in a number of ways: increased poverty, decreased access to schools and health services (destruction of buildings or displaced staff), increased sexual violence, increased use of drugs (including injecting drug use) and alcohol, decreased access to information and condoms (compounded in some places by the negative attitudes of the church), increased sexual exploitation, survival sex and sex work.

In addition it was not possible to re-direct funds from the major donors (PEPFAR and the Global Fund) to respond to the needs during the emergency, although the country did receive funds from the World Bank and a number of international NGOs working in the country to support the emergency response\textsuperscript{78}.

Increased poverty gave rise to increases in risk behaviours, and there were losses of documents, which created problems for young people in terms of accessing services and being reunited with their families (no money, no documents: no access to services, travel and support). Girls and boys were exposed to increased violence/sexual violence including rape, with young people being both the victims and the perpetrators of violence, and existing problems such as trafficking, adolescents living on the streets and sexual exploitation (some of the adolescents involved being very young).

Many young people were separated from their parents, which increased their vulnerability by denying them an important stabilizing and protective factor in their lives during the emergency. They lacked schooling and opportunities to make any money: young people with nothing to do and no support are relatively easy prey for armed groups.

2.3. Response to the crisis

Although there were some attempts at disaster planning\textsuperscript{79} (the post-election conflict was not unforeseen) and a contingency plan was drawn up within the UN (that included some focus on HIV, although adolescents were not dealt with in much detail in the plan), for many key informants there was a sense that there had been insufficient preparedness: “we needed (and need) a plan”\textsuperscript{80}. However, even accepting the importance of preparedness, it is also important to ensure that the plan is an actionable plan, has been tested, and includes specific operational considerations.

\textsuperscript{78} UNHCR, UNAIDS (2011): Rapport de la mission conjointe d’évaluation sur le VIH/SIDA au sein des personnes déplacées internes et de leur communautés hôtes dans les localités de Duekoué, Guiglo, Man et Danané
\textsuperscript{80} There have been a number of efforts at “finding out”, a World Bank study on the impact of the crisis on HIV, a study looking at vulnerability and pregnancy among young people in schools, and a number of evaluation missions, for example on chronic illness in the IDP camps and the needs of PLHIV.
While some inter-ministerial fora existed, and both the Ministry of Youth and the Ministry of Social Services and Humanitarian Affairs\(^81\) had coordinating roles (for young people and for emergencies respectively), and were both clearly concerned about the situation of young people (both in general, and in the context of the emergency), some Ministries felt that there was no real disaster-preparedness and response plan, and that where things were done they were often done without any specific attention to adolescents.

Where things worked in the humanitarian response key informants indicated that it was often because there had been some preparedness planning and/or because of on-going activities that could be built on and “used” in the emergency response, for example youth networks (les réseaux jeunes) and existing peer education programmes to disseminate information, and interventions focusing on the prevention and response to gender based violence (GBV).

There were clearly many activities implemented by the government, UN organizations\(^82\) and NGOs\(^83\) during the humanitarian response. Much of the response was dependent on NGOs working with existing community groups and youth networks that had already been sensitized/trained to work on a range of issues, including HIV and ASRH, but often in a spontaneous rather than a systematic way. There did not seem to have been many efforts to evaluate these interventions in terms of coverage, quality or impact – something that is clearly important not only for the national response but also for the wider evidence base for effective interventions, for some of which the evidence remains fragile (peer programmes, for example).

There were a number of programmes directed to the population in general that young people were able to benefit from (even if their specific needs were not explicitly taken into consideration), for example food distribution to vulnerable families, therapeutic feeding for people living with HIV (PLHIV) and conditional/unconditional cash transfers. However, adolescents were not a group that were given specific consideration: food security, for example, was more family-focused.

In general the cluster system seems to have worked well, although there was not much explicit focus on adolescents, and while the issue of young people was raised in the clusters there was not much actually being done explicitly for them and no platform for pulling all the pieces together around adolescents involving UN and non-UN partners, and government. Within the cluster system there was a sub-cluster on Child Protection that included a focus on a number of the factors that increased the vulnerability to HIV of particularly vulnerable adolescents.

While most UN organizations are contributing in one way or another to the national response to HIV and to young people, within the UN, UNFPA is the lead organization. Within the UN Joint Plan on HIV in Côte d’Ivoire there is an explicit section on youth, which includes a focus on providing information, strengthening the Ministry of Youth

\(^{81}\) The Ministry of Social Services and Humanitarian Affairs stressed that adolescents are a vulnerable group (vulnerable before, and even more vulnerable after the post-election violence) and that they need something to do and they need social inclusion (work), instruction and capacity development (school): “a focus on young people is very important for a sustainable peace”

\(^{82}\) UNICEF (2011): Contribution from HIV/AIDS to the Sitrep from 03 to 14 October 2011

\(^{83}\) Organisation pour le Développement des Activités des Femmes (ODAFEM) (2012): Projet de prévention des IST-VIH/SIDA chez les adolescents et jeunes ainsi que parmi les populations déplacées internes (IDPs) dans la commune de Man – Rapport de fin de Projet
(that is responsible for youth out of school) and the development of a Business Case (which is still being developed). In June, UNAIDS and UNFPA provided capacity building on young people/HIV for the Ministry of Youth. Also included in the joint UN plan is a national meeting on young people that is tentatively planned to take place early in 2013 and involve a range of partners (see Annex 4) that would provide an opportunity to focus on HIV, ASRH, young people and emergencies.

UNFPA was involved before the crisis with ASRH, including the provision of condoms for adolescents, pregnancy care of adolescents (a major issue), the training of service providers and ensuring the involvement of young people in programme design and implementation. As lead agency for young people UNFPA built on these experiences in the humanitarian response, basing its response on the UNFPA/SCF Boîte à outils84, the Policy Guidelines developed by the Inter-agency Task Team on Young People85 and the IASC Guidelines86: it focused primarily on supporting the implementation of the minimum package in Côte d’Ivoire.

UNICEF had a modest preparedness plan to respond to the needs of adolescents, including HIV, involving about 20 NGOs, predominantly in the West, using the IASC Guidelines as a basis (but noted that these do not deal in much detail with young people). UNICEF had the advantage of having people working at field level, working with the Ministry of Youth and with NGOs, and had prepared with the purchase of tents and kits, for example PEP and STI treatment.

UNICEF worked in the IDP camps, identifying young people and training peer educators to provide information and distributing condoms, identify ALHIV and refer them to hospitals for treatment and set up support groups for ALHIV (support with food and support for adherence). In addition schools were set up in the camps that provided information and life skills, including on HIV; the police, military and community were trained to protect adolescents from sexual abuse and violence. In addition, UNICEF worked with a range of partners to support HIV testing and treatment for ALHIV, the distribution of STI kits and PEP kits, training of health workers to work with young people, the provision of HIV and ASRH related information using radio (involving young journalists), and the training of disk jockeys to provide information and promote condom use in night clubs, including the distribution of condoms.

UNICEF held regular meetings with NGOs and supported coordination through the Ministère de la Famille. Currently UNICEF is starting to identify young people to distribute condoms and will support them to make a small mark-up in the price for income-generation. PMTCT was an important entry point for testing, prevention and identifying young people in need of continuing treatment, and UNICEF also worked with young soldiers, ensuring that condoms are in their “war kit”, and through the programmes with OVCs to ensure that these included a focus on vulnerable and orphaned adolescents, to ensure that they had access to legal and health services, and education.

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84 Save the Children, UNFPA (2009): Boîte à outils pour la santé sexuelle et reproductive des adolescents en situations de crise humanitaire
85 Groupe de Travail Inter-Agences sur le VIH et les Jeunes (2008): Actions VIH à mener en faveur des enfants et des jeunes dans le cadre des situations d’urgence humanitaire
86 Comité permanente inter-institutions (IASC) (2010): Directives sur les interventions relatives au VIH dans les situations humanitaires
In addition to interventions focusing on awareness and condom distribution that many UN and NGO organizations contributed to, there were a number of smaller projects focusing on a range of interventions, for example: strengthening community health workers to work with women (including young women, during their pregnancy, who tend to only visit ANC services at the beginning and at the end); strengthening adherence among adolescents living with HIV through sensitization, peer programmes (ALHIV supporting ALHIV), and working with parents and support groups; sensitizing and training the army, prisons and police; strengthening the human rights perspective (ONUCI); working with parents (IRC); and supporting advocacy activities (e.g. children mobilized to make a statement to parliamentarians).

2.4. Challenges

There was wide consensus among the key informants about the challenges and, for the most part, about the priorities for action.

As a general point, responding to emergencies is challenging! Many things need to be done at the same time, with a view to the present and the future, including access to food, shelter, protection, schools, services and commodities; and awareness raising and capacity development for many groups. Without good disaster-preparedness and contingency planning (that involves a range of key partners and the government) and flexible funding in the face of an emergency, it is very difficult to respond in a systematic way, in collaboration with the government and with a view to sustainability in the recovery phase.

2.4.1. HIV and ASRH

HIV is a sensitive/taboo subject for many people, as is adolescent sexual and reproductive health (ASRH) more generally. There is significant under-reporting of ASRH problems among adolescents, and insufficient attention to sexual violence, including rape, which is also seriously under-reported and has many challenges in terms of prevention and response (awareness raising, supporting the apprehension of perpetrators, responding to the needs of survivors).

Adolescents with ASRH problems often hold back from using available services because of “la crainte et la honte” (fear and shame). There is a need not only to get young people to use those services that are available, but also to improve the quality and scale-up of effective approaches to ensuring that available services meet their needs. In addition, improving young people’s access to health services can only be seen within the context of the availability and access of health services more generally, which remains a challenge, both in terms of facilities and personnel. However where health services do exist it is important to provide service providers with some basic training to help them respond to the health needs of adolescents; ensure that there are some basic changes in the facilities (e.g. a place for confidential consultations and IEC materials designed for adolescents); and to generate demand and community support for the services.

There are some shocking stories about gender-based violence, and survivors of sexual violence are frequently “dans l’ombre” (hidden: in the dark/shadow) - survival sex

87 Note: much of the HIV information and life-skills interventions have focused on broader issues of ASRH
seems almost to be encouraged in some families ("le sac noir"), and a recent survey indicates that school children are often not safe from their own teachers in terms of sexual abuse.

To this end, and in the absence of a strong adolescent HIV programme or effective disaster preparedness/contingency planning, several Key Informants identified the need to have a briefing workshop early in the humanitarian response to orient people to the specific needs of adolescents and to approaches to responding to these needs (what to do and how?); and a need to have regular follow-up to share experiences, programme support materials and other resources. This could additionally help to make people and organizations accountable, contribute to the development of a joint plan of action and clear indicators to assess progress.

Unfortunately, a number of the NGOs working on ASRH have focused on abstinence (often, they say, as a result of stipulations from funders), and there is significant resistance to talking about condoms for young people less than 18 years of age. This is a major challenge in a country where the early initiation of sex is relatively common.

2.4.2. Emergency response and development

Coordination

The relative absence of disaster preparedness (in terms of planning, capacity development, systems for broader collaboration) is likely to have compounded the challenges in the early period of the humanitarian response.\(^{88}\)

Although there is an inter-agency coordinating group, there was little specific focus on young people. There is a specific section in the current plan of the Joint UN Team (see Annex 4), and it would be helpful to be clearer about what is going on and which organizations are doing/supporting what in the different geographical areas (situation analysis/mapping) prior to Activity 3.1 of the plan (the national consultative meeting on young people).\(^{89}\)

It was felt by some key informants that "a stronger networking within the UN is needed", and that there was a need for a forum for the key people who are working with UN agencies, NGOs or government that have a particular interest/expertise in adolescents and HIV/ASRH to meet regularly: the people primarily involved with young people and HIV may not be the people who participate in the interagency group. This issue needs to be discussed during the national meeting that is being planned as part of the Joint UN Team plan.

An additional challenge for coordination concerns the agreement and use of common indicators for planning and monitoring. There are indicators proposed in the IASC, but in general these are weak in terms of their attention to adolescents; the UNFPA/SCF Tool Kit also promotes some indicators, but it may be necessary to further develop these in terms of indicators to use to assess the coverage and quality of what is being implemented (e.g. peer education, condom availability, training of service providers, use

\(^{88}\) One key informant stressed the importance of preparedness in terms of identifying the potential use of buildings for new purposes (e.g. schools)

\(^{89}\) Appuyer l'organisation de la réunion nationale consultative sur la priorisation des interventions VIH chez les jeunes pour appuyer l'atteinte des 3 résultats clés de la prévention du VIH
of services, protection). Certainly there needs to be better age-disaggregation of all data that are collected, but some additional adolescent-specific indicators may also be necessary.

It needs to be remembered that coordination is a challenge – as one Key Informant pointed out, one is often trying to coordinate organizations that do not particularly want to be coordinated, despite the mechanisms that exist (e.g. the cluster system, and the inter-cluster coordinating mechanism). There were several examples given of organizations not following guidance that had been agreed upon: coordination depends a lot on people’s willingness to be coordinated. This emphasizes the importance of having clear standards developed prior to the emergency, with buy-in from different partners during their development, and a system for disseminating them (for example through the proposed briefing/workshop on HIV/ASRH and young people, early in the emergency), and monitoring their implementation.

At the same time, some funders/international NGOs/UN want to have the freedom to go where they want to go, where they think that the need is. However the fact that not all young people feel that they have access to free, or even affordable condoms stresses the point that without a clear and coordinated plan and system of monitoring, coverage may be poor, and some young people in some places may be very neglected (for example the challenge of obtaining condoms if there is no shop in the village).

2.4.3. Advocacy

Even without the emergency young people were “une génération oubliée” (a forgotten generation). There were additionally many post-emergency challenges: reconciliation, re-integration, recruitment, civil registration (loss of basic documents) – young people faced many inter-linked problems and were often particularly vulnerable, and yet are often not really a priority group for donors, or for the government. “Many people talk about the importance of young people, but this often not turned into action” … “young people are stressed in the introduction of documents/plans, but not in the action sections!” The government does not seem to have the same sense of urgency about many of the issues confronting young people (e.g. GBV).

There is an on-going need for advocacy for young people (“il faut ouvrir la porte pour les jeunes” – we need to open the door for young people): adults need training to know how to involve them effectively and young people need capacity development, support and organization to enable them to be involved.

There is a need for a strong Business Case focusing on young people, HIV and ASRH and the evolving humanitariandevelopment situation, that can be put in front of donors (currently being developed): to make a compelling case (a good situation analysis/mapping of what is going on); to be clear about what needs to be done (i.e. stand alone guidance for young people, perhaps based on the UNFPA/SCF Boîte à Outils90); and to be able to demonstrate that what is being recommended is do-able, in Côte d’Ivoire, or elsewhere. What young people need is often not so different from adults (food, shelter, security, services) - but while what needs to be done is much the same, how it is done needs to be different if it is to move beyond words, and young people are

to benefit. This applies to HIV/ASRH, and also to meeting the other health needs of adolescents and youth, including their mental health and psychosocial support needs.

### 2.4.4. Making linkages and thinking of the future

HIV needs to be integrated into everything, as do young people (both in general, and in terms of HIV). At the same time, there is a need to make the linkages with existing (pre-emergency) interventions/programmes directed to vulnerable adolescents (e.g. adolescents living on the streets), since there is likely to be significant overlap. There is also a need to identify ways to build on on-going programmes for the general population of young people (e.g. life skills).

Many of the longer-term issues remain a challenge (e.g. how to re-energise education in the country), and responding to these challenges will be important for decreasing young people's vulnerability to HIV and ASRH (education, vocational training, protection) and preventing girls from resorting to sex work or being sexually exploited, and providing boys with alternatives to being recruited by armed groups.

While responding to the emergency it is important wherever possible to strengthen the structures and systems that will continue to protect, respect and fulfil the rights of adolescents in the non-crisis situation: to strengthen the links between the emergency and development. “The needs are often long-term needs but the responses are usually short-term”, although in terms of responding to some of the challenges it needs to be recognized that what can be done is dependent on many things, including the availability of funds, the ability/willingness to work with the government, and the support of international organizations (and unfortunately, when they leave, the actions may stop).

### 2.4.5. Neglected areas

A number of areas that require more attention were raised during the Key Informant Interviews, all of which have implications for HIV and ASRH, although they are not necessarily HIV/ASRH specific:

- Support for reconciliation and reintegration of adolescents that have been members of armed groups
- Provision of psychosocial support (in addition to interventions directed to adolescents' physical health)
- Attention to the particular problems of adolescents with disabilities
- Strengthen the adolescent focus of existing programmes that are primarily directed to/reaching the general population
- More guidance on the adolescent component of child protection – there are many difficult protection issues to deal with for the adolescent age group that are not necessarily addressed effectively by traditional child protection programmes, which often tend to focus on younger children

### 3. Focus Group Discussions
There was strong consensus between what the young people in the FGDs had to say and the information that was provided in the Key Informant Interviews (see Annex 3 for the detailed summaries of the FGD discussions).

The young people in the focus groups had a very clear idea of the problems confronting them (e.g. insecurity, lack of schools, family breakdown) and the priorities for action: protection (in particular for adolescent girls), the opportunity to go to school, and work.

Although there was fairly good knowledge about HIV, there were concerns about the many difficulties of obtaining condoms, including price/free availability and attitudes of service providers (despite many of the key informants having indicated that they were supporting condom distribution), and about girls being unable to negotiate condom use, particularly when this was linked to survival sex but even in the sexual relationships taking place in the IDP camps.

4. Lessons Learned

Not easy!
Responding to the humanitarian crisis in Côte d'Ivoire is challenging for many reasons, including the fact that there are a number of layered crises taking place at the same time with varying levels of chronicity. What needs to be done is often not so difficult to define – but doing it is difficult under the conditions of an emergency.

“Youth” - who are we talking about?
Although the UN defines “youth” as 15-24 years, many countries (Côte d'Ivoire for example) and many regional bodies (e.g. the African Union) define youth as up to 35 years of age. Although the present review was intended to focus primarily on adolescents, it generally dealt more with young people (10-24 years), and mostly with the upper end of this age cohort – data for younger adolescents are mostly unavailable91.

The crisis has exacerbated the vulnerability of adolescents
There is a “perfect storm” in Côte d'Ivoire for undermining ASRH and potentially increasing HIV incidence among young people - the problems may have become exacerbated during the crises, but the statistics indicate that the problem of HIV among young people was not waiting for the crises to happen: early sex, forced sex, low condom use, negative attitudes to condom use for adolescents, negative gender attitudes: giving rise to HIV, STIs, early unwanted pregnancy, illegal abortion, maternal mortality. And with the crises the problems have become worse: increased breakdown of health services and schools, increased sex for money, increased rape and sexual violence, increase social/family disintegration, increased alcohol and substance use.92

The crisis compounds existing problems
Although a crisis may be an entry point and provide opportunities to think about and do things differently, an emergency response cannot solve serious underlying/structural issues, for example poverty, lack of schooling, poor access to services and high

91 This raises a broader question for the global project: in order to ensure more attention to adolescents would there be advantages to linking adolescents with children (i.e. “children and adolescents”), rather than with youth? (taking into consideration the CRC definition of “child”)
unemployment among young people. At the same time, these problems make the response more difficult.

The situation is made more difficult by different crises co-existing
There have been chronic problems in Côte d’Ivoire since 2002 with acute exacerbations (e.g. post-election violence, control of land in the West). Much emergency work is project based, which is not a problem for short-term emergencies, where the challenge is to ensure that the services are provided now, but it is a problem for “chronic” emergencies when there is a need to start rebuilding, with the government, in ways that are sustainable.

The humanitarian response is affected by the state of existing services
What can be done in terms of service provision for adolescents needs to be seen within the socio-economic context of the country more generally, and take into consideration the state of the health and other systems. While it is clear that the crises have exacerbated the situation, the health system had many challenges prior to the crises, for adolescents and for other groups in the population. This stresses the need to think of linking emergency and development contexts, and has important implications both for what is possible during the emergency and also for identifying ways to use the emergency to strengthen the health system overall.

Existing attention to adolescents affects the response
Although there is a recently developed national youth policy in Côte d’Ivoire, it risks facing many of the problems that it identifies in previous youth policies as having made them difficult to implement (e.g. being over-ambitious), and does not deal in any detail with adolescents or adolescents and HIV in emergencies. And while there are many expressions of concern about the vulnerability of young people, this is often not turned into specific actions. If adolescents are not really a priority in the non-crisis situation, are they likely to be one when the crisis comes? This applies to programming for adolescents in general and to interventions for HIV and ASRH in specific?

The importance of advocacy for adolescents
There is a need for more advocacy for adolescents, to ensure that decision makers are clear about:

- Why it is important to focus on adolescents
- What needs to be done (the what?)
- How to do what needs to be done (the how?) i.e. not developing parallel systems

The importance of disaster preparedness
When the crisis occurs, it is not the time to prepare things, to set up structures for coordination, to strengthen the capacity of local organizations, etc. Most crises do not come as a surprise – how can more resources and effort be devoted to disaster preparedness?

The ability to respond depends on pre-emergency activities
In the West of the country UNICEF and partners were in a relatively good position to respond because there had been significant work with young people (through the Réseau Jeunesse) and with youth-serving NGOs, to plan and implement a range of interventions in response to HIV/ASRH, including (e.g. peer educators and school clubs),

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93 USAID Côte d’Ivoire (2010): HIV/AIDS Health Profile
and develop collaboration, capacity, linkages and referral mechanisms. It was this prior engagement and the experiences gained that enabled them to respond in the camps.

**Priority activities**

Many things need to be done for young people in emergencies, and most of these are also needed in non-emergency situations. There is a need to be clear about different things need to be done for adolescents, in comparison with other age groups, and what interventions/settings are the same for adolescent and other population groups, but need to be done differently?

**Different:** schooling, protection/safe spaces, something to do/involvement (peer programmes, involvement in food distribution, working in the clinics, etc.)

**Same-but-different:** information, condom distribution (programmes for adolescents and community members), HIV testing, STI testing and treatment, maternity care, ARVs (interventions for community members and health workers), availability and provision of PEP and emergency contraception. The special needs of adolescents need to be thought about in programmes that are primarily directed to adults (e.g. maternity care) and small children (e.g. OVCs).

**Selecting interventions: A 5S Priority Package**

- Schools
- Safety and safe spaces
- Sensibilization/awareness-raising
- Services and commodities
- Support and something to do (young people can contribute to the response, and being involved contributes to their protection and development)

**Decision-making needs to be nuanced**

Most interventions require a number of things to be in place for them to be effective. The process of prioritizing interventions needs to take this into consideration (e.g. is HIV testing a priority if (a) information and testing are available, but there is no access to treatment; or (b) testing and treatment are available, but there is insufficient support in terms of information and counselling?).

**Importance of acknowledging the links between HIV and ASRH**

It is clear that in terms of determinants and interventions HIV and ASRH are linked. Recommendations have already been made in Côte d’Ivoire for strengthening these linkages.

**The need for clarity about what is being done, by whom**

There are clearly many organizations doing many things in response to the needs of young people in the humanitarian setting, but the coverage and quality are often not at all clear. There is an on-going need for better monitoring (coverage and quality, inputs and outputs/impact) and mapping (with age/sex disaggregation), and meetings to share information and experiences (an inter-agency focus on adolescents and youth).

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94 Many of these activities are being implemented in the West: it would be useful for other humanitarian responses if this could be documented

95 Ensuring that there is an explicit focus on young people in all programmes is an opportunity to set standards in the country for adolescent-friendly health services and initiate training of service providers

96 IPPF, UNFPA, WHO, UNAIDS (2011): Côte d’Ivoire - Rapid assessment of sexual and reproductive health and HIV linkages
Coordination
It is important to ensure that there is a mechanism that provides a forum for bringing together the different organizations and interventions focusing explicitly on interventions for adolescents (directed to HIV and related health problems and determinants), within the UN and with government and other partners (e.g. NGOs). This is important for many reasons including the sharing of experiences and programme support tools, ensuring coverage and quality of priority interventions, and developing advocacy materials and strategies97.

Key Questions

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<tr>
<th>Levels of knowledge and understanding, and implications for actions</th>
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<tbody>
<tr>
<td>1. Is everything that needs to be done being done?</td>
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<tr>
<td>- Yes: monitor coverage and quality (and cost) and start planning for the next phase (sustainable funding)</td>
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<td>- No: find out why not? (surveys, key informant interviews, FGDs)</td>
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<td>- Don’t know: start finding out (monitor, map, share information)</td>
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2. If not, why not?
- Don’t know that adolescents need special attention: advocacy
- Know that adolescents need special attention but don’t know what needs to be done: “what?” guidance, technical assistance and training
- Know what needs to be done for adolescents but don't know how to do it: “how to?” guidance, technical assistance, capacity development
- Know what to do and how to do it, but lack the resources to make it happen: strengthen advocacy and coordination mechanisms

97 The planned national meeting on young people and HIV in the emergency response, that is part of the Joint UN Work-plan, may provide an opportunity to do many things; link HIV and ASRH, explore coverage of interventions (situation analysis), set up coordinating mechanisms that involve many actors, etc.
### Annexes

**Annex 1: Agenda, Côte d’Ivoire, 24-29 September 2012**

**ETUDE SUR LE VIH ET LES JEUNES DANS LA REPONSE HUMANITAIRE**

**23-29 septembre 2012**

**PROGRAMME**

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<td><strong>Arrivée : Dimanche 23/09/ 2012</strong></td>
<td>Arrivée du consultant international à Abidjan</td>
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<td><strong>Jour 2 : Mardi 25/09/ 2012</strong></td>
<td></td>
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<tr>
<td>Heure</td>
<td>Activités</td>
<td>Lieu</td>
<td>Participants/ Responsables</td>
<td>Statut</td>
</tr>
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</tr>
</tbody>
</table>
| 08H00-10H30 | **Visite de courtoisie**  
DGLS : 08H30  
Banque Mondiale: 10H  
RC/ CH : 13H30  
UNICEF :  
PEPFAR :  
**Visite de courtoisie**  
DGLS : 08H30  
Banque Mondiale: 10H  
RC/ CH : 13H30  
UNICEF :  
PEPFAR : | Lieux indiqués | | |
| 11H00-13H00 | **Réunion de travail**  
- Equipe conjointe  
- Coordonnateur de Cluster leads, (éducation, santé, VBG, protection),  
- ONUCI DH, ONUCI/VIH Protection, | ONUSIDA en groupe | | |
| 13H | Pause Déjeuner  
| 14H30 | Visite de courtoisie à UNFPA  
| 15H00 | **Focus Group**  
(Jeunes / Abidjan/Quartiers Yopougon & Abobo, Anyama)  
| | | | |
| **Jour 3 : Mercredi 26/09/ 2012** | | | | |
| 06H00 | Départ pour MAN  
Aéroport GALT/ | ONUSIDA | | |
| 15H00 | Briefing avec les acteurs Humanitaires  
MAN | Point focal UNICEF/ UNFPA / OCHA / UNHCR/ PAM | | |
| **Jour 4 : Jeudi 27/09/ 2012** | | | | |
| 09H00 | Départ pour Duékoué  
Briefing avec les acteurs humanitaires  
Par route | Point focal UNICEF/ UNFPA / OCHA/ UNHCR/ PAM | Security issue | |
| 11H00 | **Focus Group** avec la plate forme de la jeunesse de Duékoué /Interviews  
Duékoué | Point focal UNICEF/ UNFPA/ OCHA/ UNHCR/PAM | Security issue | |
| 13H30 | Pause Déjeuner  
| 15H00 | Retour sur MAN  
| | | | |
| **Jour 5 : Vendredi 28/09/ 2012** | | | | |
| 08H30 | **Debriefing** avec les acteurs humanitaires (fonction de l’heure de départ du vol)  
MAN | Point focal UNICEF/ UNFPA /OCHA/UNHCR/ PAM | | |
| 10H | Retour sur Abidjan  
Aéroport de Man | Point focal UNICEF/ UNFPA /OCHA/UNHCR/ PAM | | |
| 14H | Pause Déjeuner  
|

<table>
<thead>
<tr>
<th>Jour 6: Samedi 29/09/ 2012</th>
</tr>
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<tbody>
<tr>
<td>08H00 Temps libre</td>
</tr>
<tr>
<td>17h30 Départ FHB Airport ONUSIDA</td>
</tr>
</tbody>
</table>

98 Although there had been a plan to have a general debriefing at the end of the mission, this was not possible because of weather-delays in the flights back from Man. However, it was fortunately possible to debrief with ONUSIDA the following morning.
Annex 2: Focus Group Discussions

Synthesized Results of A and B focus group discussions Doukué

1. Have you received information about HIV?
   • Many organizations NGOs providing information
   • A number of NGO carried out awareness campaigns, some with condoms and HIV testing in addition to information
   • Only one person had not had any contact with
   • However, levels of knowledge vary and young people not always doing what they were taught
   • In general though good knowledge about HIV and prevention, but girls don’t use condoms all the time either for the money or for the relationship
   • Many sexual active (Note: two of the adolescent girls participating in the FGD were with their babies)

2. Can young people get access to condoms?
   • Yes, condoms are available, for example from NGOs and small shops (and even the private sector to employees), but they are not available everywhere and not available at all times, and when they are available they are generally not free
   • Need to let young people know where condoms area available and use other structures to distribute the condoms
   • Young people don’t always use them because even though they are cheap (100 CFA for 4) they still cost money, which many young people do not have ... and young people don’t like using them (”have to peel a banana to eat it”)
   • Girls have difficulty negotiating condom use with older men and don't want to spoil things and risk loosing their boyfriend, so don’t always insist

3. Are there any interventions to provide young girls with protection?
   • Yes there are the Centres Sociales, although these are more focused on taking care of girls after abuse etc.
   • There are some activities that give girls some protection (e.g. road cleaning activities involve young girls (gives them preference) and they are protected - other opportunities for income generation are needed and would help
   • However, boys may be jealous of the girls getting special attention and therefore force themselves

4. Have you ever been asked for your opinions about what needs to be done?
   • No!
   • But they have ideas: going back to school for adolescents who had to leave; employment/income generation/training facilities/small loans for the to start working

5. What are the main challenges confronting young people?
   • Lack of schools/loss of education
   • Poverty
   • Lack of social cohesion
   • Sex-based violence and rape
   • Social insecurity/instability
   • Young people not taken into consideration in day-to-day life
• Lack of health services

6. What are the most important things that need to be done for young people?
• Families often very disorganized: what can be done to help?
• Schools
• Economic activities and follow-up/support for those projects that are started (e.g. the small fridges that were provided for one project, but no training about how to upkeep them)
• Funding for youth projects (information and training)
• Young people have been making money from sex (“night work”) and small scale selling
Summary of the Focus Group Discussions in Abidjan (Yopougon and Abobo)

Adolescents between 14 and 21 years of age were included in the Focus Groups, which were facilitated by Mr Bahikoro and Ms Aidah.

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>REPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>What were the main problems facing young people during the emergency?</td>
<td>Sexual abuse and rape of young girls &lt;br&gt; Adolescents mourning the death (murder) of their parents &lt;br&gt; Children attacked and killed &lt;br&gt; Many psychosocial problems &lt;br&gt; Lack of food &lt;br&gt; Lack of health services &lt;br&gt; Insecurity &lt;br&gt; No schools</td>
</tr>
<tr>
<td>Were there any national NGOs or international organizations that implemented activities to protect young girls against sexual abuse/rape?</td>
<td>No, but there were programmes implemented by MESAD, Médecins sans frontières and ONUCI for the victims of rape</td>
</tr>
<tr>
<td>Were there any national NGOs or international organizations that implemented activities for young people?</td>
<td>Very few. MESAD provided nutrition kits in one of the communes.</td>
</tr>
<tr>
<td>What were the main interventions that the government should have carried out during the emergency for young people?</td>
<td>A strong focus on the insecurity that young people faced.</td>
</tr>
<tr>
<td>Have you had any contact with international organizations who provided information to young people but HIV prevention?</td>
<td>No contact with organizations focusing on HIV; only with organizations providing nutrition kits for people in need affected by the emergency.</td>
</tr>
<tr>
<td>Quel devait être le rôle des organisations internationales ou des ONG pour venir en aide aux victimes de violences sexuels ?</td>
<td>- Soutenir les personnes violentées moralement &lt;br&gt; - Faire le test de dépistage &lt;br&gt; - Les référer à des centres comme la croix rouge si elles étaient infectées du VIH</td>
</tr>
<tr>
<td>Were condoms available during the emergency?</td>
<td>There is poor access to condoms (although people who have managed to get hold of them may share them with others who need them)</td>
</tr>
<tr>
<td>Is sexual violence/rape still a problem?</td>
<td>Yes, because there is still a serious level of insecurity.</td>
</tr>
</tbody>
</table>
Annex 3: PNLS and young people

The national plan has highlighted a number of determinants underlying HIV in Côte d’Ivoire that may particularly affect young people, including: the political, economic, social and armed crises; poverty and the general deterioration of living conditions; lack of knowledge about HIV transmission ad methods of prevention; early marriage and multiple partners; cultural practices; the status of women; and population mobility and displacements. The post-election violence has in particular limited people’s access to health services, education and protection.

In addition a number of factors specifically related to young people are highlighted: ignorance about sexuality in general; limited access to information and services necessary for prevention and treatment of HIV/AIDS; lack of understanding by parents and teachers about sexuality; high-risk behaviours, such as early and unprotected sex, and sex with multiple partners (often coerced); inability to negotiate condom use, particularly with older partners.

There does seem to have been some decrease in HIV prevalence (likely to be related to decreases in incidence) in HIV among 15-24 year olds between 1997 and 2008 (despite no change in age at first sex), but in general the quality of the data are not good and most of the data are not disaggregated by age. However, young people are a high-risk group in the plan, particularly those who start having sex early and those who are exposed to sexual violence (and also, of course, young people in all the other particularly vulnerable groups in the plan: sex workers, injecting drug users, MSM, migrants, displaced people, uniformed services, people involved in transactional sex, in alcohol abuse, et.)

Extrait 1.2.1 : 80% des jeunes (12-24 ans) adoptent des comportements sexuels à moindre risque

Stratégies
- Promotion des moyens de prévention contre le VIH et les IST chez les jeunes (prendre en compte la question du sexe intergénérationnel et la communication parent-enfant)
- Développement des programmes de prévention des IST/VIH ciblant les autres jeunes non scolarisés selon les standards
- Renforcement de l’implication des jeunes dans les programmes de prévention ciblant les jeunes
- Création d’un environnement favorable à l’utilisation des services de SR/VIH pour les jeunes

Responsables du Pilotage de la mise en œuvre :
- Ministère en charge de l’éducation
- Ministère en charge de la jeunesse et sport
- Ministère en charge de la famille et des affaires sociales

Partenaires stratégiques
- Les Partenaires Techniques et Financiers
- Réseaux des jeunes
### Tableau 11 : Répartition des coûts de l’axe prévention

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Jeunes</strong></td>
<td>3 273</td>
<td>4 800</td>
<td>4 800</td>
<td>4 582</td>
<td>4 363</td>
<td>21 815</td>
</tr>
<tr>
<td><strong>PS</strong></td>
<td>836</td>
<td>1 302</td>
<td>1 302</td>
<td>1 243</td>
<td>1 184</td>
<td>5 867</td>
</tr>
<tr>
<td><strong>Programmes sur le lieu de travail</strong></td>
<td>2 712</td>
<td>3 977</td>
<td>3 977</td>
<td>3 796</td>
<td>3 615</td>
<td>18 077</td>
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<tr>
<td><strong>HSH</strong></td>
<td>188</td>
<td>275</td>
<td>276</td>
<td>263</td>
<td>251</td>
<td>1 253</td>
</tr>
<tr>
<td><strong>Détenus</strong></td>
<td>727</td>
<td>1 067</td>
<td>1 067</td>
<td>1 018</td>
<td>970</td>
<td>4 849</td>
</tr>
<tr>
<td><strong>Hommes/femmes en uniforme</strong></td>
<td>181</td>
<td>265</td>
<td>265</td>
<td>253</td>
<td>241</td>
<td>1 205</td>
</tr>
<tr>
<td><strong>Fourniture de préservatifs</strong></td>
<td>2 475</td>
<td>3 634</td>
<td>3 634</td>
<td>3 469</td>
<td>3 303</td>
<td>16 515</td>
</tr>
<tr>
<td><strong>Traitement des IST</strong></td>
<td>622</td>
<td>912</td>
<td>912</td>
<td>871</td>
<td>829</td>
<td>4 146</td>
</tr>
<tr>
<td><strong>Conseil et test volontaire</strong></td>
<td>3 701</td>
<td>6 661</td>
<td>9 252</td>
<td>9 252</td>
<td>8 140</td>
<td>37 006</td>
</tr>
<tr>
<td><strong>PTME</strong></td>
<td>2 777</td>
<td>3 498</td>
<td>3 926</td>
<td>4 514</td>
<td>4 300</td>
<td>19 010</td>
</tr>
<tr>
<td><strong>Média de masse</strong></td>
<td>331</td>
<td>486</td>
<td>486</td>
<td>464</td>
<td>442</td>
<td>2 209</td>
</tr>
<tr>
<td><strong>Sécurité du sang</strong></td>
<td>338</td>
<td>496</td>
<td>496</td>
<td>473</td>
<td>451</td>
<td>2 254</td>
</tr>
<tr>
<td><strong>Prophylaxie post exposition</strong></td>
<td>26</td>
<td>39</td>
<td>39</td>
<td>37</td>
<td>35</td>
<td>176</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18 182</td>
<td>27 412</td>
<td>30 432</td>
<td>30 235</td>
<td>28 124</td>
<td>134 385</td>
</tr>
</tbody>
</table>
### Activité 3.1 : Appuyer l'organisation de la réunion nationale consultative sur la priorisation des interventions VIH chez les jeunes pour appuyer l'atteinte des 3 résultats clefs de la prévention du VIH

<table>
<thead>
<tr>
<th>UNFPA</th>
<th>UNICEF</th>
<th>ONUSIDA</th>
<th>115,000</th>
<th>70,000</th>
<th>45,000</th>
</tr>
</thead>
</table>

*• Le rapport de réunion est disponible*

### Activité 3.2 : Apporter un appui technique et financier au MSLS et du Ministère de la jeunesse dans l'élaboration d'un cadre stratégique intégré de prévention du sida chez les jeunes et les adolescents

<table>
<thead>
<tr>
<th>UNICEF</th>
<th>OMS</th>
<th>UNFPA</th>
<th>BM</th>
<th>PAM</th>
<th>ONUSIDA</th>
<th>100,000</th>
<th>50,000</th>
<th>50,000</th>
</tr>
</thead>
</table>

*• Le cadre stratégique intégré de prévention du sida chez les jeunes et les adolescents est disponible*

*• Nombre d’adolescentes et jeunes dépistés et référés*

### Activité 3.3 : Appuyer les ministères en charge de la jeunesse à mettre en œuvre des interventions réduisant la vulnérabilité des jeunes

<table>
<thead>
<tr>
<th>UNICEF</th>
<th>ONUSIDA</th>
<th>PNUD</th>
<th>115,000</th>
<th>85,000</th>
<th>70,000</th>
</tr>
</thead>
</table>

*• Nombre de projets/programmes mis en œuvre*

*• Nombre d’adolescents/jeunes formés en leadership*

*• Nombre d’adolescents/jeunes à l’identification de leurs besoins*

*• Nombre de jeunes formes en gestion des associations et réseaux et vie associative*

### Activité 3.4 : Elaborer et mettre en œuvre un projet conjoint sur la prévention du VIH chez les jeunes

<table>
<thead>
<tr>
<th>UNFPA</th>
<th>UNICEF</th>
<th>SNU</th>
<th>115,000</th>
<th>70,000</th>
<th>45,000</th>
</tr>
</thead>
</table>

*• Nombre de jeunes ayant accès à l’information juste sur le VIH*

*• Nombre de jeunes touchés par les activités de clubs santé et life-skills*

*• Nombre de jeunes dépistés et PEC*

### Activité 3.5 : Renforcer les activités de prévention des IST/VIH/SIDA, VBG et GND en direction des jeunes (en milieu scolaire et non scolaire) et les capacités nationales pour l’élaboration et la mise en œuvre de programmes d’enseignement formel et non formel intégrant l’EVF/EmP et les compétences à la vie

<table>
<thead>
<tr>
<th>UNFPA</th>
<th>UNICEF</th>
<th>SNU</th>
<th>300,000</th>
<th>150,000</th>
<th>150,000</th>
</tr>
</thead>
</table>

*• Nombre de jeunes ayant accès à l’information juste sur le VIH*

*• Nombre de jeunes touchés par les activités de clubs santé*

*• Nombre de jeunes dépistés et PEC,*

*• Nombre de pairs éducateurs formés,*

*• Nombre de facilitateurs formés à l’animation des interventions de prévention*

*• Nombre de jeunes dépistés et PEC*

*• Nombre d’adolescents/jeunes du secteur informel formés sur les lifeskills*

*• Nombre d’établissement intégrant l’EVF/EmP dans le système scolaire*

*• Nombre de prestataires du système scolaire formés à...*
<table>
<thead>
<tr>
<th>Activité 3.6 : Renforcement des capacités nationales pour pourvoir aux services conviviaux de SSR pour les adolescents et jeunes</th>
<th>UNFPA</th>
<th>UNICEF</th>
<th>63 000</th>
<th>50 000</th>
<th>13 000</th>
<th>• Nombre d'agents de santé formés à la PEC des adolescents/jeunes dans le domaine de la SSRAJ</th>
</tr>
</thead>
<tbody>
<tr>
<td>l’animation de discussions interactives sur les IST/VIH, l'usage de la drogue, la violence et l’exploitation sexuelle</td>
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</table>
Haiti Review

1. Setting the scene

Prior to January 2010, many factors in Haiti increased the vulnerability of adolescents to HIV and posed many challenges in terms of responding to the HIV epidemic in the country (and of course to other related sexual and reproductive health problems such as STIs, adolescent pregnancy, abortions and maternal mortality): poverty, weak government structures, inadequate provision of prevention and treatment/care, relatively low levels of educational attainment, frequent emergencies\textsuperscript{99}, civil conflict and unsafe sexual practices\textsuperscript{100}. Haiti was confronted by a generalized epidemic with high rates in key affected populations such as street children, sex workers (8%) and MSM (18%), and significant transmission taking place in the 15-24 year old age group\textsuperscript{101} \textsuperscript{102} \textsuperscript{103} \textsuperscript{104} \textsuperscript{105}.

The earthquake in January 2010 compounded an already difficult situation and increased adolescents' vulnerability to HIV\textsuperscript{106}: approximately 2 million people were displaced, more than 300,000 people died, there were countless injuries and significant psychological trauma; extensive destruction of buildings and production facilities, and negative economic, social and psychological impacts that seriously undermined the quality of life for Haitians throughout the country. In addition to the earthquake elections were conducted in 2010 that resulted in a new president and the replacement of one third of the senate; there was an on-going presence of MINUSTAH (United Nations Stabilization Mission in Haiti); major changes with the management of the grant form the Global Fund\textsuperscript{107} \textsuperscript{108}, and a cholera epidemic with more than 550,000 cases and over 7,000 deaths between October 2010 and June 2012\textsuperscript{109}.

\textsuperscript{99} Fiona Samuels and Helen Spraos Overseas Development Institute (2008): \textit{HIV and Emergencies: Haiti Country Case study}. Many of the problems relating to the current humanitarian response were raised in this report about the response to Tropical Storm Noel, in terms of PLHIV and other aspects of HIV (October 2007)

\textsuperscript{100} Perspectives pour la Santé et le Développement (PESADEV) 2010: \textit{Attitudes et Pratiques des Jeunes et des femmes en âge de procréer dans quatre Communes du Département des Nippes}

\textsuperscript{101} Hempstone H, Diope-Sidibé, N et al (2004): HIV/AIDS in Haiti: A Literature Review

\textsuperscript{102} Ministère de la Santé et de la Population, ONUSIDA (2011): \textit{Base de données et de références bibliographiques des études épidémiologiques, comportementales et du financement de la réponse au VIH/SIDA en Haïti entre 2000 et 2010}


\textsuperscript{104} Yves Marie Dominique Georges (2010): \textit{HIV/AIDS in Haiti. An analysis of demographics, lifestyle, STD awareness, HIV knowledge and perception that influence HIV infection among Haitians}

\textsuperscript{105} USAID (2010): \textit{Haiti HIV/AIDS Health Profile}

\textsuperscript{106} Anecdotal evidence indicating that following the earthquake there were more girls on the streets (more survival sex) and increased adolescent pregnancy; and that 40% of rape victims were adolescents


\textsuperscript{108} PEPFAR and Global Fund have given a firm indication of a reduction in levels of funding in the near future. From previous levels of about US$45m a year in funding, the next Global Fund round is US$34m (maximum offer) over 2.5 years, starting in 2013, and contingent on certain conditions being met.

\textsuperscript{109} OCHA (2012): \textit{Cholera Cumulative Cases and Fatality Rates since November 2010}
The existing national multisectoral HIV/AIDS plan was expanded following the earthquake in order to take into consideration the changing situation that the earthquake brought in its wake. Young people were one of the target groups explicitly mentioned in the plan, which had the following objectives:

1. Continue the implementation of the multisectoral national strategic plan.
2. Ensure the availability of preventive services and care for people living with HIV in temporary shelters.
3. Stimulate effective community involvement in prevention activities and care.
4. Ensure the availability of HIV prevention and care services for people involved in the reconstruction, to ensure that these activities did not increase the spread of HIV.
5. Strengthen the institutional capacity of the public and private sector to restore and extend services for prevention and treatment of HIV/AIDS, in order to respond adequately to the needs of the general population (host populations and displaced populations).
6. Provide assistance to PLHIV and their families.
7. Strengthen monitoring and evaluation in order to assess progress and adapt the planning and strategies.
8. Ensure epidemiological surveillance in temporary shelters and in host communities.

In terms of the response to the earthquake a number of studies have highlighted a range of issues, from the challenges of accessing services to the overall response to protecting women and girls. Despite some positive reports of the response to the earthquake, in general and more specifically in relation to HIV (including explicit mention of young people and ensuring that PLHIV received treatment), significant decreases in the populations in the IDP camps and some suggestions that it was a

112 Human Rights Watch (2011): “Nobody Remembers Us”, Failure to Protect Women’s and Girls’ Right to Health and Security in Post-Earthquake Haiti. This report paints a very bleak picture, with increased vulnerability and decreased services: “The crisis is reflected in pregnancy rates in displaced person camps that are three times higher than in urban areas before the earthquake, and rates of maternal mortality that rank among the world’s worst”.
113 UNICEF (2012): Children Of Haiti: Two Years After. What is changing? Who is making the change?
115 IOM, DPC, IASC (2012): Displacement Tracking Matrix V2.0 Update, 30 April 2012
116 IDP camps 2010 to 2012

<table>
<thead>
<tr>
<th>IDP Pop</th>
<th>IDP camps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-10</td>
<td>1,500,000</td>
</tr>
<tr>
<td>Sep-10</td>
<td>1,300,000</td>
</tr>
<tr>
<td>Nov-10</td>
<td>1,070,000</td>
</tr>
<tr>
<td>Jan-11</td>
<td>800,000</td>
</tr>
<tr>
<td>Mar-11</td>
<td>600,000</td>
</tr>
<tr>
<td>May-11</td>
<td>650,000</td>
</tr>
<tr>
<td>Jul-11</td>
<td>600,000</td>
</tr>
<tr>
<td>Sep-11</td>
<td>570,000</td>
</tr>
<tr>
<td>Nov-11</td>
<td>520,000</td>
</tr>
<tr>
<td>Jan-12</td>
<td>520,000</td>
</tr>
<tr>
<td>Feb-12</td>
<td>490,000</td>
</tr>
<tr>
<td>Apr-12</td>
<td>420,513</td>
</tr>
<tr>
<td>Dec-12</td>
<td>320,000</td>
</tr>
</tbody>
</table>

“wake-up call” about the plight of adolescents in the country, it is clear that many challenges remain\(^\text{117}\) and that a number of these were identified early in the response\(^\text{118}\).

2. Key Informant interviews

Prior to the earthquake, there were a number of national NGOs and some international NGOs actively involved in responding to the SRH and HIV needs of adolescents and youth (much of this explicitly directed to adolescent girls). NGOs had experiences of working with younger adolescents (e.g. MARCH’s 4H programme and the Haitian Red Cross “Together we can” programme), marginalized adolescents, including young LGBTs\(^\text{119}\), adolescents living with HIV\(^\text{120}\) and the development of supportive policies (for example informed consent for younger adolescents using the concept of “jeune émancipé”, that has been written into law).

These NGOs were able rapidly to build on their experiences to respond to the emergency, to mobilize the networks and support groups that they had developed so as to provide information, support and condoms (e.g. women and adolescents – FOSREF, MARCH and the Red Cross); to use materials that had developed prior to the emergency response – materials that had already been endorsed by the government (e.g. the Haitian Red Cross); and to take advantage of their programme experiences (e.g. SEROVIE, promoting approaches to mainstreaming support for marginalized groups of adolescents\(^\text{121}\) and MARCH using their experiences of working with adolescents living on the streets and adolescent sex workers).

Prior to the earthquake the UN agencies were involved in supporting a range of activities directed to HIV, SRH and adolescents (for example PMTCT and life skills education in schools, which had been on-going for several years and was starting to be scaled up just before the earthquake), although much of this was project based. However, despite some coordinating mechanisms, there was little systematic collaboration around young people within the government, within UN agencies or between UN agencies, or between NGOs focusing on young people. The UN funds were

\(^{117}\) Fiona Perry (World Vision), 2010: Situational Analysis of HIV in Haiti Post Emergency: Recommendations for response to HIV in an emergency context

\(^{118}\) UNAIDS (2010): Joint UNAIDS Mission to Haiti March 20-28, 2010: Synthesis Report. The report identified significant problems with coordination, and highlighted a number of priorities: rebuild health systems, protect displaced people from HIV, rebuild the national network of people living with HIV, support social protection measures, revitalize HIV prevention programmes, re-establish comprehensive coordination mechanisms for the aids response, develop a comprehensive monitoring and evaluation mechanism.

\(^{119}\) FOSREF: [http://www.fosref.org/](http://www.fosref.org/)
MARCH Foundation
SEROVIE
VDH: [http://vdhayiti.org/](http://vdhayiti.org/)
PSI: [http://www.psi.org/haiti](http://www.psi.org/haiti)

\(^{120}\) Bertrand R et al (2010): Adolescents, a population with special needs: The GHESKIO experience

\(^{121}\) MSM were particularly vulnerable as they were blamed for the earthquake by some groups and faced many additional challenges in the camps; providing services for adolescent MSM is a challenge, both for the adolescents and for the service providers, even in non-emergency times
generally small in comparison with the major donors (the Global Fund and PEPFAR), and the UN’s comparative advantages were not always clear or acted on (for example leveraging others and strengthening coordination, including supporting the government with standards, training and supervision/monitoring)

For the first three months following the earthquake the UN worked collectively through the UN Joint Team on its comparative advantages, providing significant support for the response, mostly through support for NGOs. It carried out a joint post-disaster needs assessment (IOM, OCHA, UNFPA, UNAIDS), supported information/sensitization and condom distribution, made the case for a need to include issues such as health and education in the post-disaster response (beyond the focus on agriculture and economic/financial concerns), and facilitated collaboration around lessons learned between Haiti and the DRC. Unfortunately the subsequent cholera epidemic diverted much of this initial collaboration/cohesion.

However, despite some positive experiences in the immediate post-disaster response, a major challenge in Haiti was the fact that prior to the earthquake there was no clear or strong overall responsibility for adolescents in general, or for HIV and SRH among adolescents in specific - no central coordinating body or structure for adolescent health (or more broadly for adolescents), no clear champion with overall responsibility for policy/strategy. Despite some efforts to develop a national policy on young people (through the Ministry of Youth and Sports), a national meeting to develop consensus on priorities for programming directed to HIV and young people, a UN Joint Team focusing on HIV and activities in a range of sectors and a person in the Direction de Santé de la Famille, Ministère de la Santé Publique et de la Population, with responsibility for adolescent health, there is not really any strong coordinating mechanism in the country for supporting the government to bring together the different actors around adolescent health, in general or in relation to HIV/ASRH.

Despite the rapid response of some national NGOs, they were not working everywhere and there were no effective on-going mechanisms for collaborating and sharing experiences or programme support tools, either between the national NGOs or to orient

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122 For the first year after the earthquake there was a collaborative effort between UNAIDS, UNFPA, IOM and UNICEF to make condoms available in the IDP camps. UNICEF funded two projects (GESKIO & FOSREF) to address the issue of young people in camps (16,000 youths reached per FOSREF report). Trainings and condoms distribution took place, although some of the momentum was lost as resources were diverted to responding to the cholera epidemic.

123 There were significant differences of opinion among the key informants interviewed about the need for a focus on adolescents, from “while child and maternal mortality are so high adolescents are a problem for the future” to “adolescents are our biggest challenge” to “everyone is concerned, but few are doing”

124 The draft policy has so far not been endorsed by the government

125 The Montana Hotel meeting report

126 Note: The Joint Team focused on HIV in general – it was not set up explicitly to focus on HIV and adolescents


128 In the immediate response to the earthquake there were much broader questions about the effectiveness of the government’s overall coordination of the activities of international NGOs and donations, and its efforts/capacity to avoid duplication
international NGOs and develop standards\textsuperscript{129}; no systems for “getting the big picture” of what was happening for/with adolescents, for assessing and monitoring the overall coverage and quality of the interventions being provided to meet adolescents’ needs. “Because it is being done (somewhere), doesn’t mean that it is being done in a systematic and coordinated way to try to ensure universal access”.

The IASC guidelines were used as the basis of the initial planning of the extended multisectoral AIDS plan, and although most of the core IASC elements have been implemented, it is not clear if they have been implemented in an on-going, systematic and coordinated way? IASC training was carried out\textsuperscript{130}, but it was very generic, and with the exception of the Education section of the Guidelines, there is little explicit focus on adolescents in these Guidelines. Furthermore, the cluster system, which was initially used to plan and support the response, was subsequently taken over by the government, and it is not clear how much focus there was within the clusters on young people (or whether there was any cross-communication between the clusters around adolescents).

\section*{3. Focus group discussions}

Most of the adolescents talked to have been living in the same camp for two years, since the earthquake. The majority were living with their families or relatives, and a number of them were in school.

They were unanimous in the bleak picture that they painted of the time immediately following the earthquake, including psychological trauma, lack of privacy and protection, and specific gender-based issues (violence, sex work and sexual exploitation). And that while some things had improved in the camps, much had not.

Adolescents had received some information about protecting themselves from HIV\textsuperscript{131} but often not much else (they received condoms\textsuperscript{132} when the sensibilisation was done, but not afterwards\textsuperscript{133}: “we use condoms when they are available, but when they aren’t we don’t ...”). The fact that 4 out of the 7 adolescent girls in one of the FGDs either had children or were pregnant provided some indication of the lack of access to/use of condoms or contraceptives.

The young people had many ideas about what needs to be improved, but in general were not being involved in the response, and had not been asked about what they needed (although IOM had made an effort in some of the camps), what they thought should be done or how they could be more actively involved in doing it (see Annex 2 for a more detailed summary of the FGDs with young people).

\textsuperscript{129} The involvement of UN organizations with experience and technical expertise in the development of standards for services for adolescents is likely to be important to ensure that standards are not set too high, but acknowledge that NGOs can do more than the standard, but nobody should be doing less.
\textsuperscript{130} Note: it might be useful to follow-up with the participants of the course to ask them how useful it was, what they learned about adolescents/youth, what they did differently as a result of the training (not possible in the time available)
\textsuperscript{131} In one IDP camp information had only been provided for young women, and only those over the age of 18 years.
\textsuperscript{132} During the key informant interviews there were different opinions about how sensitive the issue of condoms-for-adolescents is in Haiti.
\textsuperscript{133} IOM and other UN organizations had initially been active in supporting condom distribution to adolescents. Currently however, condom distribution has not been made easier by the DSF/FMH taking over responsibility for condom supplies/logistics (there is a UNFPA report on condoms: need to get)
4. Lessons learned

Very challenging work
It needs to be stressed from the start that post-earthquake Haiti was, for many reasons, an extremely difficult setting in which to respond to the many needs of many vulnerable people, including adolescents. What can be done in such situations depends on many things other than knowledge about what needs to be done (e.g. people, money, logistics and supplies), and this is likely to vary over time (from the emergency to the recovery phase).

Importance of Disaster preparedness
It is very difficult to think of what is done during the emergency outside the context of what was being done before the emergency. If there is no real focus on adolescents by the government before the emergency, it is likely to be difficult to get serious attention to this age group during the emergency for example, in terms of PMTC, HIV testing and counselling, and treatment/care: things that are difficult/neglected in normal times are likely to be even more so during emergency situations.

This highlights the importance of disaster preparedness\textsuperscript{134} in a disaster-prone country like Haiti, since frequently it is the same problems and the same vulnerable groups that require assistance before and after emergencies\textsuperscript{135}. At a minimum there needs to be a synthesis of experience and an understanding of the priorities for the response to HIV and adolescents (programme support tools, IEC materials, quality standards) and mechanisms for collaboration between different sectors/actors who need to work together for a coordinated response in emergency situations and in the pre and post-emergency development settings.

Coordination
There needs to be support for the government (the Ministry of Health) to be in the drivers seat for coordinating the response around adolescents and youth and within the UN a process for bringing together the Cluster system around adolescents in general, and adolescents and HIV in specific\textsuperscript{136}. It is important to orient people early to the needs of adolescents and to help them learn from what is already taking place in the country, for example a one-day orientation workshop for decision makers and practitioners, including the involvement of young people (see diagram 1)\textsuperscript{137}.

\textsuperscript{134} It is of course a challenge to identify ways to use some of the emergency funds to support some basic disaster preparedness in disaster-prone countries
\textsuperscript{135} Haiti has not had good experiences with contingency plans: some have remained “on the shelf” and even worst case scenario had not foreseen such a devastating earthquake
\textsuperscript{136} There are many challenges related to this, including the lack of any strong coordination by the government around adolescents and HIV/ASRH in the pre-disaster situation
\textsuperscript{137} Note: this Figure is merely a diagrammatic representation and does not include all of the clusters that included some focus on adolescents in the response to HIV – the Nutrition Cluster for example
Diagram 1: Coordinating the focus on young people within the Cluster system

Linkages: problems, vulnerability and response
HIV and ASRH need to be thought of together - it makes no sense, either in terms of the priority interventions, or in terms of making a compelling case for a focus on adolescents, not to focus simultaneously on HIV and STIs and adolescent pregnancy.

There is a need to link the response to vulnerable adolescents in the IDP camps with groups of adolescents outside the camps who have similar problems (and who, prior to and after the emergency, are likely to coalesce)\(^{138}\), for example adolescents living on the streets and young sex workers (many of who are sexually exploited adolescents). Need to ensure that there is an explicit focus on adolescents in programmes for OVCs\(^ {139} \).

A focus on a few priority interventions
Governments, the UN and others need to be able to focus on a few priority interventions: there is of course much to be done, but if there is not a strategic focus it is not likely to get done\(^ {140} \). There is a need to identify a few do-able interventions that can pull some other interventions behind them (commodity-driven interventions are a good example of this, for example condoms and kits for sexual violence/rape):

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\(^{139}\) USAID (2011): *HAPSAT Haiti: The Sustainability Of OVC Programs*

\(^{140}\) At a global guidance level, there is a challenge between being prescriptive and focused, and being comprehensive and risking being overwhelmed, both during the minimum and the expanded response. Of course there is very little that adults need for HIV prevention/treatment that adolescents do not need (even if they often need to be done differently). But within this, what is essential and could leverage some focus explicitly on adolescents?
• Adolescent girls (and boys) need to be protected from sexual abuse/rape (there are a number of positive experiences of preventing and responding to sexual violence in Haiti\textsuperscript{141});
• All adolescents need to have access to free condoms (and the knowledge and skills to use them);
• Health workers need some minimal orientation to respond to the specific needs of adolescents (STIs, ARVs, pregnancy care)\textsuperscript{142};
• Adolescents need something to do (need to be organized) and to have somewhere to go (schools, safe spaces)

If these activities are not implemented then the response to HIV and ASRH is unlikely to be effective. In general it is likely that a horizontal/integrated approach to adolescents will have more traction than a stand-alone vertical adolescent project, but need to avoid the death-knell of “mainstreaming”\textsuperscript{143}

**Data collection and analysis**
Guidance needs to be available for/from the UN so that a good and systematic situation analysis can rapidly be carried out, including the involvement of young people themselves (who/where are the particularly vulnerable adolescents e.g. adolescents without families) and need to be able to make the adolescent age group visible in the data collection (in Haiti they were hidden in the 0-14, 15-49 age groupings), and to be able to identify specific gender differences among adolescents that are important for the response\textsuperscript{144} (e.g. sanitary needs of adolescent girls). Need systems for monitoring the response and for listening to young people in the emergency and subsequent phases (some experience of doing this in Haiti\textsuperscript{145}).

**Guidance on “how to do it?”**
There is extensive guidance available for responding to HIV in humanitarian emergencies: in general\textsuperscript{146 147 148 149 150 151}, in relation to young people\textsuperscript{152 153 154}, in terms

\textsuperscript{141} Brigade de vigilance, training young people and women to watch out for each other and react, lighting in sanitation facilities and more generally, safe spaces for adolescents (schools outside of school hours), stay in groups, whistles ... lessons learned from pre-emergency programmes to prevent rape among sex workers

\textsuperscript{142} There are some good experiences of training community health workers to work in the camps (in terms of adolescents responding to: fever, STIs and pregnancy) and the development of systems for referral between the camps and health facilities outside the camps (IOM). But again, what is the coverage and follow-up/supervision overall?

\textsuperscript{143} For example, in Haiti the UBRAF priorities are: Vulnerable Groups; PMTCT; Stigma; and Women and girls. Adolescents should be crosscutting issue in all of these priorities.

\textsuperscript{144} Gender in Humanitarian Response Working Group (2010): *Gender Mainstreaming in the Humanitarian Response in the Aftermath of the Earthquake in Haiti* - many of the more general recommendations on gender are also applicable to the situation of adolescents (e.g. the need for inter-cluster coordination and post-disaster needs assessment)

\textsuperscript{145} Plan (2010): *Anticipating the future: Children and young people's voices in Haiti's Post Disaster Needs Assessment (PDNA)*

\textsuperscript{146} IASC (2009): *Guidelines for Addressing HIV in Humanitarian Settings*

\textsuperscript{147} Women's Commission for Refugee Women and Children (2004): *HIV/AIDS Prevention and Control: A Short Course for Humanitarian Workers*

\textsuperscript{148} WCRWC (2011): *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: a distance learning*

\textsuperscript{149} Inter-agency Working Group on Reproductive Health in Crises (2010): *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*

\textsuperscript{150} CAFOD: *Development and disasters in a time of AIDS: An HIV mainstreaming toolkit*
of different sectors and within the context of ASRH. The content of “What needs to be done?” seems to be well covered – and there seems to be good consensus about the priorities.

Where additional guidance may be useful is to focus on “how to do it?” (how to set up coordination, how to protect adolescent girls (and boys) from sexual abuse: brief case descriptions, how to quickly get a working group on adolescents up and running?) - need to document some good practice (short and sharp): to demonstrate that what needs to be done is do-able.

**Advocacy for adolescents**

It is important that guidance is provided for advocacy for a focus on adolescents who are the neglected of the neglected: within the emergency response HIV may not be seen as a priority, within HIV young people may not be a priority, and among young people the 10-19 year olds (the adolescents) may be less of a priority – less vocal and more hidden/vulnerable (and HIV may be well down the list of priorities for adolescents themselves). There is a need to help countries make a compelling case, focusing on key problems and evidence-informed interventions (for HIV and ASRH).

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152 Groupe de travail inter-agences (IATT) sur le VIH et les jeunes (2010): *Notes D’information Globales Actions VIH en faveur des jeunes*


156 The Sphere Project and the Inter-Agency Network for Education in Emergencies (2009): *Integrating Quality Education With Humanitarian Response For Humanitarian Accountability: The Sphere-INEE Companionship*

157 Save the Children, UNFPA (2009): *Boîte à outils pour la santé sexuelle et reproductive des adolescents en situations de crise humanitaire*


159 Women’s Commission on Refugee Women and Children (WCRWC): *A Resource List for Adolescent Reproductive Health Programming in Conflict Settings*


161 UNHCR, WCRWC (2007): *Work with Young Refugees to Ensure Their Reproductive Health and Well-being: It’s Their Right and Our Duty.*


163 IASC (2010): *The need for HIV/AIDS interventions in emergency settings* - there is very little in this document that deals explicitly with adolescents
## Annexes

### Annex 1: Agenda: Haiti, 3-9 June 2012

#### Day 1
**Sunday**
**3 June 2012**

<table>
<thead>
<tr>
<th>Time</th>
<th>Theme</th>
<th>Venue</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:45</td>
<td>Arrival in Port au Prince</td>
<td>Aéroport International de Port au Prince</td>
<td></td>
</tr>
<tr>
<td>10:15</td>
<td>Travel to hotel</td>
<td>Hotel La Reserve</td>
<td>Bruce Dick, Carlot Auguste (driver)</td>
</tr>
<tr>
<td>16:00 – 17:00</td>
<td>Welcome</td>
<td>La Reserve</td>
<td>Bruce Dick, Kate Spring, Other?</td>
</tr>
</tbody>
</table>

#### Day 2
**Monday**
**4 June 2012**

<table>
<thead>
<tr>
<th>Time</th>
<th>Theme</th>
<th>Venue</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00</td>
<td>Pick up from hotel</td>
<td>La Reserve</td>
<td>Ernesto Guerrero</td>
</tr>
<tr>
<td>09:00 – 10:00</td>
<td>Day 2 Debrief</td>
<td>UNAIDS</td>
<td></td>
</tr>
<tr>
<td>10:00 – 13:00</td>
<td>Meet with support team? Drive around PAP to see locations of camps</td>
<td>UNAIDS</td>
<td>TBC, Translator? Field support?</td>
</tr>
<tr>
<td>13:00 – 14:00</td>
<td>Lunch</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>14:00 – 16:30</td>
<td>Meet with partners</td>
<td>TBC</td>
<td>TBC, UNAIDS, FNUAP, UNICEF, IOM, UNDP, OMS</td>
</tr>
<tr>
<td>16:30</td>
<td>Return to base</td>
<td></td>
<td></td>
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</tbody>
</table>

#### Day 3
**Tuesday**
**5 Jun 2012**

<p>| Time     | Theme       | Venue       | Participants |
|----------|-------------|-------------|--------------|--------------|
|          |             |             |              |              |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Theme</th>
<th>Venue</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00</td>
<td>Pick up from hotel</td>
<td>La Reserve</td>
<td></td>
</tr>
<tr>
<td>08:30 – 09:00</td>
<td>Day 3 Debrief</td>
<td>UNAIDS</td>
<td></td>
</tr>
<tr>
<td>09:00 – 09:45</td>
<td>Travel time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:45 – 12:00</td>
<td>Courtesy call <em>(Min Health, Women, Youth or Social Affairs)</em></td>
<td>TBC</td>
<td>DR.Douyon/Dr.Deans</td>
</tr>
<tr>
<td>12:00 – 12:45</td>
<td>Travel time</td>
<td></td>
<td></td>
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<tr>
<td>12:45 – 13:45</td>
<td>Lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:45 – 14:30</td>
<td>Travel time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00 – 16:00</td>
<td><em>Site visit to NGO? Eg FOSREF Lakay or VDH</em></td>
<td>TBC</td>
<td>Marche OMS</td>
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**Day 4**
**Wednesday**
**6Jun 2012**

<table>
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<tr>
<th>Time</th>
<th>Theme</th>
<th>Venue</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00 – 08:30</td>
<td>Day 2 Debrief</td>
<td>Croix Rouge Haitienne</td>
<td>Dr.Sherley Bernard (+509-44381247) Inf.Sherline Dodié Mlle Tessa Jean Pierre</td>
</tr>
<tr>
<td>08:30 – 09:15</td>
<td>Preparations for Joint Team</td>
<td>UNAIDS</td>
<td></td>
</tr>
<tr>
<td>10:00 – 12:30</td>
<td>JOINT TEAM MEETING</td>
<td>UNAIDS</td>
<td></td>
</tr>
<tr>
<td>12:30 – 13:30</td>
<td>Lunch</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td>14:00 – 16:00</td>
<td><em>Meet with NGO stakeholders</em></td>
<td>UNAIDS</td>
<td>FOSREF/VDH/Marche</td>
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</table>

**Day 5**
**Thursday**
**7Jun 2012**

<table>
<thead>
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<th>Time</th>
<th>Theme</th>
<th>Venue</th>
<th>Participants</th>
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<tbody>
<tr>
<td>09:00</td>
<td>IMIS meeting</td>
<td>IMIS</td>
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</tr>
<tr>
<td>10:00</td>
<td>Early lunch for the team?</td>
<td>??</td>
<td></td>
</tr>
</tbody>
</table>
11:00 – 11:45 | travel - UNAIDS office/IMIS to Tabarre (Mega 4) | Travel
11:45 – 12:00 | Introduction of Focus Group Discussion | Mega 4
12:00-13:30 | Focus Group Discussion | Mega 4
13:40 - 14:20 | Travel from Tabarre to Marassa 9 (Croix de Bouquet) | Travel
14:30-14:45 | introduction of FGD | Marassa 9
14:45- 16:15 | Focus Group Discussion | Marassa 9
16:30 | Back to base |

**Day 6**
**Friday**
**8 Jun 2012**

<table>
<thead>
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<th>Time</th>
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<th>Venue</th>
<th>Participants</th>
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<tbody>
<tr>
<td>08:00-09:00:</td>
<td>Travel from UNAIDS office to HUEH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>09:00- 10:00</td>
<td>Meeting with staff, clients?</td>
<td>HUEH</td>
<td></td>
</tr>
<tr>
<td>10:00-10:30</td>
<td>travel to GHESKIO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00 – 12:00</td>
<td>Meeting with staff, clients?</td>
<td>GHESKIO</td>
<td></td>
</tr>
<tr>
<td>12:00-13:30</td>
<td>Lunch</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>13:30 – 14:00</td>
<td>Travel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Introduction</td>
<td>Teleco Sans Fil</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Theme</td>
<td>Venue</td>
<td>Participant</td>
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</tr>
<tr>
<td>14:15:14:30</td>
<td>Introduction of FGD</td>
<td>TSF</td>
<td></td>
</tr>
<tr>
<td>14:30-16:00</td>
<td>Focus Group Discussion</td>
<td>TSF</td>
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<tr>
<td>16:15</td>
<td>Travel back to base</td>
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**Day 7**

**Saturday**

**9 Jun 2012**

<table>
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<th>Time</th>
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<tbody>
<tr>
<td>??</td>
<td>Depart for Airport</td>
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</table>
Annex 2: Focus Group Discussions

Questions for focus group discussions with young people (Haiti)

1. Introductory warming-up questions:
   a. How long have you live in this camp?
   b. Have you lived in other camps?
   c. Are you living with your parents?
   d. How do you keep yourselves busy during the day?
2. What were the main problems for you immediately after the earthquake?
3. How did the problems after the earthquake differ for girls and boys?
4. How have things changed since the earthquake?
5. Is anything being done especially for young people in this camp?
6. Have you had any contact with organizations that provide information on young people about HIV?
7. Are (free) condoms available to young people in this camp if they need them?
8. Do young people in this camp have health services that they can go to?
9. What do they say about the services?
10. Is there anything being done in this camp to protect young girls?
11. What was good about what was done after the earthquake?
12. What didn’t work well after the earthquake?
13. Have you or any of your friends been involved in activities in the camp?
14. Have you ever been asked about what you think should be done for the young people in the camp?
15. What are the main challenges facing young people in the camps?
16. What are the most important things that need to be done in the camps for young people (that aren’t being done)?

Results: Teleco Sans Fil IDP Camp

1. Introduction
   a. 2 years
   b. The same camp
   c. One orphan
   d. School-studying- Home stuff (food preparation, cleaning)-playing soccer in the streets-TV-church-group discussion-cultural things-theatre

2. Big problems
   a. Too much deaths/too much persons with handicap
   b. Too much collapsed buildings
   c. Loss of friends
   d. Loss of relatives
   e. Nightmares from the time spent under “dekomb”
   f. More international people help Haitians instead of Haitians themselves
   g. Life under tents is not a life, you just try to survive
   h. Security and safety problems in the camp

3. Yes, young girls left family tent and went to live alone and we saw more really young couples, more rapes. We saw :
   a. More rapes
b. More early pregnancies
c. More delinquencies
d. More safety and security issues

4. The situation became more sad, more bad

5. Yes trainings: about health issues, about social behaviour, about sexual violence. In the camps we had more information. People became more indolent, more dependent. No real available place for inviting friends: felt bad to let them come and visit them under tents.

6. IOM (mainly about health, and specifically AIDS/and other STI), IRC, KOFLA, MO-IRJ: health, cultural, educational, recreational activities (dancing, singing,)

7. Yes, we just have to ask (from IOM health workers)

8. Only for cholera (IOM ORPs), health centre far away (30 minutes by walking)

9. Access to services is ok

10. No, we had to protect ourselves
   a. If we can have trainings for specific issues: early pregnancies, how to protect our community members

11. A lot of trainings, housing options: tents; decontamination products for cholera, condoms, mosquito nets, distribution of NFI; recreation activities: beach;

12. Too much delinquency
   a. No space for bathing
   b. No intimacy

13. Yes, almost:
   a. Parties for most common things: mother’s day, specific holidays

14. The first time this kind of meeting has been held

15. Education- Lack of health centres; trainings about main issues; help young people develop constructive thoughts - same chances for everyone: forum between rich and poor teenagers (activities can be planned all together: library access, theatre); authorities need to care about main concern of young people and have to talk with them and involve them in their plans for young people. Education without “limitations”, without borders

16. Libraries-professional schools-recreation spaces - a “free space for sharing, for discussions”; relocation; art school; sports space.

Note: funds to help for personal development among young people

**Results: Mega 4 IDP Camp**

1. Intro
   a. Mega 4 camp (1077 families)
   b. 5 girls and 13 boys
   c. They lived there since 2 years
   d. No the same camp
   e. 3 are orphans, some of them are living with other relatives
   f. Some go to schools, one has financial issues and he left.
   g. This is the first focus groups for teens
2. What were the main problems for you immediately after the earthquake
   a. Housing
   b. During the first days The life under the stars / after The life in the camps
   c. Sexual violence
   d. Lot of people didn’t accept the principle of volunteer
   e. No help for orphans
   f. No school
   g. No space for recreation
   h. No personal latrine
   i. No light /safety problems/

3. How did the problems differ for girls and boys?
   a. No personal Space for bath for girls
   b. Prostitution due to lack of money for eating, drinking, etc.
   c. Loss of parents during the earthquake affect equally girls and boys

4. How have things changed since the earthquake?
   a. No changes!
   b. No activities for young people
   c. The same bad life under the tents
   d. Too much problems
   e. No one thinks to provide a space for handiwork, or other professional activities
   f. After high school, no more opportunities

5. Is anything being done especially for young people in this camp?
   a. Soccer/ but no more balls!
   b. Training about health issues (HIV/STI/MCH/Malaria/Dengue); protection; human rights
   c. VCT for STI
   d. ONG activities are more related to eat fish than fish it!
   e. CASH for work
   f. No job opportunities after training
   g. No more recreation activities

6. Have you had any contact with organizations that provide information to young people about HIV?
   a. IOM/REDCROSS/CITYMED
   b. Churches

7. Are free condoms available to young people in this camp if they need them?
   a. No fix point
   b. Sporadic distribution
   c. We bought but generally they had unsafe sex

8. Do young people in this camp have health services that they can go to?
   a. No regular health services access
   b. No health centre
   c. Call ambulance: *300 or 116
   d. Or they have to pay
9. What do they say about the services?
   a. Waste of time before finding services
   b. An ORP (IOM) helps for diarrhoea cases
   c. Community approach: after some specific sensitization they received materials (mosquito net, condoms)

10. Is there anything being done in the camps to protect young girls?
   a. Training about sexual violence
      i. Their rights
      ii. How they can reach authorities
      iii. Where they have to go for specific cares

11. What was good about what was done after the earthquake?
   a. How they can protect their life
   b. Prevention for health issues
   c. Products for decontamination

12. What didn’t work well after the earthquake?
   a. World vision started registration for orphans: but no help
   b. Submission of requests for specific needs (recreation): nothing has been done

13. Have you or any of your friends been involved in activities in the camp?
   a. YES: CASH for WORK
   b. Training

14. Have you ever been asked about what you think should be done for the young people in the camp?
   a. This is the first focus groups for teens

15. What are the main challenges facing young people in the camps?
   a. No real and comfortable places to live (housing issues)
   b. No Schools
   c. No Job opportunities
   d. No Recreation: cultural activities, religious activities, disco, beach parties,

16. What are the most important things that need to be done in the camps for young people (that aren't being done)?
   a. Foster families for orphans
   b. Professional schools for learning
   c. Social assistance /Health assistance (insurance)
   d. Centres to help them manage stress
   e. Increase number of latrines/increase number of light points
   f. Relocation

What follow up do they expect?
   Light
   Centre for recreation
   Safety/Security